ATTACHMENT 4.11-A

Standards for Institutions

KANSAS MEDICAID STATE PLAN

Attachment 4.11-A

Standards for Institutions

The following institutions may provide medical care and services under the Kansas Medicaid State Plan.

1. Public and private general hospitals.

2. Public and private institutions for the mentally ill.

3. Public or private skilled and intermediate care facilities, licensed as such by the Kansas Department of Health and Environment, and, in addition, those which have been determined to meet the requirements for skilled and intermediate care facilities as specified in the Kansas Administrative Regulations.

The institutions specified above are subject to the following standard-setting authority(ies):

1. Public and private general hospitals must be licensed by the Kansas Department of Health and Environment, and certified by Medicare.

2. Public and private institutions for the mentally ill are subject to the standard-setting authority of the Division of Mental Health and Retardation Services, Department of Social and Rehabilitation Services. They must be either certified by Medicare for those age 65 and over, or accredited by the Joint Commission on Accreditation of Health Care Organizations for those under age 21 (or under age 22 if in the hospital on their 21st birthday).

3. Public and private skilled and intermediate care facilities are licensed by the Kansas Department of Health and Environment, and, in addition, have been determined to meet the requirements for skilled nursing facilities as specified in the Kansas Administrative Regulations.

ATTACHMENT 4.14-B

Utilization Review for Intermediate Care Facilities

KANSAS MEDICAID STATE PLAN

Attachment 4.14-B

This attachment is deleted. Reference the change to 4.14 (e), page 50, MS-85-5.

re: Utilization + QC of ICFs

TN# MS-85-5 Approval Date 2/27/85 Effective Date Jul 1, 1985 Supersedes

2740M

AGREEMENT BETWEEN THE

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

AND THE

KANSAS STATE DEPARTMENT OF EDUCATION

THIS AGREEMENT entered into by and between the Secretary, Kansas Department of Social and Rehabilitation Services, hereinafter referred to as "SRS", and the Commissioner of Education, Kansas State Department of Education, hereinafter referred to as "KSDE".

WHEREAS, the purpose of this agreement is to expand services provided to children of this state; and

WHEREAS, SRS is authorized by K.S.A. 39-708C, to enter into a contract for services; and

WHEREAS, KSDE is desirous of entering into this contractual relationship;

NOW, THEREFORE, the parties agree to the terms and conditions as hereinafter set forth, to wit:

KSDE WILL:

1. Develop service description and quality standards for covered services in accordance with Federal and State laws and regulations.

2. Assure that each Local Education Agency (LEA) specifies the services required for the treatment of each recipient in an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) in accordance with Federal and State law and regulations.

3. Notify SRS of LEA providers approved to deliver covered services, and promptly notify SRS of any additions or deletions.

4. Provide technical assistance and consultation to LEA providers as needed to implement this agreement.

SRS WILL:

1. Determine maximum reimbursement levels for services.

2. Enroll qualified LEA providers.

3. Provide workshops, manuals, and technical assistance regarding billing procedures for service providers.

4. Determine client eligibility for Medical Assistance.

5. Make payments to LEAs based on claims submitted by enrolled LEA providers.

6. Provide a quarterly report to each LEA reflecting payments for covered services.

IN WITNESS WHEREOF, the parties hereto have affixed their signatures the date first above written.

By: _____ By: _____

Title: Secretary of Social and Rehabilitation Services

Title: Commissioner of Education

Date: 9-18-90

Date: 9/7/90

Agreement Between
Alcohol and Drug Abuse Services
and
The Division of Medical Programs within
Income Maintenance and Medical Services
Kansas Department of Social and Rehabilitation Services

I. Purpose of Agreement

The purpose of this agreement is to satisfy the requirements of 42 CFR 431.615.

This Agreement is entered into between the Division of Medical Programs (DMP) within Income Maintenance and Medical Services (IMMS), and Alcohol and Drug Abuse Services (ADAS) for the mutual objective of providing reimbursement for alcohol and drug addiction treatment to Medicaid and MediKan eligible individuals in community alcohol and drug addiction treatment facilities and in other facilities appropriate to a recipient's individual needs.

II. Definition of Terms

A community alcohol and drug addiction treatment facility provides alcohol and drug addiction counseling, guidance, supervision and personal services to people living within a licensed/certified, medically-oriented, 24-hour facility in accordance with ADAS licensing standards.

A community alcohol and drug addiction treatment facility may also provide day treatment. Day treatment is the delivery of alcohol and drug addiction services and supportive services on less than a 24 hour a day basis. Programs must average at least 15 hours per week of structured activities and 8 hours per week of counseling services per recipient.

III. Responsibilities of Alcohol and Drug Abuse Services

1. Arrange funding and develop appropriate community treatment services for indigent clients needing alcohol and drug addiction intermediate or day treatment services within approved budget constraints.

2. Utilize state funds transferred from the Medical Assistance budget to augment other ADAS funds to provide a continuum of services for indigent clients.

3. Ensure the availability of space to provide an alternative service to the drug and alcohol addiction rehabilitation service currently provided in the hospital inpatient facilities within approved budget constraints.

4. Assure that state match dollars are available through the ADAS grant process prior to the start of each fiscal year. Maintain documentation for each facility reflecting the available state match at any given time during this year for federal review purposes.

5. Provide a certification statement to DMP within three weeks after the end of a quarter stating that state funds were available to match the federal funds.

6. Notify DMP of any facility's loss of licensure in a timely manner.

7. Accept responsibility for federal financial penalties or adjustments which result if it is found on retrospective review or audit that state funds were not available to match federal funds.

IV. Responsibilities of the Division of Medical Programs within Income Maintenance and Medical Services

1. Submit and obtain federal approval of contracting process, contract documents and this agreement.

2. Provide State General Fund monies to ADAS to be used to develop treatment services to operate within the intent of this agreement. The actual amount of transfered monies will be decided by the Governor, Legislature or through negotiation between ADAS and IM & MS.

3. Coordinate federal reviews, if any.

4. Enroll qualified treatment providers and designate to the fiscal agent those who will receive reimbursement. Determine individual reimbursement rates and notify the fiscal agent.

5. Provide workshops, manuals and technical assistance regarding billing procedures for service providers.

6. Determine client eligibility for Medical Assistance.

7. Notify the fiscal agent of routine and special reports necessary for the administration of this activity.

V. Joint Responsibilities of IMMS and ADAS

1. Promote service implementation and usage by Medicaid/MediKan recipients by coordinating plans directly and indirectly related to the services within the scope of this agreement provided to or arranged for recipients.

2. Cooperatively implement utilization review procedures.

3. Cooperatively solicit bids and engage in contracting activities with qualified facilities. This includes:

   a. Writing IFBs or RFPs, addenda, contracts and other documentation necessary for contracting activities.

   b. Interface with the Kansas Department of Administration, Division of Purchases, in the contracting process.

   c. Evaluate bids/proposals, and make recommendations for awards.

   d. Participate in contract negotiations, if held.

4. Develop and maintain documentation which satisfies federal and state requirements. Participate in federal reviews, if any.

5. Annually engage in fiscal planning based upon budgetary decisions.

6. Develop and exchange reports, as necessary, concerning services provided to recipients.

VI. Periodic Review and Joint Planning for Changes in the Agreement

This agreement will be reviewed on an annual basis. The review and joint planning for changes in this agreement will be held at least one month prior to the anniversary date of this agreement.

VII. Continuous Liaison Between the Parties and Designation of Staff Responsible for Liaison Activities

Liaison will be maintained by the Commissioner of Alcohol and Drug Abuse Services and the Commissioner of Income Maintenance and Medical Services or their designees.

VIII. Joint Evaluation of Policies that Affect the Cooperative Work of the Parties

Policies that affect cooperative work of both Commissions will be jointly reviewed and signed off prior to implementation. Differences in policies will be resolved through joint discussion. Operational disagreements which become apparent in the course of this Agreement shall be resolved by discussions between the concerned parties at the organizational level closest to its problem.

IX. Duration of Agreement

This agreement shall continue until it is revised or terminated. Revision or termination may be accomplished by either party by giving ninety days written notice or by mutual consent and the return of any unspent (after reimbursement/match adjustment) state dollars indicated in IV. 2. above for the current state fiscal year.

X. Signature

WHEREAS Income Maintenance and Medical Services and Alcohol and Drug Abuse Services do hereby agree to the terms and conditions of the Agreement as specified herein effective with the signature of both Commissioners.

Commissioner of Income Maintenance and Medical Services

Commissioner of Alcohol and Drug Abuse Services

May 29, 1990
Date

4-27-90
Date

AGREEMENT BETWEEN THE SECRETARY OF SOCIAL AND REHABILITATION SERVICES OF KANSAS AND THE SECRETARY OF HEALTH AND ENVIRONMENT OF KANSAS

THIS AGREEMENT by and between the Secretary of Social and Rehabilitation Services of Kansas on behalf of the Kansas Department of Social and Rehabilitation Services (SRS) as the single State agency for administration of the Kansas Medicaid Plan (pursuant to 42 U.S.C. 1396a et seq.) and the Secretary of Health and Environment of Kansas on behalf of the Kansas Department of Health and Environment (KDHE) is entered and effective on June 18, 1989. This agreement shall be in effect through June 30, 1990, and may be extended for specific periods beyond that time by mutual written agreement of the parties.

I. MUTUAL OBJECTIVES

The purpose of this agreement is to provide for the orderly transfer and funding of inspection of care (IOC) team services as organized and performed under the requirements of 42 C.F.R. Part 456, Subpart I, from the Department of Social and Rehabilitation Services to the Kansas Department of Health and Environment. This transfer is to be conducted so that SRS, as the single State Medicaid agency, will remain in compliance with all requirements of the Medicaid Program pursuant to 42 U.S.C. 1396a et seq. and 42 C.F.R. Part 430 et seq. Particularly all efforts are to be made that the transfers are to be orderly, of minimum inconvenience to the affected employees, of minimum disruption to the functions of the IOC teams, and to avoid any resulting disallowances and deferrals of any federal financial participation (FFP).

II. OBLIGATIONS OF EACH AGENCY

A. KDHE Responsibilities:

1. Duties - KDHE shall perform the following duties. Wherever applicable, the requirements of 42 U.S.C. 1396a(a)(26) and (31) and of 42 C.F.R. Part 456, Subpart I shall be fully met.

   a. KDHE agrees to receive and orderly arrange the employment transfers of all SRS employees as mutually agreed with SRS. KDHE will assume payroll payment responsibilities from June 18, 1989.

   b. KDHE will utilize all of the transferred employees in duties directed to first meet the priority requirements of the Kansas Medicaid Program during all periods in which this agreement is in effect. All such priorities shall be determined by SRS.

   c. KDHE agrees to complete an annual review on each home and community-based services (HCBS) recipient prior to the anniversary date of each such recipients agreement. Such reviews shall be from a list furnished from SRS on the 20th day of the last month of each calendar quarter.

d. KDHE agrees to annually review all certified adult family homes to confirm compliance with K.S.A. 39-1501.

e. KDHE agrees to take all review actions necessary to then send information necessary to SRS for the completion of the HCFA quarterly showing that is due to the HCFA Regional Office 30 days after the close of each quarter. The information shall be furnished to SRS no later than 10 days following each quarter. A copy of the completed quarterly showing shall be returned to KDHE.

f. KDHE agrees to review utilization review billings and to make payments for services rendered, subject to upper limits approved by SRS.

g. KDHE agrees to have professional personnel review heavy care prior authorization requests and to make evaluations as to whether subsequent billings are consistent with cost to the provider. KDHE will make recommendations when called upon by SRS on heavy care prior authorization requests.

h. KDHE agrees to have the IOC/UR/MR teams continue to complete and forward the MS-2008 forms to SRS.

i. KDHE agrees to contract for a physician as a part of the utilization review process.

j. KDHE agrees to contract for a physician to assist and be a part of the annual medical review of the State Institutions for Mental Disease.

k. KDHE agrees to maintain the utilization review contract with the Medical Society of Sedgwick County and to reimburse them for their services.

l. KDHE agrees to allow and maintain contact to SRS with the transferred employees for all necessary preparations and appearances in any hearing appeals or judicial actions that may arise from or related to any action or duties of such employees. All such preparations and appearances shall be given priorities as determined by SRS.

m. KDHE agrees to maintain all records pertaining to the services of this contract for a period ending five years from the expiration date of this contract.

n. KDHE agrees to take all actions necessary and to perform all of its duties with due diligence to follow all applicable requirements of the Medicaid Program and to avoid any sanctions and penalties to the Kansas Medicaid Program related to such duties.

2. Delegation of Authorities - KDHE agrees that its duties under this agreement are delegated in conformity with the requirements of 42

C.F.R. 431.10 and that SRS retains all discretion and authorities necessary to act as the single State agency for the administration of the Kansas Medicaid Plan. KDHE agrees that all employees assigned to IOC team services shall be considered as contract agents of the single State medicaid agency, SRS, for the purposes of the administration of the Kansas Medicaid Plan.

B. SRS Responsibilities:

1. Duties - SRS shall perform the following duties. Wherever applicable, Medicaid requirements shall be given priority.

   a. SRS shall pay for all expenses, except payroll, of the IOC teams through June 30, 1989. SRS shall provide KDHE with the personnel records of the transferred employees. SRS shall provide KDHE with agreed office equipment on the attached list for the transferred employees. This list may be modified as mutually agreed by the Secretaries or their designees. SRS shall allow the transferred employees to temporarily remain as agreed in SRS offices.

   b. SRS shall make available to KDHE a listing of adult care homes and swing be hospitals participating in the Medicaid Program quarterly.

   c. SRS agrees to provide a psychologist to assist with the ICF-MH annual reviews.

   d. In the event of limited resources or extended growth, SRS shall set the priorities for the workload. These priorities are in the following order: regular IOC reviews, UR's, HCBS reviews, and case mix assessments.

   e. SRS agrees to timely send a listing of facilities that need to be reviewed quarterly to KDHE. SRS reserves the right to modify such lists to meet Medicaid priorities.

   f. SRS agrees to provide all necessary forms to KDHE as required for services under this agreement.

   g. SRS agrees to provide necessary Medicaid Bulletins from its fiscal agent to KDHE.

   h. SRS agrees to provide such legal services as it deems necessary for advice to and representation of the IOC teams.

   i. SRS agrees that it will take such actions and send such notices as it deems necessary from IOC team reports and findings. SRS agrees that it will provide all legally required due process proceedings for review of such actions and notices.

2. Restriction on Delegations - SRS agrees that any duties delegated under this agreement are subject to al necessary restrictions of 42 C.F.R. 431.10 and that SRS retains all discretions and authorities

necessary to act as the single State agency for the administration of the Kansas Medicaid Plan.

III. COOPERATIVE RELATIONSHIPS

A. Meetings - To further the functioning of this agreement, a meeting shall be held at least quarterly between the staffs of the two agencies. SRS shall call, chair, and document the meetings.

B. Training - Each agency agrees to provide, upon its own request or the request of the other agency, necessary training programs for the staff of the other agency.

IV. FINANCIAL AGREEMENT

Payments to KDHE for services under this agreement shall be pursuant to the Governor's Budget Amendment No. 3, Item No. 4, for FY 1990 and shall not exceed $1,206,880 for the base period of this agreement. The payment process shall be construed and applied to meet all applicable Medicaid requirements.

V. CONSTRUCTION AND APPLICATION OF AGREEMENT

This agreement shall be construed and applied to be in conformity with all federal Medicaid requirements and standards, including but not limited to: 42 U.S.C. 1396a et seq., 42 C.F.R. Title 42 and Title 45, and especially 42 C.F.R. 456, 600 et seq. and 42 C.F.R. 431.10. In the event of conflict of any of the provisions of this agreement with those federal requirements and standards, the conflicting provisions of this agreement shall be void.

VI. ATTACHED PROVISIONS

The provisions found in Contractual Provisions Attachment - Form DA-146a, which is attached hereto and executed by the parties to this agreement, are hereby incorporated in this contract and made a part hereof.

VII. EXTENSION

Extensions of this agreement beyond its base term ending June 30, 1990, shall be agreed in writing by the Secretaries and shall be for specific, limited periods and fiscal amounts.

Winston Barton, Secretary of
Social and Rehabilitation Services

Stanley Grant, Secretary of
Health and Environment

CONTRACTUAL PROVISIONS ATTACHMENT

Important: This form contains mandatory contract provisions and must be attached to or incorporated in all copies of any contractual agreement. If it is attached to the vendor/contractor's standard contract form, then that form must be altered to contain the following provision:

> *"The provisions found in Contractual Provisions Attachment (form DA-146a), which is attached hereto and executed by the parties to this agreement, are hereby incorporated in this contract and made a part hereof."*

The undersigned parties agree that the following provisions are hereby incorporated into the contract to which it is attached and made a part thereof, said contract being dated the ____ day of _____, 19____.

1. TERMS HEREIN CONTROLLING PROVISIONS
   It is expressly agreed that the terms of each and every provision in this attachment shall prevail and control over the terms of any other conflicting provision in any other document relating to and a part of the contract in which this attachment is incorporated.

2. AGREEMENT WITH KANSAS LAW
   All contractual agreements shall be subject to, governed by, and construed according to the laws of the State of Kansas.

3. TERMINATION DUE TO LACK OF FUNDING APPROPRIATION
   If, in the judgment of the Director of Accounts and Reports, State Department of Administration, sufficient funds are not appropriated to continue the function performed in this agreement and for the payment of the charges hereunder, State may terminate this agreement at the end of its current fiscal year. State agrees to give written notice of termination to contractor at least 30 days prior to the end of its current fiscal year, and shall give such notice for a greater period prior to the end of such fiscal year as may be provided in this contract, except that such notice shall not be required prior to 90 days before the end of such fiscal year. Contractor shall have the right, at the end of such fiscal year, to take possession of any equipment provided State under the contract. State will pay to the contractor all regular contractual payments incurred through the end of such fiscal year, plus contractual charges incidental to the return of any such equipment. Upon termination of the agreement by State, title to any such equipment shall revert to contractor at the end of State's current fiscal year. The termination of the contract pursuant to this paragraph shall not cause any penalty to be charged to the agency or the contractor.

4. DISCLAIMER OF LIABILITY
   Neither the State of Kansas nor any agency thereof shall hold harmless or indemnify any contractor for any liability whatsoever.

5. ANTI-DISCRIMINATION CLAUSE
   The contractor agrees: (a) to comply with the Kansas Act Against Discrimination (K.S.A. 44-1001 *et seq.*) and to not discriminate against any person who performs work hereunder, because of race, religion, color, sex, physical handicap unrelated to such person's ability to engage in this work, national origin or ancestry; (b) to include in all solicitations or advertisements for employees, the phrase "equal opportunity employer"; (c) to comply with the reporting requirements set out at K.S.A. 1975 Supp. 44-1031; (d) to include those provisions in every subcontract or purchase order so that they are binding upon such subcontractor or vendor; (e) that a failure to comply with the reporting requirements of (c) above or if the contractor is found guilty of any violation of such act by the Kansas Commission on Civil Rights, shall constitute a breach of the contract and it may be cancelled, terminated or suspended in whole or in part by the Director of Purchases, State Department of Administration.

   Parties to this contract understand that subsections (b) through (e) of this paragraph number 5 are not applicable to a contractor who employs fewer than four employees or whose contract with this agency of the Kansas state government total less than $5,000 during this fiscal year.

6. ACCEPTANCE OF CONTRACT
   This contract shall not be considered accepted, approved or otherwise effective until the statutorily required approvals and certifications have been given.

7. ARBITRATION, DAMAGES, WARRANTIES
   Notwithstanding any language to the contrary, no interpretation shall be allowed to find the State or any agency thereof has agreed to binding arbitration, or the payment of damages or penalties upon the occurrence of a contingency. Further, the State of Kansas shall not agree to pay attorney fees and late payment charges; and no provision will be given effect which attempts to exclude, modify, disclaim or otherwise attempt to limit implied warranties of merchantability and fitness for a particular purpose.

8. REPRESENTATIVE'S AUTHORITY TO CONTRACT
   By signing this document, the representative of the contractor thereby represents that such person is duly authorized by the contractor to execute this document on behalf of the contractor and that the contractor agrees to be bound by the provisions thereof.

9. RESPONSIBILITY FOR TAXES
   The State of Kansas shall not be responsible for, nor indemnify a contractor for, any federal, state or local taxes which may be imposed or levied upon the subject matter of this contract.

10. INSURANCE
    The State of Kansas shall not be required to purchase, any insurance against loss or damage to any personal property to which this contract relates, nor shall this contract require the state to establish a "self-insurance" fund to protect against any such loss or damage. Subject to the provisions of the Kansas Tort Claims Act (K.S.A. 1979 Supp. 75-6101 *et seq.*), the vendor or lessor shall bear the risk of any loss or damage to any personal property in which vendor or lessor holds title.

~~Vendor/Contractor~~ Secretary

6/15/89 Winston Barton
Date Signature

Agency Head/Authorized Representative:

7/18/89 [signature]
Date Signature

Salina Team:

2 desks
2 chairs
1 metal stand
1 wastebasket
2 file cabinets
1 folding chair
1 fan
2 floor mats

Wichita Team:

2 desk
3 file cabinet
2 chairs
1 lamp
1 wastebasket

Concordia Team:

2 desks
2 chairs
6 drawer file cabinet
1 shelf for forms
2 phones
2 wastebaskets

Hoxie Team:

1 desk
1 chair
1 5 drawer
1 typewriter
1 phone
1 cabinet for forms
1 trash can

Topeka Team(s)

1 Herman Miller desk units-
(overhead cabinet, drawers, & bulletin board)
4 Herman Miller extender tables
4 straight chairs
4 filing cabinets
2 typewriters
4 trash cans
4 telephones

Darcy: Topeka AC

1 desk
1 chair
1 DG
1 Herman Miller table
1 typewriter
1 4 drawer lateral file
1 3 drawer file cabinet
1 book shelf
1 telephone
1 wastebasket
1 fan
2 bulletin boards

Coldwater Team:

2 desks
2 chairs
2 file cabinets
1 wastebasket
1 phone

Evelyn: Topeka Off

1 desk
1 Herman Miller desk
1 table
3 chairs
1 file cabinet
2 small stands
1 bookcase
2 bulletin boards
1 wastebasket
1 telephone

Chanute SRS Area Office: (2 teams)

2 desks - pedestal
2 chairs
2 file drawers, 1 5 drawer/1 4 drawer
1 2 drawer
1 long conference table

Osawatomie SRS Area Office:

1 5 drawer file
1 book case
1 table
1 chair (broken)

Wichita SRS Area Office:

2 desks
2 file cabinet
1 chair
1 waste basket

Kansas City Area Office:

NO FURNITURE

Kansas City Area Office has for their use:

2 modular Herman Miller units with 3 file dra
units built in.
1 5 drawer file cabinet
2 2 drawer file cabinets

Hutchinson Area Office:

2 desks - Herman Miller
2 chairs
2 file cabinets 4 drawer

Veletta / Dr. Zimmerman Topeka Office

1 desk
1 table, typing
1 plastic floor mat
1 Herman Miller panel 5' x 5'
1 Herman Miller panel 2' x 5'
1 bulletin board 3'x2'
1 5 drawer lateral
1 4 drawer lateral
4 5 drawer file cabinets
1 secretary chair
1 IBM typewriter

1 small desk
1 chair
1 3 shelf book case
1 table
2 chairs

Pat Topeka Office

1 desk
1 4 shelf file cabinet
3 small tables
3 chairs
1 desk chair
1 fan
1 5 drawer file cabinet
1 desk lamp

SPECIAL LIMITED POWER OF ATTORNEY

Know all men by these presents, that I, the undersigned, Stanley C. Grant, Ph.D., Secretary of Health and Environment, in the county of Shawnee, State of Kansas, hereby appoint David M. Traster, General Counsel, Kansas Department of Health and Environment, in the county of Shawnee, State of Kansas, as my attorney in fact to execute in my behalf all official Kansas Department of Health and Environment documents including, but not limited to, orders, contracts, letters, notices, licenses, and permits.

RATIFICATION

Be it also known that I, Stanley C. Grant, Ph.D., hereby ratify the execution of all official Kansas Department of Health and Environment documents previously made in my behalf by David M. Traster.

LIMITATIONS OF AUTHORITY

The powers of said General Counsel shall be limited to the extent set out in writing in this limited power of attorney, and shall not include any other power not herein specified.

EFFECTIVE TIME

This limited power of attorney shall become effective immediately and shall remain in full force and effect until such time that either Stanley C. Grant, Ph.D. or David M. Traster no longer serve the Department of Health and Environment in their present capacities as Secretary and General Counsel respectively, or upon revocation by the Secretary.

PRESERVATION OF POWER

The power herein granted to the General Counsel shall in no way limit or diminish any other power presently held by said General Counsel in his capacity as attorney to the Secretary.

EXECUTION

Executed this 11th day of [signature], 1989, at Topeka, Kansas.

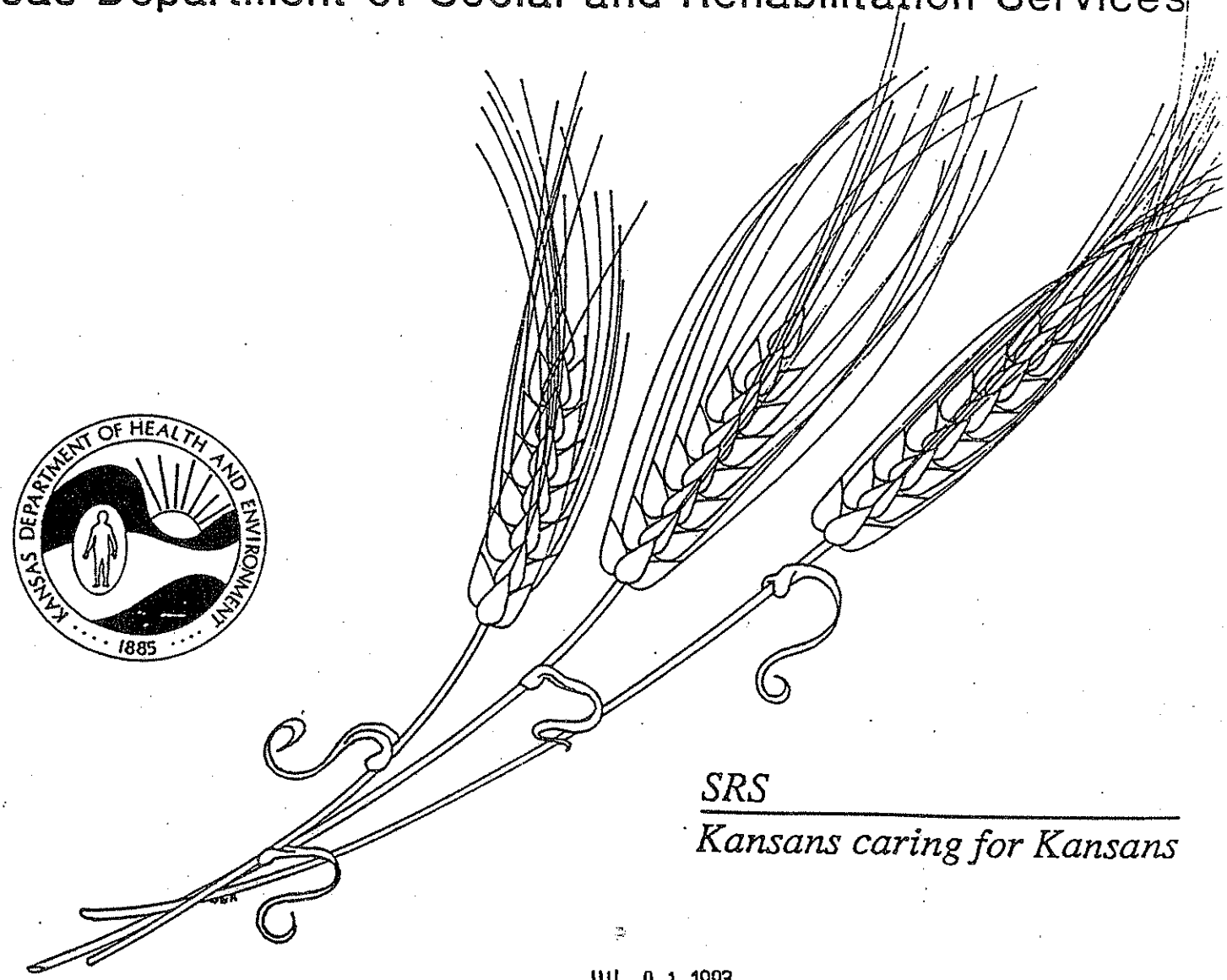
Stanley C. Grant, Ph.D.
Kansas Department of Health and Environment

COOPERATIVE AGREEMENT

Kansas Department of Health and Environment

and

Kansas Department of Social and Rehabilitation Services



SRS

Kansans caring for Kansans

OCT 25 1993

JUL 0 1 1993

This Interagency Agreement was developed under the Auspices of

Robert C. Harder, Secretary

Kansas Department of Health and Environment

and

Donna Whiteman, Secretary

Kansas Department of Social and Rehabilitation Services

July 1, 1993

COOPERATIVE AGREEMENT BETWEEN KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT AND KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

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COOPERATIVE AGREEMENT BETWEEN KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT AND KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

I. Purpose and Philosophy

The purpose of this agreement is to provide an integrated system of high quality, comprehensive health services to citizens of Kansas, many of whom are underserved.

This Agreement between Kansas Department of Health and Environment, hereinafter referred to as KDHE, and the Kansas Department of Social and Rehabilitation Services, hereinafter referred to as SRS, shall assure the following:

A. A mutually agreed upon goal and set of objectives that delineates both the mutual and individual responsibilities of the parties in the provision of services to low income families in Kansas, including individuals determined eligible for both Title V and the Medical Assistance services;

B. A definition of the scope of services provided either on-site or by referral;

C. The development of a cooperative relationship at the State level to prevent duplication of services; and to assist local SRS area offices, health departments, and other local agencies to develop cooperative relationships;

D. A joint plan to establish a fiscal protocol that will maximize utilization of funds in providing services to the beneficiaries.

II. Authority for Agreement

In the State of Kansas, authority and responsibility for the administration of health programs including Title V and Title XIX of the Social Security Act of 1935, as amended, has been delegated to KDHE and SRS. In addition to Title V and Title XIX Programs, KDHE and SRS have the administrative responsibility to serve similar populations in programs such as Food Stamp, Migrant, Refugee, family planning, special supplemental food program for women, infants and children (WIC) and immunization.

Federal laws and regulations mandate cooperation between State agencies responsible for the administration and/or supervision of both Title V and Title XIX of the Social Security Act. The following specific sections delineate the authority and intent of this Agreement.

A. Legislative

Title XIX of the Social Security Act (Grants to States for Medical Assistance Programs). Section 1902(a)(11)(A) provides for the entering into cooperative arrangements with the State agencies responsible for administering and/or supervising the administration of services to ensure maximum utilization of such services. Section 1902(a)(11)(B) requires

provision of appropriate reimbursement to any Title V funded project by Title XIX for services and care provided to Medicaid recipients.

Title V of the Social Security Act as amended through January 1, 1991. Section 505(5)(F)--KDHE which administers the State's program under this Title will: (i) participate in the coordination of activities between such program and the early and periodic screening, diagnosis, and treatment program under section 1905(a)(4)(B) (including the establishment of periodicity and content standards for early and periodic screening, diagnosis, and treatment services), to ensure that such programs are carried out without duplication of effort, (ii) participate in the arrangement and carrying out of coordination agreements described in section 1902(a)(11) (relating to coordination of care and services available under this title and title XIX), (iii) participate in the coordination of activities within the State with programs carried out under this title and related Federal grant programs (including supplemental food programs for mothers, infants, and children, related education programs, and other health, developmental disability, and family planning programs), and (IV) provide, directly and through their providers and institutional contractors, for services to identify pregnant women and infants who are eligible for medical assistance under subparagraph (A) or (B) of section 1902(1)(1) and, once identified, to assist them in applying for such assistance.

B. Regulatory

42 CFR 431.615 requires that the State Title XIX plan include written cooperative agreements with the state health agencies and Title V grantees to assure that Title V recipients eligible for Title XIX (Medicaid) receive services with particular emphasis on EPSDT services.

Therefore, this Agreement is to enable KDHE and SRS of the State of Kansas to carry out the mandate of cooperation contained in the related provisions of the Federal statutes and regulations.

The Department Secretaries are authorized to enter into agreements and make commitments which shall be binding on the operation of the programs of the agencies including Title XIX and Title V programs.

III. Mutual Objectives and Respective Responsibilities

KDHE and SRS will establish financing mechanisms for health care services for Title V and Title XIX, respectively. There shall be mutual quality control procedures used by both agencies. The agencies will share data for use in program planning and evaluation and to meet federal reporting requirements. The two agencies have jointly committed major fiscal and personnel resources to improve the quality of health services provided statewide and to assure access to appropriate health services. It is understood by the parties to this agreement that the goal is to be attained within the constraints of available resources. It is therefore agreed that potential benefits from cooperation between KDHE and SRS, in the attainment of the goal of this Agreement, include the following:

A. Promotion of continuity of care;

B. Sharing of medical, social and technical expertise through staff consultations;

C. Reduction of duplication of effort;

D. Efficient allocation of resources based on need;

E. Utilization of Title V overmatch to provide Title XIX services.

F. Achievement of greater accountability in regard to outcome.

Enhanced and expanded health-care services to mutual clients and the improvement of the health of the citizens of the State of Kansas are inherent benefits of this agreement.

It is further agreed by the parties that each shares responsibility in the attainment of the following mutual objectives:

1. To increase access to programs for Kansans by mutual efforts of the state agencies.

2. To maximize resources and expertise of KDHE and SRS in order to increase the quality and continuity of care for eligible clients.

IV. Eligible Populations

The programs conducted by the parties to this Agreement have different, although overlapping, eligible populations and distinct target groups for specific services within eligible populations. The following descriptions are set out in order to define populations which may be impacted by this Agreement.

A. KDHE - Division of Health

The eligible population for maternal and child health program services are all women of childbearing age and children up to age twenty-one (21). Men and special populations such as migrants and refugees over the age of 21 may be eligible for services of other categorical programs. Men are also eligible for services in the tuberculosis, substance abuse and family planning programs.

B. SRS

All individuals presently living in Kansas who meet the eligibility criteria for Public Assistance, Medical Assistance, and the Food Stamp Program in accordance with KAR Chapter 30, Article 4 and federal rules and regulations.

V. Program Areas

Programs subject to the terms of this agreement include but are not limited to:

A. General MCH Services

B. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- o Expanded Nutrition Services for High Risk Children
- o Enhanced Provider Participation

C. Services for Children with Special Health Care Needs (SHS)

D. Prenatal Health Promotion/Risk Reduction
- o Expanded Nutrition Services for High Risk Pregnant Women
- o Expanded Social Work Services

E. Newborn/Postpartum Home Visit

F. WIC/Medicaid Referral

G. Commodity Supplemental Food Program (CSFP)

H. Family Planning

I. Migrant Program

J. Refugee Program

K. Services for Tuberculosis

L. Immunizations

M. Substance Abuse Services

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A. GENERAL MATERNAL AND CHILD HEALTH (MCH) SERVICES

The Kansas Department of Health and Environment (KDHE) goal for maternal and child health programs and services is to prevent morbidity and mortality for mothers and children by facilitating the provision of services at the community level for the target population. To accomplish this goal, KDHE contracts with local agencies to provide services designed to assure mothers and children, particularly those with low income or limited availability of or access to quality health care. Title V projects are the local agencies that provide MCH services funded in full or in part by Title V funds including: M&I, Healthy Start, MCH.

The purpose of this section is to describe the cooperative agreement between KDHE and the Kansas Department of Social and Rehabilitation Services (SRS) in relation to general MCH programs/services:

Some other specific examples of Maternal and Child Health services include the following: children and youth, dental, and WIC. In addition, the newborn home visit and prenatal risk reduction services are described in detail in Sections D and E of this agreement.

o HEALTH CARE SERVICES

KDHE will:

1. Support through consultation and funding (if available) maternal and child health projects at the community level.

2. Provide SRS with documentation of Title V overmatch.

3. Report to SRS, documented concerns relating to health services availability and/or barriers for Medical Assistance clients.

4. Identify and establish standards for maternal and child health services for potential Medical Assistance reimbursement.

SRS will:

1. Identify maternal and child health services to be covered by Medical Assistance, utilizing KDHE consultation.

2. Work with KDHE and local providers to resolve barriers to health care services.

o PROGRAM INFORMATION AND SERVICE

KDHE will:

1. Provide to SRS a copy of the current Kansas maternal and child health program plan and updates, as necessary.

2. Designate staff, upon request, to participate on SRS permanent and/or ad hoc committees related to maternal and child health programs and services.

3. Request participation of SRS staff on permanent and/or ad hoc committees relating to Medical Assistance reimbursable maternal and child health services, as appropriate.

4. Promote early identification and referral of individuals to SRS who may be eligible for Medical Assistance benefits.

5. Promote cooperative program planning and monitoring of maternal and child health efforts at the state and local levels.

6. Encourage local health departments and agencies to provide follow-up and outreach activities for Medical Assistance clients.

7. Provide state and local SRS offices with maternal and child health program brochures for distribution to Medical Assistance clients.

SRS will:

1. Provide a copy of the Medical Assistance State Plan with updated amendments to KDHE.

2. Designate staff, upon request, to participate on KDHE formal and/or ad hoc committees related to Medical Assistance maternal and child health programs and services.

3. Request participation of KDHE staff on permanent or ad hoc committees related to maternal and child health programs and services, as appropriate.

4. Inform and refer, when appropriate, Medical Assistance applicants or recipients to appropriate public health programs and/or services in the client's community.

5. Facilitate dissemination of program/service brochures to local SRS offices.

6. Participate with KDHE in cooperative program planning and monitoring of maternal and child health services covered by Medical Assistance.

7. Provide KDHE and local health departments with SRS program brochures related to maternal and child health services.

o COLLABORATION, CONSULTATION AND CONTINUING EDUCATION

KDHE will:

1. When applicable, attend workshops held by SRS related to maternal and child health Medical Assistance services.

2. Respond to questions and issues presented by Medical Assistance staff or recipients related to maternal and child health programs and services.

3. Discuss client referrals to Medical Assistance during consultation and continuing education presentations.

4. Facilitate continuing education programs for public health staff providing maternal and child health services.

5. Inform and/or invite SRS staff to maternal and child health conferences and programs.

6. Provide perinatal statistics or other data to SRS, on request.

7. Establish standards and guidelines for maternal and child health programs including services for pregnant women and children under the Medical Assistance Program.

8. Provide consultation, on request, from the Kansas Regional Perinatal Program Medical Council, Office of Nutrition and Health, and Dental Program regarding perinatal services and issues.

9. Participate with SRS in evaluating the impact of Medicaid case management programs on local health department services and client access.

SRS will:

1. When applicable, attend workshops held by KDHE or local health departments relating to maternal and child health programs/services.

2. Respond to questions and issues presented by KDHE relating to Medical Assistance.

3. Inform and/or invite KDHE staff to SRS sponsored conferences and programs related to Medical Assistance maternal and child health services.

4. Provide copies to KDHE of reports relating to maternal and child health programs, services, and studies.

5. Utilize, when appropriate, the Kansas Regional Perinatal Program and Medical Council for consultation relating to perinatal services and issues.

6. Include KDHE staff in the evaluation of the Medical Assistance case management program's impact on maternal and child health services in the public and private sectors.

o FEES AND REIMBURSEMENT

KDHE will:

1. Upon request, provide technical assistance to SRS for setting Medical Assistance rates for maternal and child health services.

2. Assist local agencies to obtain Medical Assistance reimbursement for services provided.

3. Utilize Title V overmatch for Title XIX maternal and child health services.

SRS will:

1. Assure availability of a list of Medical Assistance maximum allowable rates for procedures and updates, as necessary.

2. Assist local agencies, through the SRS fiscal agent, to obtain correct reimbursement for services provided.

3. Provide reimbursement for the following services: maternal and infant (prenatal), prenatal risk reduction, and newborn home visits.

B. **KAN-BE-HEALTHY**

Early and periodic screening, diagnosis and treatment (EPSDT) is a federally mandated program under Title XIX-Medicaid. It is called Kan-Be-Healthy in Kansas. It is a preventive health program for Medicaid recipients under age 21 and MediKan recipients under age 18. The objectives of the program are to foster good health through the early detection and treatment of conditions which, if left untreated, could become more chronic and handicapping.

KDHE will:

1. Establish standards for screening, diagnosis and treatment, and evaluation in accordance with HCFA guidelines, and, in cooperation with other medical, dental, health, and educational representatives.

2. Establish educational standards and criteria for professional staff of KAN-Be-Healthy providers.

3. Designate the KDHE staff to serve as members of the KAN-Be-Healthy Advisory Committee.

SRS will:

1. Adopt standards for screening, diagnosis and treatment, and evaluation, as developed by KDHE in accordance with HCFA guidelines, and, in cooperation with other medical, dental, health and education representatives.

2. Adopt educational standards and criteria for professional staff of KAN-Be-Healthy providers.

3. Develop and provide provider manuals to Medicaid providers who perform KAN-Be-Healthy screenings.

4. Determine reimbursement rates, payment codes and billing/claims procedures.

5. Enroll qualified providers to perform KAN-Be-Healthy screenings.

6. Determine Medicaid eligibility and assist client to choose a health care provider.

7. Explain and offer KAN-Be-Healthy to each applicant for Medical Assistance.

8. Offer, arrange and provide transportation and scheduling assistance for the client to obtain screening, diagnosis and treatment.

9. Maintain communications with providers and KDHE through the use of bulletins and other mechanisms.

10. Maintain an KAN-Be-Healthy Advisory Committee and support of activities.

11. Request appointment of KDHE staff to serve as members of KAN-Be-Healthy Advisory Committee.

12. Reimburse providers for KAN-Be-Healthy services.

13. Reimburse KDHE for the costs of establishment and implementation of standards for Medicaid providers who perform KAN-Be-Healthy screenings.

KDHE and SRS will:

1. Participate in the identification of service providers or agencies for KAN-Be-Healthy.

2. Provide consultation and technical assistance to providers in the management and implementation of KAN-Be-Healthy services.

3. Develop protocols and procedures for making referrals for services of KDHE and SRS.

4. Provide timely information on development and implementation of any administrative and/or fiscal change which will/may impact on mutual clients.

5. Develop and implement an outreach program with local health agencies.

6. Market, promote and advertise the KAN-Be-Healthy and other child health programs throughout the state, with each agency providing the necessary materials.

7. Appoint staff to promote liaison between KDHE and SRS at regular meetings.

8. Collaborate on reports and review the data provided by SRS related to KAN-Be-Healthy services.

o EXPANDED NUTRITION SERVICES FOR HIGH RISK CLIENTS

Expanded nutrition services for high risk Medicaid children will be provided by registered/licensed dietitians through authorized local providers. The purpose of expanded nutrition services is to provide ongoing nutrition assessments and risk appropriate interventions for high risk children and to ensure they are current on KAN-Be-Healthy screens.

KDHE will:

1. Develop service description, risk criteria, assessment and intervention protocols and referral/follow-up guidelines, as an addition to the KAN-Be-Healthy Nutrition Screening Tools.

2. Define entry point/referral process to initiate receipt of high risk nutrition services.

3. Recommend number of contacts/service units for services and related reimbursement levels.

4. Designate qualified local providers for delivering high risk nutrition services.

5. Provide technical assistance and consultation to service providers.

6. Assure that state match dollars are available prior to the start of the fiscal year and notify SRS prior to the beginning of a calendar quarter in the event funding will not be available.

7. Provide a certification statement to SRS within three weeks after the end of a quarter stating that state general funds were available to match the federal funds.

8. Require each local agency that receives more than $25,000 to have a circular A-128 audit and follow-up on any findings including return of funds if necessary.

9. Accept responsibility for federal financial penalties or adjustments which result if it is found on retrospective review or audit that state general funds were not available to match federal funds.

SRS will:

1. Approve expanded nutrition service content/units of service as an addition to the EPSDT Program.

2. Determine reimbursement levels for service.

3. Enroll qualified local providers and designate those approved for this service.

4. Provide workshops, manuals, and technical assistance regarding billing procedures for service providers.

5. Determine client eligibility for Medical Assistance.

6. Provide information about high risk nutrition services for KAN-Be-Healthy clients who are identified at nutritional risk.

SRS and KDHE will:

1. Promote early identification of KAN-Be-Healthy high risk nutrition clients and use of KAN-Be-Healthy program services.

2. Implement utilization review procedures.

3. Evaluate impact of services on child health outcomes for service recipients through cooperative sharing of outcome/statistical data.

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o ENHANCED PROVIDER PARTICIPATION

The purpose of this provision in the cooperative agreement is to assure maximum availability of qualified providers of KAN-Be-Healthy services in public health departments and in local school districts throughout the state.

KDHE will:

1. Staff a full-time Public Health Nurse VI position to provide education to enhance provider participation in KAN Be Healthy screenings and to provide the State General Fund portion of the salary and State General Fund portion of the other operating expenses to support this position.

2. Certify to SRS, all State General Funds available and used in order to match with Federal Financial Participation.

3. Fund a KAN Be Healthy brochure to be distributed as agreed upon by KDHE and SRS jointly. The design and format of the brochure shall be jointly agreed to by KDHE and SRS.

4. Provide an updated budget by June 1 of each year, or as needed, subject to approval by SRS.

SRS will:

1. Provide the Federal Financial Participation, at the current match rates for the salary of a full-time Public Health Nurse VI position and other operating costs associated with this program. The salary will be matched at the 75% FFP, all other costs will be matched at the administrative match rate.

2. Develop and produce a brochure on KAN Be Healthy in Cooperation with KDHE.

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C. SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS (SHS)

This section provides for child find and case management of SHS eligible youth who are also eligible for Medical Assistance.

The purpose of SHS is to promote the functional skills of young persons in Kansas who have a handicap, disability, or chronic disease, by providing or supporting a system of specialty health care. SHS is responsible for the planning, development and promotion of the parameters and quality of specialty health care for the handicapped youth of Kansas. The objectives of the program are to provide identification, diagnosis and treatment of children who are at risk for or suspected of, or with a handicapping condition.

Cooperation between Medical Services and SHS is required for effective delivery of services to those individuals eligible for both programs.

Financial responsibility for the health service costs of mutual recipients is held by three major sources -- private insurance, Medical Assistance and SHS. Private health insurance coverage for recipients is to be the "first dollar". In the event that insurance coverage is insufficient or not available, Medical Assistance is "second dollar" and is to be billed for the services covered for Medical Assistance recipients. SHS is "last dollar", and is responsible for services authorized in advance by SHS that are not covered by private insurance or by Medical Assistance.

o GENERAL

KDHE will:

1. Determine eligibility for SHS as defined in K.A.R. 28-4-403, 28-4-406, and 28-4-407.

2. Designate responsibility for specific professional health care for children with discernible physical handicaps or chronic disease through an individualized health care plan and/or prior authorization.

3. Provide secondary case management services for handicapped or chronically ill youth who are service recipients of both Medical Assistance and SHS.

4. Designate SRS to monitor the adequacy of services for SSI children in state institutions, with selective participation in program evaluation.

5. Refer potential recipients to SRS at the time of application and annual review for continued SHS eligibility.

6. Include KAN-Be-Healthy participation as part of case management services for recipients of both Medical Assistance and SHS.

7. Provide transportation assistance for non-KAN-Be-Healthy/SHS recipients.

8. Authorize in advance of purchase, Durable Medical Equipment (DME) items for children receiving Medical Assistance and SHS under criteria established with SRS.

SRS will:

1. Determine eligibility for Medical Assistance in accordance with KAR Chapter 30, Article 6.

2. Enroll, certify and monitor providers of services to Medical Assistance recipients.

3. Promote referral to SHS of Medical Assistance eligible children who may also be eligible for SHS. Publicize the advantages of SHS referral to all providers and SRS area staff through provider bulletins, special letters to physicians and health departments, provider workshops and professional meetings.

4. Provide transportation assistance for KAN-Be-Healthy participants to and from medical services. Non-KAN-Be-Healthy participants must make other arrangements for transportation.

5. Notify SHS of policy or program changes by forwarding appropriate provider bulletins and Medical Assistance provider material.

6. Provide a list of those eligible for Supplemental Security Income (SSI) to SHS on a monthly basis.

7. Provide to SHS copies of each Independent Professional Review (IPR) and Utilization Review (UR) completed for each SSI child who is in a state institution.

8. Provide to SHS a list of Medical Assistance maximum allowable rates for procedures provided by both SHS and Medical Assistance, and update the list as rates change.

9. Approve SHS access to A.I.S. (Automated Information System).

KDHE and SRS will:

1. Make available, upon request, program information, applications, brochures and technical assistance.

2. Respond to questions and inquiries concerning SHS and Medical Assistance.

3. Provide statewide public awareness activities related to programs of mutual interest.

4. Provide information prior to implementation of changes in policies and procedures which affect mutual clients.

5. Provide input into the development of program and reimbursement policies and procedures which affect the service delivery of mutual clients when requested.

6. Designate a person to serve as a liaison to foster cooperative working relationships among personnel of SHS and Medical Assistance. These designees shall confer at least quarterly.

o MEDICAL ASSISTANCE PRIMARY CARE NETWORK CASE MANAGEMENT

KDHE will:

1. Obtain the name of the Medical Assistance case manager from the family of the SHS child at the time of assignment and at anytime the Medical Assistance case manager changes.

2. Notify Medical Assistance case manager through a joint letter with Medical Assistance that a Medicaid eligible child assigned to them is also a SHS recipient. The letter will explain the need for specialty care and SHS secondary case management. The letter will be accompanied by a turnaround document which, when returned, will constitute a referral. (A 10 day turnaround time is requested.)

3. Forward the referral to all secondary care providers for each child.

4. Contact the Medical Assistance case manager for follow up if the referral is refused or is not returned within 10 calendar days.

5. Forward those referrals not returned within ten days of the followup contact with the Medical Assistance case management to the Director of the Medical Assistance Program.

6. Forward those referrals which are refused to the Medical Director of the Medical Assistance Program.

7. Develop a Health Care Plan and forward it to the Medical Assistance case manager within 10 calendar days after the referral is documented for ongoing cases. When the first service is a diagnostic evaluation by a medical specialist to determine SHS eligibility, develop and forward the Health Care Plan to the Medical Assistance case manager within 10 calendar days after the client is determined eligible.

8. Forward medical reports from secondary providers to Medicaid case managers within 2 days of receipt.

9. Furnish program information to Medical Assistance case managers.

10. Provide families with information and assistance upon request relative to appeals when a referral is denied by the Medical Assistance case manager.

SRS will:

1. Notify the Medical Assistance case manager via joint letter when a referral to SHS is requested.

2. Respond when notified to any Medical Assistance case manager who is reluctant to refer to SHS and promote the referral after a follow up contact is made or when the written referral is not returned. If a referral is not deemed appropriate, inform SHS by telephone. The total time from notification to telephone call to SHS is not to exceed 5 days.

3. Allow referrals to SHS from Medical Assistance case managers to be effective for the length of the SHS treatment plan.

4. Provide SHS with a current claim denial code manual and updates as they occur.

5. Forward those referrals not returned within ten days of the follow up contact with the medical assistance case manager.

o SUPPLEMENTAL SECURITY INCOME (SSI)

KDHE will:

1. Provide DDRS access to SHS automated case management system to identify children and youth known to SHS for the purpose of obtaining medical evidence in the SSI eligibility determination process.

2. Provide DDRS access to SHS automated case management system for the identification of providers meeting SHS standards per K.A.R. 28-4-405 for pediatric care.

3. Provide DDRS access to SHS children's records to copy medical evidence of documentation.

4. Pull SHS records for DDRS staff review based on list provided by DDRS.

5. Provide work space for DDRS staff to review and copy pertinent medical records.

6. Designate SRS to monitor the adequacy of services for SSI children in state institutions, with selective participation in program evaluation.

SRS will:

1. Assure that a release of information for each individual is part of their DDRS record when obtaining medical evidence from SHS.

2. Provide training to SHS providers regarding medical documentation and other information required to document disability claims.

3. Provide SHS a list of cases they wish to review for medical evidence.

4. Provide staff to review and copy medical evidence documentation from SHS records.

5. Provide a list of those eligible for SSI to SHS on a monthly basis.

6. Provide to SHS copies of each Independent Professional Review (IPR) and Utilization Review (UR) completed for each SSI child who is in a state institution.

KDHE and SRS will:

1. Make available program information, applications, brochures and technical assistance.

2. Respond to questions and inquiries concerning SHS, DDRS and SSI.

3. Provide statewide public awareness activities and training related to programs of mutual interest.

4. Designate a person to serve as a liaison to foster cooperative working relationships among personnel of SHS and DDRS. These designees shall confer at least quarterly.

5. Develop a protocol to establish a standard for the evaluation of medically complex children.

D. PRENATAL HEALTH PROMOTION/RISK REDUCTION

Prenatal Health Promotion/Risk Reduction is a client service designed to reduce the incidence of poor pregnancy outcomes for Medicaid childbearing clients and their newborns. Services are provided by local Title V agencies and assure access for the Medicaid eligible client to prenatal health promotion services.

KDHE will:

1. Develop program content criteria, guidelines and related program standards.
2. Recommend content of program services.
3. Recommend reimbursement level for program services.
4. Provide technical assistance and consultation to local health departments.

SRS will:

1. Approve content of program services.
2. Determine reimbursement levels for program services.
3. Enroll qualified providers.
4. Provide workshops, manuals and technical assistance regarding billing procedures.
5. Determine client eligibility.
6. Provide information about services to Medicaid applicants and eligible prenatal clients.
7. Make referrals to local Title V agencies.

SRS and KDHE will:

1. Promote early identification of pregnant women and infants and use of services.
2. Encourage cooperation between local Title V agencies and local SRS offices to develop outreach, eligibility determination and referral procedures.
3. Implement utilization review procedures.
4. Evaluate impact of program services on perinatal outcomes for service recipients.

o EXPANDED NUTRITION SERVICES FOR HIGH RISK PREGNANT WOMEN

Expanded nutrition services for high risk Medicaid prenatal clients will be provided by registered/licensed dietitians at local Title V agencies. The purpose of expanded nutrition services is to provide ongoing nutrition assessments and risk appropriate interventions for high risk prenatal clients.

KDHE will:

1. Develop service description, risk criteria, assessment and intervention protocols and referral and follow-up guidelines, as an addition to the Prenatal Health Promotion/Risk Reduction Implementation Guidelines.

2. Define entry point/referral process to initiate receipt of expanded nutrition services.

3. Recommend number of contacts/service units for services and related reimbursement levels.

4. Designate qualified local agencies for delivering expanded nutrition services.

5. Encourage cooperation between local Maternal and Infant (M&I) Projects and local WIC providers to facilitate the identification of eligible Medicaid prenatal clients and to establish referral procedures.

6. Provide technical assistance and consultation to service providers.

7. Assure that state match dollars are reasonably available through local Maternal and Infant Projects prior to the start of the fiscal year and notify SRS prior to the beginning of a calendar quarter in the event funding will not be available.

8. Maintain documentation for each local agency reflecting the available state match at the end of each calendar quarter.

9. Provide a certification statement to SRS within three weeks after the end of a quarter stating that state general funds were available to match the federal funds.

10. Require each local agency that receives more than $25,000 to have a circular A-128 audit and follow-up on any findings including return of funds if necessary.

11. Accept responsibility for federal financial penalties or adjustments which result if it is found on retrospective review or audit that state general funds were not available to match federal funds.

SRS will:

1. Approve expanded nutrition service content/units of service as an addition to the Prenatal Health Promotion/Risk Reduction Program.

2. Determine reimbursement levels for service.

3. Enroll qualified local health department providers and designate those approved for this service.

4. Provide workshops, manuals, and technical assistance regarding billing procedures for service providers.

5. Determine client eligibility for Medical Assistance.

6. Provide information about expanded nutrition services for medical prenatal clients who are identified at nutritional risk and participating in a local Maternal and Infant Project.

7. Provide a quarterly report to KDHE reflecting payments for nutrition services.

SRS and KDHE will:

1. Promote early identification of pregnant women and infants and use of program services.

2. Implement utilization review procedures.

3. Evaluate impact of services on perinatal outcomes for service recipients through cooperative sharing of outcome/statistical data.

o EXPANDED SOCIAL WORK SERVICES

Enhanced social work services for Medical eligible prenatal clients will be provided by licensed social workers through local agencies implementing approved Maternal and Infant Projects (M&I).

1. Develop services description, risk categories, assessment and intervention protocols and referral and follow-up guidelines, as an addition to the Prenatal Health Promotion/Risk Reduction Implementation Guidelines.

2. Define entry point/referral process to initiate receipt of enhanced social work services.

3. Recommend number of contacts/service units for services and related reimbursement levels.

4. Designate qualified local agency Maternal & Infant Projects for delivering enhanced social work services.

5. Provide technical assistance and consultation to service providers.

6. Assure that state match dollars are available through local Maternal and Infant Projects prior to the start of the fiscal year and notify SRS prior to the beginning of a calendar quarter in the event funding will not be available.

7. Maintain documentation for each local agency reflecting the available state match at the end of each calendar quarter.

8. Provide a certification statement to SRS within three weeks after the end of a quarter stating that state general funds were available to match the federal funds.

9. Require each local agency that receives more than $25,000 to have a circular A-128 audit and follow-up on any findings including return of funds if necessary.

10. Accept responsibility for federal financial penalties or adjustments which result if it is found on retrospective review or audit that state general funds were not available to match federal funds.

SRS will:

1. Approve enhanced social work content/units of service as an addition to the Prenatal Health Promotion/Risk Reduction Program.

2. Determine reimbursement levels for service.

3. Enroll qualified local agency providers and designate those approved for this service.

4. Provide workshops, manuals, and technical assistance regarding billing procedures for service providers.

5. Determine client eligibility for Medical Assistance.

6. Provide information about enhanced social work services for Medicaid eligible prenatal clients who are identified at psychosocial risk and participating in a local Maternal and Infant Project.

7. Provide a quarterly report to KDHE reflecting payments for enhanced social work services.

SRS and KDHE will:

1. Promote early identification of pregnant women and infants and use of program services statewide.

2. Implement utilization review procedures.

3. Evaluate impact of services on perinatal outcomes for service recipients through cooperative sharing of outcome/statistical data.

E. NEWBORN/POSTPARTUM HOME VISIT

The Newborn/Postpartum Home Visit Program is provided for Medicaid infants and their mothers by local health departments. The purpose of this program is to reduce the incidence of newborn and maternal physician, psychosocial and environmental crises post delivery.

KDHE will:

1. Develop program content criteria, guidelines and related program standards.
2. Recommend content of program service.
3. Recommend reimbursement levels for program service.
4. Provide technical assistance and consultation to local health departments.

SRS will:

1. Approve content of program services.
2. Determine reimbursement levels for program service.
3. Enroll qualified providers.
4. Provide workshops, manuals and technical assistance regarding billing procedures.
5. Determine client eligibility.
6. Provide information about program to Medicaid applicants and eligible prenatal clients.
7. Make client referrals to local health departments.

SRS and KDHE will:

1. Promote use by clients and providers statewide.
2. Encourage cooperation between local health departments and local SRS offices to develop local outreach, eligibility determination and referral procedures.
3. Implement utilization review procedures.
4. Evaluate impact of program services on perinatal outcomes for program recipients.

F. WIC/MEDICAID COORDINATION

The Women, Infants and Children (WIC) Program authorized by Section 17 of the Child Nutrition Act of 1966, as amended, provides nutrition education and supplemental nutritious food packages to low-income pregnant, postpartum and breast-feeding women, infants, and children up to age 5 who are at nutritional risk. SRS Division of Medical Programs authorized by Title XIX of the Social Security Act provides medical care to those low income individuals who meet SRS eligibility standards. To assure that these individuals receive the health and nutrition services for which they are eligible, procedures will be established for cross referrals.

KDHE will:

1. Establish and coordinate procedures for the provision of SRS information and referrals to WIC program participants.

2. Inform local WIC agencies about changes in Medicaid eligibility rules.

3. Send WIC eligibility information updates to SRS for distribution.

4. Send local agency WIC clinic directories to SRS for distribution.

SRS will:

1. Establish and coordinate procedures for the provisions of WIC information and referrals to local WIC agencies.

2. Notify and refer in a timely manner all individuals in the State who are determined to be eligible for Medical Assistance, and who are pregnant, breastfeeding or postpartum women, or children below the age of 5 of the availability of WIC program benefits.

3. Inform SRS local offices about changes in WIC eligibility rules.

4. Send eligibility fact sheet updates to the state WIC agency for distribution.

5. Send SRS local office directory updates to the state WIC agency.

SRS and KDHE will:

1. Promote the distribution of program eligibility information and client referrals by local units.

2. Assure local units have appropriate referral systems.

3. Exchange participant information through local units for the purpose of making cross-referrals, increasing program participation, determining program eligibility and conducting outreach.

4. Participant eligibility information will not be shared with a third party.

G. COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)

The Commodity Supplemental Food Program (CSFP) authorized by Section 5, Public Law 93-86, as amended, provides supplemental nutritious commodity foods and nutrition education to eligible pregnant, breastfeeding and postpartum women, infants and children up to six years old. In order to implement the CSFP in Kansas, a joint effort has been initiated between SRS and KDHE. This interagency agreement identifies the various areas of responsibility for each department and provides an overview of the Kansas CSFP operations.

KDHE will:

1. Serve as the lead state agency administering the program.
2. Coordinate and implement fiscal management, program policy and procedures, and certification activities.
3. Contract with local agencies and provide administrative funds.
4. Maintain financial records and reports for the program.
5. Prepare and maintain contract with the commercial vendor to provide data processing and other computer services.
6. Provide consultation on and evaluation of program management, nutrition education and clinic services.

SRS will:

1. Coordinate and implement all food ordering, storing, packaging, and transporting activities from USDA to the point of delivery at the local distribution sites.
2. Oversee state and local CSFP inventory and distribution activities.
3. Maintain and monitor record-keeping systems for commodity food distribution and recipient participation.
4. Prepare and maintain contracts with commercial vendors to assure food availability for the program.
5. Assist in locating and providing technical assistance for local agencies and distribution sites.
6. Prepare and submit appropriate participation and distribution reports to USDA.

SRS and KDHE will:

1. Plan and coordinate program operations and development of the CSFP State Plan.

2. Monitor local CSFP agency operations in compliance with federal and state regulations and procedures.

3. Evaluate service delivery and revise the program to better serve the needs of recipients within program guidelines.

4. Plan and prepare strategies to best utilize caseload slots statewide.

5. Exchange financial, participation and food ordering options information for the purpose of maintaining optimal program operations.

H. FAMILY PLANNING

Family Planning Services help individuals of childbearing age to determine freely the number and spacing of their children. Local agencies that receive Title X funds to provide comprehensive family planning services are referred to as Title X local agencies. The agency will assume responsibility for managed reproductive health care for all individuals enrolled in the program.

KDHE will:

1. Establish and maintain standards and guidelines for quality of health services provided by Title X local agencies. These services include but are not limited to the following: complete health histories, physical assessment, health counseling and health screening for venereal disease, hypertension, cancer of the cervix and breast, urinalysis, and anemia. Contraceptive services and pregnancy testing are also available.

2. Monitor on-site the quality of care in all Title X local agencies in Kansas at least every two years. Ensure that all medical components of family planning clinics are supervised by a licensed physician.

3. Refer SRS family planning recipients to other services as needed.

4. Provide statistics regarding SRS-family planning recipients served in authorized family planning clinics.

5. Provide a certification statement to SRS within three weeks of the quarter's end stating that funds are available to match Federal funds.

6. Provide documentation for each local health department provider reflecting available match at the end of each calendar quarter.

SRS will:

1. Determine the eligibility of individuals who apply for Medical Assistance.

2. Offer family planning services to all those determined eligible for Medical Assistance and refer those who request services to the provider of their choice. For eligible clients who request services but have no provider preference, referral will be to a Title X local agency.

3. Establish the scope of services, to include eligibility for six months post-partum at 150% ov the federal poverty level, and reimbursement levels for Medical Assistance family planning services.

4. Provide statistics annually regarding SRS referrals to family planning clinics, the number of family planning procedures reimbursed by Medical Assistance programs and expenditures for these services.

5. Maintain effort based on FY 93 local health department family planning State General Fund expenditures by executing transfer of funds using the interfund voucher system.

6. Provide a quarterly report to KDHE reflecting payments for family planning services.

KDHE and SRS will:

1. Develop an outreach and referral system that will increase access to family planning services by appointing appropriate personnel.

2. Develop in-service education for appropriate SRS staff and public health nurses.

3. Implement joint bidding and contracting for cervical and vaginal Pap tests.

4. Negotiate an annual fee for each individual receiving managed reproductive health care based on cost.

I. MIGRANT HEALTH

The goal of the KDHE Kansas Migrant Health Program is to assure availability of medical and dental care to migrant and seasonal farmworkers and their families who would otherwise not have access to care because of their transient lifestyle. The purpose of this section is to describe the cooperative agreement between KDHE and SRS Medical Assistance in relation to Migrant Health. This agreement will assist in increasing utilization of Migrant Health and Medical Assistance through sharing of program information and services covered, and provision of referrals.

KDHE will:

1. Provide preventive health screening and services including routine physical examinations, anemia screening, nutrition assessments, vision and hearing screening, for eligible Migrant clients. Diagnostic, treatment and follow-up services are also provided.

2. Provide payment for hospitalization as funds are available, if clients are not eligible for Medical Assistance.

3. Conduct outreach visits to field workers, employers and crew leaders at least weekly, to identify those individuals eligible for and requiring services and to provide routine screening and services as necessary.

4. Report to SRS through written/oral communication, documented concerns of projects relating to health services availability and/or barriers for Medical Assistance eligible clients.

5. Provide written referral or assist in transporting clients who appear to be eligible for Medicaid reimbursement to the local SRS office.

6. Inform SRS of Migrant Health programs and locations, as well as services provided, on a yearly basis through written and verbal communication as well as through available project brochures.

7. Promote identification and referral of individuals to SRS who may be eligible for Medical Assistance program benefits.

8. Promote cooperative program planning and monitoring of Migrant Health efforts at the state and local levels..

SRS will:

1. Identify those clients who may be eligible for both Migrant Health and Medical Assistance.

2. Work with KDHE and local agencies to resolve barriers to health care for migrants and their families through identification of providers willing to accept migrant clients. Reimbursement will be requested directly from SRS by the local provider.

3. Refer Medical Assistance clients, eligible for Migrant Health services, to the Migrant Health Project.

4. Provide copies of Migrant program/service brochures as they are made available to appropriate SRS offices for dissemination to eligible Medical Assistance clients.

J. REFUGEE HEALTH

The purpose of the Kansas Refugee Health Assessment Program is to identify and treat health conditions that may affect the physical and mental well being of newly arrived refugees in order to facilitate their adjustment and resettlement in the community. The purpose of this section is to describe the cooperative agreement between KDHE and the SRS Refugee Resettlement program in relation to refugee health assessments.

KDHE will:

1. Provide health assessments for initially arriving refugees including TB testing, hepatitis and parasite screening and provide appropriate referral for treatment of conditions of public health significance.

2. Follow-up on clients referred for treatment to assure that the course of treatment is completed.

3. Report to SRS, documented concerns relating to health services availability and/or barriers for Medical Assistance eligible refugees.

4. Identify Refugee Health services for potential Medical Assistance reimbursement for eligible refugees and assist local health departments to bill SRS for services.

5. Inform SRS of refugee programs and services provided by local agencies on an annual basis through outreach, training and other available means.

6. Promote identification through routine intake, and referral of individuals to SRS who may be eligible for Medical Assistance.

7. Promote cooperative program planning efforts for refugee services at the state and local levels.

8. Encourage local agencies to provide follow-up and outreach activities for Medicaid/MediKan clients appropriate to client needs.

9. Provide to SRS a copy of the annual grant application and any update for funding from DHSS for the Refugee Health Assessment Program.

SRS will:

1. Consult with KDHE, when appropriate, regarding refugee health assessment services and treatments covered under Medical Assistance.

2. Work with KDHE and local providers to resolve barriers to health care services.

3. Provide a copy of the annual Refugee Resettlement Plan for the state of Kansas with updated amendments as necessary to KDHE.

4. Refer Medical Assistance applicants/recipients to Refugee Health Assessment services in appropriate areas.

5. Participate with KDHE in cooperative program planning for services covered by the Medical Assistance Program.

o COLLABORATION AND CONSULTATION

KDHE will:

1. When applicable, attend workshops held by SRS relating to Refugee Resettlement.

2. Respond to questions and issues presented by the Medical Assistance relating to Refugee Health Assessment.

3. Provide to SRS upon request, quarterly and annual summary statistics on refugee health and related data.

SRS will:

1. When applicable, attend KDHE or local agency workshops relating to the Refugee Health Assessment services.

2. Respond to questions and issues presented by KDHE relating to Medical Assistance and Refugee Resettlement Programs.

3. Provide KDHE copies of program reports relating to Refugee Resettlement Program.

K. SERVICES FOR TUBERCULOSIS

KDHE and SRS are required under certain circumstances by K.S.A. 65-104 et. seq. to provide and reimburse for diagnosis, treatment and follow-up for persons with or in jeopardy of contracting tuberculosis. The goal of the Departments is to stop the spread of tuberculosis infection and disease. The purpose of this section is to describe the cooperative agreement between KDHE and SRS in relation to tuberculosis services.

KDHE will:

1. Assure that diagnostic and treatment facilities meet acceptable quality assurance standards.

2. Provide a list of all approved inpatient and outpatient facilities to SRS and notify them of additions and deletions on a timely basis.

3. Refer persons who require inpatient treatment to the local SRS office in order to assure reimbursement to the inpatient facility.

4. Provide anti-tuberculosis drug, without charge, to persons eligible for Medical Assistance.

5. Notify SRS of any administrative/fiscal change which may impact mutual clients.

6. Assure to the degree practicable that inpatient and outpatient diagnosis and treatment facilities and/or providers are available to Medical Assistance recipients and refugees.

SRS will:

1. Determine eligibility for Medical Assistance and assure that persons who require inpatient treatment for tuberculosis will be determined eligible.

2. Maintain a current list of inpatient and outpatient treatment facilities approved by KDHE and provide these lists to providers participating in the Medical Assistance program.

3. Reimburse inpatient and outpatient treatment facilities approved by KDHE and certified to be Medicaid providers.

4. Notify KDHE of any administrative/fiscal changes which may affect mutual clients.

5. Reimburse for or provide transportation to clients outside a 50 mile radius of the inpatient or outpatient facility.

6. Assist KDHE, upon request, to resolve any problems which may arise from the Medical Assistance case management programs.

L. IMMUNIZATIONS

The goal of the Vaccine Replacement program is collaboration between KDHE and SRS in reducing vaccine-preventable diseases among Medicaid-eligible Kansans. The following vaccines are included: Haemophilus Influenza B, Measles/Mumps/Rubella (MMR), Diphtheria Tetanus (DT, pediatric), TB, intradermal (Mantoux, PPD), Diphtheria/Pertussis/Tetanus (DPT), Tetanus/Diphtheria (TD (adult), Oral Polio, Hepatitis B, Injectible Polio.

SRS will:

1. Process provider claims and reimburse Medicaid providers for administering the vaccines listed above according to the current SRS Medicaid fiscal agent contract.

2. Notify KDHE through the SRS fiscal agent to replace the specified vaccines used by providers enrolled with Medicaid who are licensed (certified) to administer vaccine for Medicaid clients and to specify accountability and reporting requirements.

3. Communicate with and provide information to Medicaid providers regarding claims processing and provide education about the vaccine replacement program to Medicaid providers.

4. Reimburse supply agents for the specified vaccines distributed to Medicaid providers and for postage containers and related supplies.

5. Make payments to KDHE for the actual costs of storage, shipping and handling the specified vaccines distributed to Medicaid providers. Payments include actual costs of one SRS Vaccine Program liaison position. Full compensation for this agreement shall not exceed the approved annual budget. Should the agreement terminate or not be renewed, payment will be adjusted based on actual costs.

KDHE will:

1. Secure vaccine from federally-contracted supply agents and distribute monthly a replacement supply to Medicaid providers. Billing statements from supply agents will be forwarded to SRS for direct payment to the agent.

2. Each year, submit state fiscal year budgets to SRS for approval, by January 15, 1993 for SFY 93, and by June 1 of each subsequent state fiscal year.

3. Quarterly, provide fiscal reports to SRS Division of Medical Services Fiscal Manager showing actual expenditures and make available for SRS audit such books, files, records and other data as may be necessary to clarify, substantiate or justify expenditures under this agreement.

4. Quarterly, provide copies of current contracts with pharmaceutical companies providing vaccine for services to the SRS Division of Medical Services Fiscal Manager.

5. Maintain a record of the number of doses by type of vaccine delivered to each Medicaid provider. Maintain a record, by lot number, of where each vial of vaccine was shipped.

NOTE: When a provider receives a vaccine replacement which cannot be used before expiration date, to receive a new replacement the provider must contact the SRS vaccine liaison at the Bureau of Immunization to request permission to return the vaccine. To be approved, the following conditions must be met:

a. The vaccine must be no closer to expiration date than two (2) weeks.

b. The vaccine mut be kept refrigerated at all times, and be packaged with cold packs to maintain viability. (Polio vaccine must be kept frozen.)

c. The packaged vaccine must have all pertinent sender information. It mut also be labeled in red with the following:

BIOHAZARD - VACCINE ENCLOSED

d. Improperly returned vaccine will not e accepted by the Bureau of Immunization.

Vaccine that is beyond expiration date may not be returned, unless the Bureau of Immunization is able to receive replacements free-of-charge from a manufacturer. If an expired vaccine can be replaced to the Bureau of Immunization by a manufacturer free-of-charge, the provider must follow the same process as outlined above (except for cold-packing) to return vaccine and receive new replacement.

6. Maintain inventories of the SRS Vaccine Replacement Program separately from that of other programs in the most convenient manner possible.

7. Monthly, submit payment vouchers to SRS, itemizing storage, shipping and handling costs. This voucher will show KDHE as the receiving agency and SRS as the paying agency. Through this interfund voucher, SRS will provide the funding for the administrative costs incurred by KDHE through this agreement. Payment will be made at the beginning of the month during which services are provided. In other words, the amount stated in the payment voucher is a projected amount subject to adjustment.

8. Return to SRS any unexpended funds within 60 days in the event the agreement is terminated or not renewed.

M. SUBSTANCE ABUSE SERVICES

The purpose of this section is to establish methods for ongoing collaboration and coordination between KDHE and SRS, Alcohol and Substance Abuse Services. Specifically, this section of the agreement will: prevent duplication of efforts, promote dissemination of information regarding risks of substance abuse (alcohol and abuse of legal and illegal substances) to all Kansas citizens, and establish methods for collection, sharing and analysis of data.

o PROGRAM INFORMATION AND SERVICES

SRS and KDHE will:

1. Assure staff participation on permanent and/or ad hoc intra-agency and inter-agency committees related to joint public health and substance abuse initiatives/services.

2. Share written program/agency plans regarding substance abuse initiatives.

KDHE will:

1. Provide to SRS/ADAS information about public health activities related to substance abuse prevention and early intervention initiatives.

2. Promote cooperative intra-agency and inter-agency program planning and monitoring of public health substance abuse efforts at the state and local levels.

3. Incorporate substance abuse prevention, client identification, early intervention, and referral to substance abuse treatment services in all public health protocols and standards.

SRS will:

1. Inform and refer substance abuse applicants/recipients to appropriate public health and community-based services.

2. Participate with KDHE in cooperative program planning and monitoring of public health efforts at the state and local levels.

3. Provide KDHE and other designees with SRS/ADAS program brochures related to substance abuse.

4. Establish methods for KDHE to gain access to client demographic information as needed.

o CONSULTATION AND CONTINUING EDUCATION

SRS and KDHE will:

1. Provide inter-agency consultations on request regarding public health and substance abuse initiatives.

2. Participate in mutual evaluation of the impact of public health/substance abuse services and client access through data collection and analysis.

KDHE will:

1. Plan, present and/or participate in workshops held by SRS/ADAS related to substance abuse issues and services.

2. Respond to questions and issues presented by SRS/ADAS staff.

3. Provide substance abuse data to SRS/ADAS, as requested.

SRS will:

1. Plan, present and/or participate in workshops held by KDHE relating to substance abuse issues and services.

2. Respond to questions and issues presented by KDHE staff.

3. Share reports and data relating to substance abuse programs and studies with KDHE.

o TREATMENT SERVICES

KDHE will:

1. Support through consultation and funding (if available) substance abuse treatment services at the community level.

2. Report to SRS/ADAS documented concerns relating to treatment services availability and/or barriers for Medical Assistance clients and other substance abusers.

3. Provide recommendations for public health standards for substance abuse services.

4. Work with SRS/ADAS and local providers to resolve barriers to treatment services.

SRS will:

1. Identify substance abuse services to be covered by Medical Assistance, utilizing KDHE consultation.

2. Work with KDHE and local providers to resolve barriers to substance abuse treatment and local public health services.

3. Provide a pilot project in cooperation with KDHE to place a drug counselor on site in one of the major metropolitan health departments and evaluate the effectiveness of an on-site counselor vs. referral.

o. FEES AND REIMBURSEMENT

SRS and KDHE will:

1. Identify reimbursable and potentially reimbursable substance abuse services.

2. Identify gaps in service delivery related to public health and substance abuse and propose potential solutions.

N. TOLL-FREE TELEPHONE NUMBER

KDHE will:

1. Provide and publicize a toll-free telephone number which provides adequate information on how persons can access MCH, SHS, and Medicaid services (obstetric and pediatric) in the state.

2. Provide information relating to experience in use of the toll-free telephone number for planning and evaluation purposes.

SRS and KDHE will:

1. Coordinate development, maintenance and publication of information regarding providers.

VI. Procedure for Resolution of Disagreements

Operational disagreements which become apparent in the course of this Agreement shall be resolved by discussions between the concerned parties at the organizational level closest to the problem. If the problem/issue is not resolved informally, it shall be referred to and resolved by the Secretary of KDHE or designee and the Secretary of SRS or designee. This will be done by a letter outlining the problem and circumstances with a request for a meeting between the secretaries or designees, and will involve any other affected parties.

VII. Decision Authority

Policy decisions necessary for the implementation of this Agreement shall be developed by the parties to this Agreement. SRS and KDHE program staff will develop policy recommendations. The mutually agreed upon policy shall be referred to KDHE and SRS Secretaries or Secretaries' designees for final approval.

VIII. Procedure for Referrals

Each party to this Agreement will establish a system of referrals for those services not directly rendered by the agency, but which are essential to meet the individual's need. To the degree possible, these referrals will be made at the time of client contact. Programs such as the supplemental food program for women, infants and children (WIC), Food Stamps, and Healthy Start will fall into this category.

IX. Method Developed to Coordinate the Title V Assurance Statement/Title XIX State Plan

This Agreement shall, upon its approval by the appropriate Federal Officials, become a part of Kansas' Title V Assurance Statement and Title XIX State Plan.

This Agreement shall define the health services provided or arranged for clients who are both Title V and Title XIX recipients.

A committee shall be appointed to assure this coordination. Appointment, by the Secretaries, of at least one (1) representative shall constitute the membership of this committee.

The committee shall meet at the request of either agency Secretary or designee, or at least annually, to permit the parties to this Agreement to provide input, to resolve any problems/issues which may arise, to review, evaluate, and make recommendations to the Secretaries regarding the conditions outlined in other sections of this Agreement.

X. Methods for Payments or Reimbursements

Unless there are other third party resources, SRS shall reimburse eligible providers for any service covered under the State Medicaid Plan for eligible medical assistance clients. Title XIX funds shall be the first and primary source of payment for medical services provided to mutual beneficiaries of the Title V and Medical Assistance Programs.

XI. Confidentiality of Information

The Agencies shall treat all information, and in particular information relating to recipients and providers, which is obtained as confidential information to the extent that confidential treatment is provided under federal or state law or regulation and shall not use any information so obtained in any manner except as necessary to the proper discharge of its obligations and securement of its rights hereunder.

XII. Confidentiality of Client Information

All information as to personal facts and circumstances obtained shall be treated as privileged communications, shall be held confidential, and shall not be divulged without written consent of SRS or KDHE and the written consent of the individual, the individual's attorney, or responsible parent or guardian, except as may be required by SRS, provided that nothing herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning individuals shall be limited to purposes directly connected with the administration of the agencies' programs. The use or disclosure of any information concerning an individual for any purpose directly connected with the administration of the Medicaid/MediKan Program with respect to services provided is prohibited except on prior written approval by the Director of Medical Programs. Under law, SRS cannot consent to release lists of recipients or eligible persons' names.

XIII. Continuous Liaison

Continuous liaison among the parties to the Agreement shall be the responsibility of the Secretaries or his/her appointed staff designees.

XIV. Provision for Periodic Review of the Agreement

This Agreement shall be in effect upon signature by the Secretaries of both agencies and is continuing in nature until such time as it is terminated by either party. The Agreement shall be reviewed at least annually by the parties to said Agreement or whenever a major reorganization occurs. Such reviews shall be for the purpose of development of new agreements, modifications, clarification, or redefinition of any provision as deemed necessary. Any modification shall require review by the signing parties.

Any attached individual program addenda shall be considered a part of the Agreement. Additional program addenda shall be discussed at the annual review or special meetings and added as needed. Revision of an individual program addendum may be made without affecting the terms of the general agreement. This Agreement shall become effective after signatures are affixed by the Secretary of SRS and the Secretary of KDHE.

This Agreement may be terminated by either party upon written sixty (60)-day notice to the other party.

Secretary
Department of Social and
Rehabilitation Services

Date 6-12-93

Secretary
Department of Health and
Environment

Date 6/9/93

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

AGREEMENT BETWEEN INCOME SUPPORT AND MEDICAL SERVICES
AND
YOUTH AND ADULT SERVICES

I. Mutual Objectives and Responsibilities

The purpose of this agreement is to facilitate alternative service delivery systems with the goal of maintaining Medicaid eligible individuals in their own homes and communities, to avoid institutional or other "out-of-home" treatment, and to secure federal financial participation for such service delivery systems. The mutual goal is to maintain Medicaid eligible individuals in the least restrictive environment that provides services consistent with their needs.

This agreement is between the Commission of Income Support and Medical Services (ISMS) and the Commission of Youth and Adult Services (YAS), both within the Kansas Department of Social and Rehabilitation Services which is the Single State Agency designated to administer the Medicaid Program under Title XIX of the Social Security Act. The terms of this agreement are subject to all federal terms, conditions and rules governing cooperative agreements under 42 CFR 431, Subpart M.

II. Responsibilities of Each Party

A. Duties of ISMS

ISMS will:

1. Determine Medicaid eligibility for individuals applying for services, except for foster care and adoption support individuals.

2. Through its Medicaid fiscal agent:

   a. Enroll providers of service based upon criteria developed by ISMS and YAS.

   b. Communicate with providers through bulletins, workshops and on-site technical assistance, about the nature and scope of Medicaid services and how to bill for them.

   c. Process claims for Medicaid reimbursement.

d. Provide telephone communications staff to resolve claims processing problems.

e. Collect, report and analyze data necessary to prudently manage services provided.

3. Notify the fiscal agent of payment rates and approved providers.

4. Coordinate with YAS and the fiscal agent the development of financial and statistical reports.

5. Provide the mechanism whereby federal financial participation may be claimed for services including maintenance of the Kansas Medicaid State Plan and fiscal reporting.

6. Coordinate responses to federal questions and reviews (if any).

B. Duties of YAS

For all programs involved in this agreement and the responsibility of YAS, YAS will:

1. Develop and disseminate program/service requirements for Medicaid eligible individuals and providers and monitor to see that they are met.

2. Provide funds to reimburse the Medicaid program for the federal share of overpayments resulting from inappropriate services provided to Medicaid recipients as a result of an SRS employee's failure to follow Medicaid policy concerning program/service requirements.

3. Work within individual communities to locate and establish potential providers. License, certify or otherwise approve providers of service. Provide technical assistance and consultation to providers as needed to implement this agreement.

4. Provide to Medical Services, a list of Youth Service approved providers.

5. Develop and issue instructions on the development and coordination of service plans with providers and clients, through written manuals for field staff working with Medicaid eligible individuals.

6. Train SRS field staff on policies and procedures required for the implementation of this agreement.

7. Respond to questions and inquiries about program services.

8. Request and provide through the state budget process, state matching funds, each year, to carry out this agreement.

9. Provide match for administrative and implementation costs.

III. Mutual Responsibilities

ISMS and YAS will:

A. Each designate a staff person for continuous liaison and coordination between the two commissions.

B. Meet regularly for planning, coordinating, reviewing and evaluating trends and effectiveness.

C. Annually develop a plan for service delivery and reimbursement and develop specific goals, targets and priorities in this annual plan. Annually determine funding levels and budget strategy.

D. Develop, maintain and share statistical data.

E. Jointly define and design programs while working with community providers and other interested parties.

F. Devise a payment structure based upon a fee for service methodology and set payment rates.

G. Establish special pricing cost account codes which can be assigned to claims for services covered by this agreement which will allow payment from YAS funds and federal Medicaid matching funds.

H. Participate, encourage and promote participation in the KAN Be Healthy (Early and Periodic Screening, Diagnosis and Treatment) program, Family Planning and Long Term Care issues as appropriate.

I. Develop and maintain procedures for reciprocal referrals.

IV. Agreement

This agreement supersedes any previous agreements between Youth Services, Adult Services and Income Maintenance/Medical Services. This agreement shall be in effect upon signature by the Commissioners of both Commissions and is continuing in nature until such time as it is terminated by either party. This agreement shall be reviewed at least annually by the parties or whenever a major reorganization occurs. Any modification shall require new signatures by both parties.

IN WITNESS THEREOF, THE PARTIES HERETO HAVE AFFIXED THEIR SIGNATURES

Commissioner of Income Support and Medical Services

Date 6/11/93

Commissioner of Youth and Adult Services

Date May 26, 1993

EXTRAORDINARY MEDICAL EXPENSES AGREEMENT

BETWEEN INCOME SUPPORT AND MEDICAL SERVICES
AND
YOUTH AND ADULT SERVICES

I. Statement of the Problem:

Youth Centers are budgeted adequately to provide for the routine medical and dental needs of their populations. Youth admitted occasionally come with major medical problems and some require hospitalization and/or surgery for injuries or other conditions. On a youth center by youth center basis, it is unwise to budget for these occurrences because their frequency is sporadic and unpredictable.

This agreement serves to assure proper medical care for youth admitted to youth centers by providing a mechanism to fund these extraordinary expenses which are outside the normal scope of a youth center budget. It is intended to address only those situations which clearly exceed the resources of the individual youth centers.

II. Objectives of the Agreement

A. Provide a to assure funding of extraordinary medical costs incurred by youth in youth centers.

B. To establish necessary procedures fulfilling this agreement.

III. Procedures

A. When youth centers have exhausted their contracted medical funding, the Youth Center Superintendents will advise the Chief of Support Services, Youth and Adult Services, when they have an actual or anticipated medical expense.

B. The Chief of Support Services will validate the Superintendents assessment by independent review.

C. For all validated situations a request will be made to the Claims Resolution Manager, Division of Medical Services, for funding of the individual situation.

The request will include/but not be limited to the following information:

1. Medical condition requiring treatment.

2. Estimated cost.

3. Name of youth center and a contact person.

D. Medical Services will approve or disapprove the request by Youth and Adult Services, utilizing the established Medical Necessity Criteria under the Medicaid/MediKan Programs, with a written response to Youth and Adult Services including instructions as to how to proceed if payment is approved.

E. If approved, the providers of services must submit completed Kansas Medicaid claim forms directly to the Claims Resolution Manager in the Division of Medical Services for payment. Payment made will not exceed the maximum reimbursement for Medicaid. Payment will be made from all State Funds.

IN WITNESS THEREOF, THE PARTIES HERETO HAVE AFFIXED THEIR SIGNATURES

Commissioner of Income Support and Medical Services

Date 6/11/93

Commissioner of Youth and Adult Services

Date May 26 1993

KANSAS MEDICAID STATE PLAN

AGREEMENT BETWEEN REHABILITATION SERVICES
AND INCOME MAINTENANCE AND MEDICAL PROGRAMS

I. THE MUTUAL OBJECTIVES AND RESPECTIVE RESPONSIBILITIES
The mutual objectives of Rehabilitation Services and The Division of Medical Programs are to provide evaluation, training and medical services to Kansans with disabilities. The responsibilities of Rehabilitation Services include guidance and counseling, training and job placement assistance. The responsibilities of the Division of Medical Programs include defining covered Medicaid/MediKan Services for those eligible and making payment to medical providers for those services.

II. THE SERVICES EACH OFFERS AND IN WHAT CIRCUMSTANCES
The following section outlines the services provided by Rehabilitation Services and Medical Programs.

A. Rehabilitation Services
Services are designed to help restore or develop the work skills of physically and mentally handicapped citizens to the extent that they may become gainfully employed. Counseling and many other types of services may be provided to help the person with a disability to become a self-supporting citizen. The following services may be included in a rehabilitation program for an individual client.

1. Complete medical diagnosis and vocational evaluation.
2. Medical, surgical, psychiatric, and hospital services.*
3. Prosthetic devices, such as artificial limbs, braces or hearing aids.*
4. Vocational guidance and counseling.
5. Vocational training such as post-secondary schools or on-the-job training.*
6. Personal and vocational adjustment training in rehabilitation centers or workshops.
7. Occupational tools or equipment required by a specific job.*
8. Job placement.
9. Followup to assure that the job is suitable and that both the worker and the employer are satisfied.

* In instances where the individual is not eligible for a medical card and is able to participate financially in the program (as determined by an economic needs summary), he/she is expected to pay for needed medical services, prosthetic devices, vocational training or occupational tools.

KANSAS MEDICAID STATE PLAN

B. Medicaid/MediKan Program

In Kansas, the Medicaid/MediKan Program pays providers for the following categories of service delivered to persons determined eligible for medical services and who have a medical necessity for the services: adult care home services, ambulatory surgical center services, audiological services, chiropractic services, community mental health center services, dental services for only those in the Kan Be Healthy program, durable medical equipment and supplies, family planning services, home health services, inpatient and outpatient general hospital services, laboratory and x-ray services, local health department services, medical transportation, nursing services provided by an advanced registered nurse practitioner, optometric services, orthotics and prosthetics, physician services, podiatric services, prescribed drugs, psychological services, and targeted case management services. Each category of service has specific limitations which are outlined in Attachment 3.1-A of the Kansas Medicaid State Plan. Payment of claims for covered services is detailed in the provider manuals issued by the Medicaid fiscal agent.

III. COOPERATIVE AND COLLABORATIVE RELATIONSHIPS AT THE STATE LEVEL

The Commissioner of Rehabilitation Services and the Commissioner of Income Maintenance and Medical Programs, or their designees, will be responsible for the establishment of a working relationship between the two programs. In order to facilitate this coordination the two parties will meet as needed. The parties of this agreement also agree to work with the Staff Development Section of SRS to provide appropriate in-service training to local and area office staff. Annually, the services provided by each program under this agreement will be jointly reviewed (see Section V.E.).

IV. THE KINDS OF SERVICES TO BE PROVIDED BY LOCAL AGENCIES

A. Services provided by Rehabilitation Services staff in the area offices

1. Determination of eligibility of individuals for Rehabilitation Services.
2. Referral of potentially eligible Medicaid/MediKan recipients to Income Maintenance for determination of medical eligibility.
3. Referral of individuals who are eligible for Kan Be Healthy services.

B. Services provided by local and area SRS staff who determine medical eligibility

1. Determination of eligibility of individuals for Medicaid and MediKan.
2. Referral of potentially eligible clients to Rehabilitation Services.
3. Referral of individuals who are eligible for Kan Be Healthy services.

KANSAS MEDICAID STATE PLAN

V. METHODS

A. Arrangements for Early Identification of Individuals Under 21 Years of Age in Need of Medical or Remedial Services

All Rehabilitation Services clients who are under the age of 21 and eligible for Medicaid will be referred directly to local staff responsible for the Kan Be Healthy program.

B. Arrangements for Reciprocal Referrals

Methods and procedures for intraagency referrals between Rehabilitation Services staff and IM/MS staff will be worked out on the local level.

C. Coordinating Plans for Health Services Provided or Arranged for Recipients

The Rehabilitation Services and Division of Medical Programs will each designate a representative. These representatives will be responsible for (1) maintaining coordination between the two services, (2) assuring that communication is regular and timely, and (3) assuring that rates are coordinated and in a timely fashion.

D. Reimbursement for Services

1. Medicaid or MediKan will pay for all covered services (including durable medical equipment) that meet program criteria. These services may include such services as inpatient general hospitalization, wheelchairs, and other equipment, rehabilitation hospital services, diagnostic procedures and services and equipment not related to the handicapping condition. In all instances when clients are eligible and services are covered, Medicaid and MediKan will pay for the medical services. Claims for the services will be submitted to the Medicaid fiscal agent if the provider participates in the Kansas Medicaid Program. Claims for medical services provided by providers not participating in the Medicaid Program will be paid by Rehabilitation Services.

2. Rehabilitation Services' funds will be used to pay for prior authorized major medical services and equipment not covered by Medicaid or MediKan when a client is eligible for Rehabilitation services and when these services are part of the written rehabilitation plan. Equipment may include, but is not limited to, wheelchairs, beds, respiratory equipment, prostheses and braces, if needed to provide the client accessibility to training and/or employment. Services may include training in rehabilitation centers.

3. Rates of reimbursement to be used by both Rehabilitation Services and the Division of Medical Programs will be set by the Secretary of Social and Rehabilitation Services based upon recommendations of the Division of Medical Programs. Changes in the maximum allowable rates will be recommended to the Division of Medical Programs by Rehabilitation Services prior to budget preparation each year. Single rate recommendations will be made at least two months prior to the beginning of the state fiscal year.

KANSAS MEDICAID STATE PLAN

E. Exchange of Reports of Services Provided to Recipients

Reports concerning services provided to recipients of both programs will be shared as they become available.

F. Periodic Review and Joint Planning for Changes in the Agreements

This agreement will be reviewed on an annual basis. The review and joint planning for changes in this agreement will be held at least one month prior to the expiration date of this agreement.

G. Continuous Liaison and Designation of Staff Responsible for Liaison Activities at State and Local Levels

Liaison will be maintained by the Commissioner of Rehabilitation Services and the Commissioner of Income Maintenance and Medical Services or their designees.

H. Joint Evaluation of Policies that Affect the Cooperative Work of the Parties

Policies that affect cooperative work of both divisions will be jointly reviewed and signed off prior to implementation. Differences in policies will be resolved through joint discussion. Referral of issues which cannot be resolved will be referred to the Commissioners, who may refer these to the Secretary of the Department of Social and Rehabilitation Services if necessary.

This agreement becomes effective upon its approval by both divisions. This agreement may be terminated by written confirmation of both parties, or by sixty days termination notice by either party.

Commissioner of Rehabilitation Services

Commissioner of Income Maintenance and Medical Services

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

AGREEMENT BETWEEN INCOME SUPPORT AND MEDICAL SERVICES
AND
MENTAL HEALTH/RETARDATION SERVICES

I. Mutual Objectives and Responsibilities

The purpose of this agreement is to satisfy federal requirements for cooperative agreements between Medicaid and the entity administering the services provided by state-owned acute inpatient psychiatric hospitals (IMDs), state-owned intermediate care facilities for the mentally retarded (ICFs/MR), nursing facilities for the mentally ill (NFs/MH) and Home and Community Based Services for the mentally retarded (HCBS/MR). This agreement is required to be in the Kansas Medicaid State Plan and is required for federal financial participation for the services provided to Medicaid eligible individuals in state-owned inpatient psychiatric hospitals and state-owned intermediate care facilities for the mentally retarded.

This agreement is between the Commission of Income Support and Medical Services (ISMS) and the Commission of Mental Health/Retardation Services (MHRS), both within the Kansas Department of Social and Rehabilitation Services which is the Single State Agency designated to administer the Medicaid Program under Title XIX of the Social Security Act. The terms of this agreement are subject to all federal terms, conditions and rules governing cooperative agreements under 42 CFR 431, Subpart M.

II. Services Each Party Offers and in What Circumstances

A. Responsibilities of MHRS

1. Develop and disseminate the admission criteria for individuals to a state-owned acute inpatient psychiatric hospital or state-owned ICF/MR facilities.

2. Provide for the Licensure, certification or other approval process for providers of service in state-owned acute inpatient psychiatric hospitals and state-owned ICFs/MR. MHRS will notify ISMS's fiscal agent of providers approved to deliver services and promptly notify ISMS's fiscal agent of any additions or deletions.

3. Establish program service requirements.

4. Develop and issue instructions through written ISMS manuals for SRS field staff pertaining to Medicaid/MediKan eligible individuals which include descriptions of determination of appropriate and integrated community services, procedures for admission, discharge and transfer.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

AGREEMENT BETWEEN INCOME SUPPORT AND MEDICAL SERVICES
AND
MENTAL HEALTH/RETARDATION SERVICES

5. Train local SRS staff in procedures required for determination of appropriate Home and Community Based Services for the Mentally Retarded (HCBS/MR) waiver services for Medicaid/MediKan eligible individuals.

6. Respond to questions and inquiries about IMDs, NF/MH, ICFs/MR, HCBS/MR services.

7. Request through the state budget process that state matching funds are available each year.

8. Notify the Medicaid fiscal agent of payment rates for Medicaid/MediKan providers of IMDS, NF/MH, ICF/MR and HCBS/MR services.

9. Develop MHRS program plans that impact cash, medical, or food stamp program operations in conjunction with appropriate IM/MS staff.

10. Sixty days prior to the stopping of payments, notify the Director of IM and the appropriate IM Chief when a ICF/MR or NF/MH facility has been decertified by the Department of Health and Environment.

B. Responsibilities of ISMS

1. ISMS will determine Medicaid/MediKan eligibility, at the local office level, for individuals applying for services.

2. ISMS will through its Medicaid fiscal agent:

a. enroll providers of services based upon criteria developed by MHRS.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

AGREEMENT BETWEEN INCOME SUPPORT AND MEDICAL SERVICES
AND
MENTAL HEALTH/RETARDATION SERVICES

b. communicate with providers about the requirements of the Medicaid program, the nature of services and how to bill for services through bulletins, workshops and technical assistance.

c. process claims for reimbursement.

d. collect, and report data necessary to prudently administer, monitor and plan for budget expenditures.

3. Notify and coordinate with the fiscal agent to accurately and in a timely fashion produce any financial or statistical reports.

4. Ensure a mechanism whereby federal financial participation may be claimed for services including administration of the Kansas Medicaid State Plan.

5. Promptly advise MHRS of any federal questions or correspondence affecting state-owned inpatient psychiatric hospitals and ICFs/MR, NF/MHs, or HCBS/MR. ISMS will coordinate federal reviews (if any).

III. Mutual Responsibilities

ISMS and MHRS will:

1. Each designate staff persons for continuous liaison and coordination between the two commissions by areas of program responsibility.

2. Meet monthly for joint policy development, planning, coordinating, reviewing and evaluating trends and effectiveness.

3. Where applicable, annually determine funding levels and budget strategy.

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

AGREEMENT BETWEEN INCOME SUPPORT AND MEDICAL SERVICES
AND
MENTAL HEALTH/RETARDATION SERVICES

4. Develop, maintain and share statistical data.

5. Jointly define and design Medicaid/MediKan programs including working with providers and other interested parties.

6. Devise payment structures for Medicaid/MediKan programs related to this agreement, based upon mutually agreed upon methodologies.

7. Devise and implement procedures for the early identification of individuals under the age of 21 in need of services, and promote the participation in the Kan Be Healthy (Early and Periodic Screening, Diagnosis and Treatment) program.

8. Develop and maintain procedures for reciprocal referrals.

IV. Agreement

This agreement shall be in effect upon signature by the Commissioners of both Commissions, and is continuing in nature until such time as it is terminated by either party. This agreement shall be reviewed at least annually by the parties or whenever a major reorganization occurs. Any modification shall require new signing by both parties.

IN WITNESS THEREOF, THE PARTIES HERETO HAVE AFFIXED THEIR SIGNATURES.

Robert L. Eggers
Commissioner of Income Support and Medical Services

Date 4/30/92

George O. Vega
Acting Commissioner of Mental Health and Retardation Services

Date 5/11/92

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

AGREEMENT BETWEEN INCOME SUPPORT AND MEDICAL SERVICES
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MENTAL HEALTH/RETARDATION SERVICES

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5. Train local SRS staff in procedures required for determination of appropriate Home and Community Based Services for the Mentally Retarded (HCBS/MR) waiver services for Medicaid/MediKan eligible individuals.

6. Respond to questions and inquiries about IMDs, NF/MH, ICFs/MR, HCBS/MR services.

7. Request through the state budget process that state matching funds are available each year.

8. Notify the Medicaid fiscal agent of payment rates for Medicaid/MediKan providers of IMDS, NF/MH, ICF/MR and HCBS/MR services.

9. Develop MHRS program plans that impact cash, medical, or food stamp program operations in conjunction with appropriate IM/MS staff.

10. Sixty days prior to the stopping of payments, notify the Director of IM and the appropriate IM Chief when a ICF/MR or NF/MH facility has been decertified by the Department of Health and Environment.

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c. process claims for reimbursement.

d. collect, and report data necessary to prudently administer, monitor and plan for budget expenditures.

3. Notify and coordinate with the fiscal agent to accurately and in a timely fashion produce any financial or statistical reports.

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IN WITNESS THEREOF, THE PARTIES HERETO HAVE AFFIXED THEIR SIGNATURES.

Commissioner of Income Support and Medical Services

Date 4/30/92

Acting Commissioner of Mental Health and Retardation Services

Date 5/11/92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

LIENS AND ADJUSTMENTS OR RECOVERIES

1. **The State uses the following process for determining that an institutionalized individual cannot reasouable be expected to be discharged from the medical institution and return home:**

There is a rebuttable presumption that a recipient is permanently institutionalized if the individual has 1) resided in a nursing facility, ICF/MR, or other medical institution for 6 months or longer, and 2) is required as a condition of receiving services to apply their income to the cost of care except for a Personal Needs Allowance (PNA). Verification is obtained from the individual's attending or admitting physician regarding the expectation and ability of the individual to return to the home. A lien is not imposed where the physician indicates the individual will likely return home.

If the state makes a determination that the recipient is not reasonably expected to be discharged from the medical institution and returned to their home, the state will send a notice to the recipient, and to the personal representative, guardian or conservator of the recipient. The notice will be in letter form and will contain the following information:

a. the reason for the medical determination;
b. the potential for the imposition of a lien on real estate owned by the recipient;
c. the present value of the potential lien;
d. the real estate subject to the potential lien;
e. the applicable exemptions limiting the imposition of liens;
f. the meaning of the term "lien";
g. the statement that the imposition of a lien will not change the individual's ownership interest in the property nor cause the individual to lose eligibility due to placement of the lien;
h. the administrative hearing rights of the recipient in the matter;
i. the method and applicable time period for requesting an administrative hearing;
j. the person who should receive the hearing request;
k. the office that will be responsible for determining the issues in the hearing;
l. the procedures used in the hearing;

The recipient or their representative may request a hearing within 30 days of the notice by contacting the agency or the administrative hearing office. The request for an administrative hearing must be in writing and reference the agency determination being contested by the recipient or their representative. The administrative hearing will follow the process and procedure noted in the Kansas Administrative Procedure Act. If no request for a hearing is received, the state will place a lien on the real property. If a hearing is requested, no action will occur until the final determination is reached, as specified by Kansas Administrative Procedure Act.

2. **The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):**

If a son or daughter claims they have provided care which would prevent the state from enforcing a lien on property, the state will use the following in determining the request:

a) The son or daughter:
   1) has resided in and used the home as his or her principal place of residence for a continuous period of two years immediately prior to the date the recipient was admitted to a facility; and

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

2) has resided in the recipient's residence on a continuous basis since that time.

b) The recipient required care to remain in the home as evidenced by physician's records or statement, level of care scores or other relevant information such as home health records or private insurance records.

c) The son or daughter provides a description of the type of care provided, including the duration and amounts of each service, and any documentation which supports the son or daughter's statements.

d) Other information relevant to the particular case.

3. The State defines the terms below as follows:

- **estate** – For services received prior to July I, 2004, probate estate is defined through case law as those assets in which the decedents held an interest in his or her own right. For services received on or after July 1, 2004 the medical assistance estate is defined in K.S.A. 39-709 as including all real and personal property and other assets in which a decedent had any legal interest or title at the time of or immediately before death, to the extent of the interest or title.

- **individual's home** – Real property in which the recipient has an ownership interest and which he or she occupied as a primary place of residence immediately prior to admission to a medical institution.

- **equity interest in the home** – Ownership interest as recognized under Kansas law in property meeting the above definition of the individual's home.

- **residing in the home for at least one or two years on a continuous basis** – Consensual occupancy of the home as the primary residence without absence of more than a temporary period.

- **lawfully residing** – Living in the home with permission of the owner, or person with authority to give permission, and otherwise residing in a manner not contrary to or forbidden by law.

- **discharge from the medical institution and return home** – The release of an individual to the home property with an intent to stay.

4. The State defines undue hardship as follows:

The applicant can demonstrate that enforcement of the claim would result in an undue hardship to the applicant based on the factors listed in 5 below.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause undne hardship, and when recovery is not cost-effective:

A recipient of medical assistance, a representative of the recipient, a surviving family member of a deceased recipient or a representative of a surviving family member of a deceased recipient may request a waiver of recovery action. The request should be presented to the State by giving the request to the eligibility case worker for the recipient or by sending the request to the estate recovery unit at the address noted in the pre-litigation letter. The request should be presented within 30 days of the date on the pre-litigation letter. (This letter notice is explained in more detail in Paragraph 7). The request for waiver should be:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

a) in writing;
b) identify the recipient;
c) identify the requestor of the waiver, if different than the recipient, and their relationship to the recipient;
d) identify the specific recovery action to be waived;
e) the length of the waiver, if applicable, and
f) the basis for the request for waiver of recovery.

The following guiding factors are used when making a determination on a request for waiver of recovery action:

a) The impact of recovery on the financial circumstances or livelihood of the heirs or waiver applicant; examples include:
    1. The family or individual may have to rely on public assistance if hardship is not granted;
    2. The assets are a necessary part of the trade or profession in which a significant portion of the remaining family's income is derived.
b) Actions of the family in assisting the decedent; particularly when such actions helped avoid or reduce medical costs which would have otherwise been incurred by the Medicaid program;
c) The existence of other claims or liens, besides the state's claim or lien, which prevent the waiver applicant from receiving the assets.
d) Other compelling circumstances as present by the waiver applicant.

The State will respond to a request for waiver of recovery action within 30 days of receipt of the request by sending a letter to the requestor of the waiver. The letter will state the decision of the State and its reasons for the decision.

If the State determines that a recovery would cause an undue hardship on an heir who has applied for a waiver, no recovery will be initiated. Similarly, if proceeding with the recovery would not be cost effective for the Agency, no recovery will be initiated.

In the situation where the waiver is granted and the waiver applicant dies before the expiration of the applicable time period for the filing of a probate action, the State may proceed with the recovery. This possibility will be noted in the decision letter granting the waiver.

If the waiver applicant and the State agree, the waiver of recovery may be granted for a limited time and use. If the waiver applicant and the State agree, a waiver of recovery may be granted subject to a payment plan allowing for a recovery using periodic payments by the waiver applicant.

If the State determines that no waiver, limited or complete, will be granted the recipient or their representative may request a hearing within 30 days of the date on the decision letter by the agency by contacting the agency or the administrative hearing office. The request for an administrative hearing must be in writing and reference the agency determination being contested by the recipient or their representative. The administrative hearing will follow the process and procedure noted in the Kansas Administrative Procedure Act. Any appeals from the decision of the hearing office will follow the procedure noted in the Kansas Administrative Procedure Act. No action will occur until the final determination is reached, as specified by Kansas Administrative Procedure Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

6. **The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):**

The estimated costs involved in filing, pursuing and collecting the estate claim are less than the total expected amount of recovery. These costs include, but are not limited to, administrative costs, court costs, costs of litigation, travel costs, expert witness fees and deposition expenses.

7. **The State uses the following collection procedures (include specific elements contained in the advance notice requirements, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):**

Notice Requirements

Kansas uses four general categories of notices: informational notice as part of application for medical assistance; post-death general notice to families of medical assistance recipients; pre-litigation notice to families and interested parties of recovery action; and mandated notice to recipient and/or representative of State's intent to impose a medical assistance lien on real estate.

Application Notice

When a person applies for medical assistance, they are advised about estate recovery by an advisal printed above the signature lines of the application and by a separate pamphlet concerning estate recovery. The pamphlet provides information about estate recovery in Kansas including the means of recovery, the affected population, the potential for liens, the availability of administrative hearings, the availability of waiver of recovery action, and the means for contacting estate recovery staff. The pamphlet is provided by the eligibility worker as part of the application process.

Post-Death

When the State receives notification of the death of a Medicaid recipient, the eligibility information from the case is reviewed for recovery action. If the eligibility information indicates potential estate assets, a letter is sent to the surviving family or their representative that provides:

- The name and identifying information of the deceased medical assistance recipient;
- The amount of the claim;
- The nature and value of assets available for recovery;
- Protections from recovery allowed to certain classes (surviving spouse, minor child, disabled child, etc.);
- Availability of waiver of recovery for surviving family members when recovery could create an undue hardship and how to apply for same;
- A request for information concerning the family's intent to probate the estate; and
- Information for contacting estate recovery staff.

Under Kansas probate law, the state is a creditor of the estate. If the family does not wish to initiate a probate action, a creditor may initiate a probate action but, such action must be filed and set for hearing within six months of the death of the decedent. This general post-death letter and notice is used as an information gathering device in determining whether the State should proceed with a creditor's probate action.

DEC 1 8 2004

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

Pre-litigation

If the State elects to initiate an action in court, a pre-filing letter will be sent to the recipient, if alive, or to the family or representative of the deceased recipient. This pre-filing letter is an accepted practice in collection matters in Kansas. The pre-filing letter contains the information from the general post-death letter noted above and the further advisal to the impacted party of the nature of the litigation action (probate action, quiet title, etc.) and the date by which the state anticipates filing the action. Once filed, any subsequent notices will be governed by Kansas civil code and procedure, probate code and procedure and statutes and caselaw specific to the area of law.

Lien Notice

If the State elects to initiate a lien recovery, a notice will be sent that complies with the procedure and criteria noted above.

ATTACHMENT 4.18-A

Charges Imposed on Categorically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

A. The following charges are imposed on the categorically needy for services other that those provided under section 1905 (a) (1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Ambulance nonemergency services	none	none	$ 1.00 per trip	These copayments are all based upon the ranges specified in 42 CRF 447.54 and 447.55.
Ambulatory surgical center services	none	none	$ 3.00 per visit	
Audiological services (excluding batteries)	none	none	$ 3.00 per date of service	
Community Mental Health Center Services	none	none	$ 2.00 per individual psychotherapy visit	
Durable medical equipment, orthotics or prosthetics (excluding DME rental)	none	none	$ 3.00 per item (claim)	
General hospital inpatient services	none	none	$25.00 per admission	
General hospital nonemergency outpatient services in place of a doctor's office visit	none	none	$ 1.00 per visit	
General hospital outpatient surgery	none	none	$ 3.00 per surgery	
Home health services (excluding DME rental)	none	none	$ 2.00 per skilled nursing visit	
Optometric services	none	none	$ 2.00 per date of service	
Physician services	none	none	$ 1.00 per office visit	
Podiatric services	none	none	$ 1.00 per office visit	
Prescribed drugs	none	none	$ 1.00 per new or refilled prescription	
Psychiatric free-standing inpatient facility services	none	none	$25.00 per admission	
Psychological services	none	none	$ 2.00 per office visit	

In addition to services listed on page 1, the following copayment charges are imposed on the categorically needy for the following services:

Category of Service	Copayment is Applied Per:	Copayment Amount
Ambulance, non-emergency	DOS	$3.00
CMHC	Psychotherapy Visit	$3.00
Dental	DOS	$3.00
Dietitian	DOS	$2.00
Federally Qualified Health Center	Encounter	$3.00
Home Health Agency	Visit	$3.00
Outpatient Hospital	Visit	$3.00
Physician, Physician Assistant	Visit	$2.00
Prescribed Drugs(Pharmacy)	New or Refilled Rx	$2.00
Psychology	Visit	$3.00
QMB	DOS	$2.00
Rural Health Clinic	Encounter	$2.00
General Hospital Inpatient Services	Per Admission	$48.00

There are no deductible or coinsurance charges for the above services. The above charges are based on the ranges specified in 42 CFR 447.54 and 447.55.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

B. The method used to collect cost sharing charges for categorically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

[ ] The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Recipients can assert that they are unable to pay copayment to the provider at the time of service. However, provider's are notified they cannot refuse service due to the recipient's inability to pay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) are described below:

Edits and audits, within the Kansas Medicaid Management Information System, are in place to exempt recipients and services from copayment in accordance with 42 CFR 447.53 (b).

E. Cumulative maximum on charges:

[X] State policy does not provide for cumulative maximums.

[ ] Cumulative maximums have been established as described below:

ATTACHMENT 4.18-B

Medically Needy - Premium

State Kansas

The following enrollment fee, premium or similar charge is imposed on the medically needy:

NOT APPLICABLE

Gross Family Income (per mo.)	Charge Family Size			Liability Period	Frequenc of Charg
	1 or 2	3 or 4	5 or more		
(1)	(2)	(3)	(4)	(5)	(6)
$150 or less					
151 - 200					
201 - 250					
251 - 300					
301 - 350					
351 - 400					
401 - 450					
451 - 500					
501 - 550					
551 - 600					
601 - 650					
651 - 700					
701 - 750					
751 - 800					
801 - 850					
851 - 900					
901 - 950					
951 - 1000					
More than $1000					

State Kansas

Effect on recipient of non-payment of enrollment fee, premium or similar charge:

☐ Non-payment does not affect eligibility

☐ Effect is as described below:

NOT APPLICABLE

ATTACHMENT 4.18-C

Charges Imposed on Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge: Deduct.	Coins.	Copay.	Amount and Basis for Determination
Ambulance nonemergency services	none	none	$ 1.00 per trip	These copayments are all based upon the ranges specified in 42 CRF 447.54 and 447.55.
Ambulatory surgical center services	none	none	$ 3.00 per visit	
Audiological services (excluding batteries)	none	none	$ 3.00 per date of service	
Community Mental Health Center Services	none	none	$ 2.00 per individual psychotherapy visit	
Durable medical equipment, orthotics or prosthetics (excluding DME rental)	none	none	$ 3.00 per item (claim)	
General hospital inpatient services	none	none	$25.00 per admission	
General hospital nonemergency outpatient services in place of a doctor's office visit	none	none	$ 1.00 per visit	
General hospital outpatient surgery	none	none	$ 3.00 per surgery	
Home health services (excluding DME rental)	none	none	$ 2.00 per skilled nursing visit	
Optometric services	none	none	$ 2.00 per date of service	
Physician services	none	none	$ 1.00 per office visit	
Podiatric services	none	none	$ 1.00 per office visit	
Prescribed drugs	none	none	$ 1.00 per new or refilled prescription	
Psychiatric free-standing inpatient facility services	none	none	$25.00 per admission	
Psychological services	none	none	$ 2.00 per office visit	

In addition to services listed on page 1, the following copayment charges are imposed on the medically needy for the following services:

Category of Service	Copayment is Applied Per:	Copayment Amount
Ambulance, non-emergency	DOS	$3.00
CMHC	Psychotherapy Visit	$3.00
Dental	DOS	$3.00
Dietitian	DOS	$2.00
Federally Qualified Health Center	Encounter	$3.00
Home Health Agency	Visit	$3.00
Outpatient Hospital	Visit	$3.00
Physician, Physician Assistant	Visit	$2.00
Prescribed Drugs(Pharmacy)	New or Refilled Rx	$2.00
Psychology	Visit	$3.00
QMB	DOS	$2.00
Rural Health Clinic	Encounter	$2.00
General Hospital Inpatient Services	Per Admission	$48.00

There are no deductible or coinsurance charges for the above services. The above charges are based on the ranges specified in 42 CFR 447.54 and 447.55.

"Substitute per letter dated 10/30/90"

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

B. The method used to collect cost sharing charges for medically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

[ ] The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Recipients can assert that they are unable to pay copayment to the provider at the time of service. However, providers are notified they cannot refuse service due to the recipient's inability to pay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) are described below:

Edits and audits, within the Kansas Medicaid Management Information System, are in place to exempt recipients and services from copayment in accordance with 42 CFR 447.53 (b).

E. Cumulative maximum on charges:

[X] State policy does not provide for cumulative maximums.

[ ] Cumulative maximums have been established as described below:

ATTACHMENT 4.18-D

Premiums Imposed on Low Income Pregnant Women and Infants

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

N/A

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

ATTACHMENT 4.18-E

Optional Sliding Scale Premiums

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

N/A

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kansas

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge: Deduct.	Coins.	Copay.	Amount and Basis for Determination
Ambulance nonemergency services	none	none	$ 1.00 per trip	These copayments are all based upon the ranges specified in 42 CRF 447.54 and 447.55.
Ambulatory surgical center services	none	none	$ 3.00 per visit	
Audiological services (excluding batteries)	none	none	$ 3.00 per date of service	
Community Mental Health Center Services	none	none	$ 2.00 per individual psychotherapy visit	
Durable medical equipment, orthotics or prosthetics (excluding DME rental)	none	none	$ 3.00 per item (claim)	
General hospital inpatient services	none	none	$25.00 per admission	
General hospital nonemergency outpatient services in place of a doctor's office visit	none	none	$ 1.00 per visit	
General hospital outpatient surgery	none	none	$ 3.00 per surgery	
Home health services (excluding DME rental)	none	none	$ 2.00 per skilled nursing visit	
Optometric services	none	none	$ 2.00 per date of service	
Physician services	none	none	$ 1.00 per office visit	
Podiatric services	none	none	$ 1.00 per office visit	
Prescribed drugs	none	none	$ 1.00 per new or refilled prescription	
Psychiatric free-standing inpatient facility services	none	none	$25.00 per admission	
Psychological services	none	none	$ 2.00 per office visit	

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

August 4, 1992

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payments for general hospital services. This assurance relates to MS-91-37 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253 (b)(1)(i)
Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253 (b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4.19-A, Section 6.0000.

42 CFR 447.253 (b)(1)(ii)(B)
Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

42 CFR 447.253 (b)(1)(ii)(C)
The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

Social Security Act, Section 1902(a)(13)(B)
Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change in ownership which occurs on or after July 18, 1984, in excess of the amount that would be permitted under the provision of Section 18161(v)(2)(0) of the Act.

2. Upper Payment Limits

42 CFR 447.253 (b)(2)
The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

Refers to MS-91-37.

3. Provider Appeals

42 CFR 447.253 (c)

The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

4. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253 (d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

5. Public Notice

42 CFR 447.253 (f)
The reimbursement methodology change for inpatient hospital services has met the public notice requirements.

6. Rates Paid

42 CFR 447.253 (g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

7. Related Information

42 CFR 447.255
The average payment rate is expected to be $2,637 per discharge in FY 1992. This is a decrease of 5.9% from FY 1991, primarily due to the rebasing and recalibration of the DRG system. Despite this reduction, the majority of hospitals received increases in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts as well as the cost of Medicaid/MediKan services, about 104% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments in FY 1992 to hospitals eligible for disproportionate share payments. This is based upon the best information available from the Medicare cost reports and Medicaid paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

Donna L. Whiteman
Secretary

DLW:RLE:pm
cc: Steve Otto
Refers to MS-91-37.

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

August 12, 1992

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In response to your letter dated December 2, 1991, regarding disproportionate share hospital payment methodology (MS-91-29), Kansas submits the following additional information.

1. 42 CFR 447.250ff.

Kansas assures that capital related costs due solely to a change of ownership which occurs on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(O) of the Act.

2. 42 CFR 447.253 (b)(2)(1).

Kansas assures that payment rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal Laws, regulations, and quality and safety standards.

3. 42 CFR 447.253 (b)(1)(ii)(B).

Kansas assures that services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

4. 42 CFR 447.253 (b)(1)(ii)(C).

Kansas assures that payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

5. 42 CFR 447.253 (b)(2) and 447.272.

Kansas assures that payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

6. Public Notice and Related Information.

Amendment MS-91-29 changes the State Plan by specifically excluding outpatient and including MediKan. Public notice of these changes was given on August 15, 1991. Therefore, the effective date of this plan is August 16, 1991.

During the time when the State Plan was being prepared, it was noticed that several hospitals had not filled in the forms for FY 1990 and FY 1991 completely. In particular, they left off the contractual allowances figure. Other hospitals submitted this figure, and it had been used in accordance with the Plan for FY 1990 and FY 1991. Verification was made to insure that an appropriate figure was to be included for the contractual allowances based upon the cost reports submitted to Medicare. The disproportionate share determinations were recomputed for FY 1990 and FY 1991 using this updated information and this is in process of being submitted to HCFA. With these new computations, the amount of disproportionate share based on a per hospital basis is expected to decline from FY 1991 to FY 1992. The decline is approximately 20%. While this may still seem like a substantial change, all computations are updated each year, using new Medicaid payment levels, contractual allowances, etc. Any changes in the data at individual hospitals certainly affect the amount of the disproportionate payment, but there was no methodology change which affects either how eligibility is determined or how the payment amount is determined.

7. Short or Long Term Effect on the Availability of Services.

This plan submittal will not change the availability of services as the methodology for computing disproportionate share payments has not changed. Without disproportionate share payments, services to low income and indigent clients would be affected.

8. Type of Care Furnished.

This plan submitted will not change the type of care furnished as the methodology for computing disproportionate share payments has not changed.

9. Extent of Provider Participation.

Disproportionate share funds are critical for the continued existence of hospitals which serve the low income, as these funds offset the costs of clients who cannot pay for their care.

10. Degree to which costs are covered in Hospitals that serve a Disproportionate number of Low Income Patients with Special Needs.

It is estimated that the continuation of the same methodology will result in the aggregate payment of 100% of the costs of low income patients with special needs at those hospitals eligible for disproportionate share.

11. Disproportionate Share Hospitals Formula Questions.

Federal law allows for variations in methodology, provided that at least all hospitals which meet the law requirements will also meet the State methodology. Kansas has made three adjustments to the specific formula in the law which continue to meet the law requirements. These changes are:

1. The exclusion of outpatient. By itself, this tends to reduce the likelihood of eligibility for any one hospital.

2. The inclusion of the MediKan program in addition to Medicaid. This was done as a better proxy (in addition to Medicaid) to identify which hospitals serve low income patients. By itself, this tends to increase the likelihood of eligibility for any one hospital.

3. The adjustment for contractual allowances in the formula. This adjustment was also made to identify which hospitals serve low income patients. By itself, this tends to increase the likelihood of eligibility for any one hospital.

Based upon a review of available data, the adjustments we have made would always result in our compliance with the law. In any case where there was any reduction due to the exclusion of the outpatient area, there is at least an equivalent increase due to the inclusion of MediKan and the contractual allowances adjustment. This question only affects the eligibility of hospitals and we are certain that out methodology does not result in any hospital being ineligible due to the changes which we have made.

Because of the above, we do not propose any changes in the formula such as you suggest. If the suggestions you made were included, and the other adjustments which we have made were retained, it would increase the amount of the payments which would be made for disproportionate share.

It is hoped that this additional information will expedite the approval of MS-91-29. Any further questions may be directed to Tina Hayes at 296-3981.

Sincerely,

Donna L. Whiteman
Secretary

DLW:RLE:JCS:TAH:pm

Attachment

cc: Steve Otto

Assurance Letter

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

JOAN FINNEY, *Governor*

January 14, 1992

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payments for general hospital services. This assurance relates to MS-92-03 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253 (b)(1)(i)
Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253 (b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4.19-A, Section 6.0000.

42 CFR 447.253 (b)(1)(ii)(B)
Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

42 CFR 447.253 (b)(1)(ii)(C)
The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

Social Security Act, Section 1902(a)(13)(B)
Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change in ownership which occurs on or after July 18, 1984, in excess of the amount that would be permitted under the provision of Section 18161(v)(2)(0) of the Act.

2. Upper Payment Limits

42 CFR 447.253 (b)(2)
The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

Refers to MS-92-03.

State Plan TN#_____ Effective Date 01/01/92

Supersedes TN#_____ Approval Date 08/07/92

3. Provider Appeals

42 CFR 447.253 (c)

The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

4. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253 (d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

5. Public Notice

42 CFR 447.253 (f)
The reimbursement methodology change for inpatient hospital services has met the public notice requirements.

6. Rates Paid

42 CFR 447.253 (g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

7. Related Information

42 CFR 447.255
The average payment rate is expected to be $2,637 per discharge in FY 1992. This is a decrease of 5.9% from FY 1991, primarily due to the rebasing and recalibration of the DRG system. Despite this reduction, the majority of hospitals received increases in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts as well as the cost of Medicaid/MediKan services, about 104% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments in FY 1992 to hospitals eligible for disproportionate share payments. This is based upon the best information available from the Medicare cost reports and Medicaid paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

Donna L. Whiteman
Secretary

DLW:RLE:brj

Refers to MS-92-03.

State Plan TN# _____ Effective Date 01/01/92
Supersedes TN# _____ Approval Date 08/07/92

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

JOAN FINNEY, *Governor*

March 14, 1991

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for general hospital services. This letter supersedes all previous assurance letters concerning inpatient hospital reimbursement. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-91-08 regarding changes to swing bed payment rates.

1. Payment Rates

42 CFR 447.272(b)
The State of Kansas assures that the payments to State operated facilities, when considered separately, do not exceed the Medicare upper payment list.

42 CFR 447.253(b)(1)(i)
The State of Kansas pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to P.L. 100-203, Section 4112.

Refers to MS-91-08

TN#MS-91-08 Approval Date MAY 23 1991 Effective Date JAN - 1 1991 Supersedes TN#MS-90-33

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

42 CFR 447.253(b)(1)(ii)(C)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.253(b)(2)
The State assures that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital, return on equity, and acquisition and settlement costs) due solely to a change in ownership which occur on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(O) of the Act.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. The system used between July 1, 1983, and June 30, 1989, utilized a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of depreciation which affects the 1981 base year shall result in a change in the provider's payment rate for the period July 1, 1983, to June 30, 1989.

For the period July 1, 1983, to January 18, 1987, the reimbursement system for outpatient hospital services was based on the lesser of reasonable cost or customary charges, with the exception of laboratory and radiology services which were paid on a fee-for-service basis beginning 10-01-84 and 07-01-86, respectively. We assured that reasonable costs were adjusted to reflect any recapture of depreciation for the lesser of reasonable cost or customary charges payment methodology.

Refers to MS-91-08

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement

3. Public Notice

42 CFR 447.253(f)
As corresponding changes in State regulations were made, the reimbursement methodology change for inpatient hospital services has met the public notice requirements.

4. Related Information

42 CFR 337.255
The average rate per discharge for state FY 1990 was $3,034.00. The estimated average rate per discharge for state FY 1991 is $2,919.00. The difference between 1990 and 1991 represents a 3.00% decrease in rates due to the recalibration of DRG weights.

For hospitals designated as disproportionate share hospitals (defined according to Section 1.0000, o, of MS-89-23) the disproportionate share payment can not be readily merged into the two existing payment systems (for general and special hospitals) since the disproportionate share payments are not made upon the basis of discharge, per diem or cost settlement. The average disproportionate share payment per disproportionate share hospital was $2,299.21 in state FY 1990, and $3,309.44 in state FY 1991 (44.00% increase).

	SNF	ICF	NF
Swing bed rate 01-01-90	$48.96	$39.75	N/A
Swing bed rate 01-01-91	N/A	N/A	$46.13
Daily increase/decrease	-$2.83	$ 6.38	--
Average percent increase/ decrease	-5.8%	16.1%	--

Refers to MS-91-08

Both the short-term and long-term effect of these changes are estimates:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that service a disproportionate number of low income patients with special needs.

5. Provider Appeals

42 CFR 447.253(c)
The State assures that an appeals procedure (which allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of such issues as the agency determines appropriate) is provided for payment rates.

6. Rates Paid

42 CFR 447.253(g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Sincerely,

Robert C. Harder
Acting Secretary

RCH:JWA:brj

Refers to MS-91-08

TN#MS-91-08 Approval Date MAY 23 1991 Effective Date JAN - 1 1991 Supersedes TN#MS-90-33

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

October 2, 1990

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Director
Human Resources

TIM OWENS
General Counsel

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

Enclosed with this letter is the hospital reimbursement assurance letter required to comply with the Medicaid State Plan. This assurance letter was faxed to your offices on September 28, 1990.

If you have any questions, contact Sally Adams at (913) 296-3981.

Sincerely,

L. Kathryn Klassen

L. Kathryn Klassen, R.N., M.S.
Director
Division of Medical Programs

LKK:SA:mrw

Enclosures

cc: John W. Alquest
Sally Adams
Carl Hawkins

Administrative Services
J. S. DUNCAN
Commissioner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance/ Medical Services
JOHN ALQUEST
Commissioner

Mental Health/ Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABE FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

September 28, 1990

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Director
Human Resources

TIM OWENS
General Counsel

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

Administrative Services
J. S. DUNCAN
Commissioner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance/ Medical Services
JOHN ALQUEST
Commissioner

Mental Health/ Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABE FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for general hospital services. This letter supersedes all previous assurance letters concerning inpatient hospital reimbursement. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-90-33 regarding the change to recalibration in the DRG reimbursement methodology.

1. Payment Rates

42 CFR 447.272(b)
The State of Kansas assures that the payments to State operated facilities, when considered separately, do not exceed the Medicare upper payment limit.

42 CFR 447.253(b)(1)(i)
The State of Kansas pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to P.L. 100-203, Section 4112.

Refers to MS-90-33.

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payment are recovered as appropriate.

42CFR 447.253(b)(1)(ii)(C)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas. recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.253(b)(2)
The State assures that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital, return on equity, and acquisition and settlement costs) due solely to a change in ownership which occur on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(O) of the Act.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. The system used between July 1, 1983, and June 30, 1989, utilized a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of depreciation which affects the 1981 base year shall result in a change in the provider's payment rate for the period July 1, 1983, to June 30,1989.

For the period July 1, 1983, to January 18, 1987, the reimbursement system for outpatient hospital services was based on the lesser of reasonable cost or customary charges, with the exception of laboratory and radiology services which were paid on a fee-for-service basis beginning 10-01-84 and 07-01-86, respectively. We assured that reasonable costs were adjusted to reflect any recapture of depreciation for the lesser of reasonable cost or customary charges payment methodology.

Refers to MS-90-33.

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the gency received information through the common audit agreement.

3. Public Notice

42 CFR 447.253(f)
As corresponding changes in State regulations were made, the reimbursement methodology change for inpatient hospital services has met the public notice requirements.

4. Related Information

42 CFR 337.255
The average rate per discharge for state FY 1990 was $3,034.00. The estimated average rate per discharge for state FY 1990 is $2,919.00. The difference between 1990 and 1991 represents a 3.% decrease in rates due to the recalibration of DRG weights.

For hospitals designated as disproportionate share hospitals (defined according to Section 1.0000, o, of MS-89-23) the disproportionate share payment can not be readily merged into the two existing payment systems (for general and special hospitals) since the disproportionate share payments are not made upon the basis of discharge, per diem or cost settlement. The average disproportionate share payment per disproportionate share hospital was $2,299.214 in state FY 1990, and $3,309.440 in state FY 1991 (44% increase).

Both the short-term and long-term effect of these changes are estimates:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Refers to MS-90-33.

5. Provider Appeals

42 CFR 447.253(c)
The State assures that an appeals procedure (which allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of such issues as the agency determines appropriate) is provided for payment rates.

6. Rates Paid

447.253(g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Sincerely,

Dennis R. Taylor
Acting Secretary

DRT:JWA:SA:mrw

cc: Sally Adams
Carl Hawkins

Refers to MS-90-33.

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, 915 S.W. Harrison, Topeka, Kansas 66612

(913) 296-3271

December 29, 1989

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

Administrative Services
J. S. DUNCAN
Commissioner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance/ Medical Services
JOHN ALQUEST
Commissioner

Mental Health/ Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABRIEL FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

Mr. William R. Blake, Jr.
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Blake:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for general hospital services. This letter supersedes all previous assurance letters concerning inpatient hospital reimbursement. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-89-24 regarding the change to a DRG reimbursement methodology.

1. Payment Rates

42 CFR 447.272(b)
The State of Kansas assures that the payments to State operated facilities, when considered separately, do not exceed the Medicare upper payment limit.

42 CFR 447.253(b)(1)(i)
The State of Kansas pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to P.L. 100-203, Section 4112.

Refers to MS-89-24.

State Plan TN: 89-24 Effective Date: 7/1/89
Supersedes TN: _____ Approval Date: 2/22/90

8

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

42 CFR 447.253(b)(1)(ii)(C)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.253(b)(2)
The State assures that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital, return on equity, and acquisition and settlement costs) due solely to a change in ownership which occur on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(O) of the Act.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. The system used between July 1, 1983, and June 30, 1989, utilized a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of depreciation which affects the 1981 base year shall result in a change in the provider's payment rate for the period July 1, 1983, to June 30, 1989.

For the period July 1, 1983, to January 18, 1987, the reimbursement system for outpatient hospital services was based on the lesser of reasonable cost or customary charges, with the exception of laboratory and radiology services which were paid on a fee-for-service basis beginning 10-01-84 and 07-01-86, respectively. We assured that reasonable costs were adjusted to reflect any recapture of depreciation for the lesser of reasonable cost or customary charges payment methodology.

Refers to MS-89-24.

State Plan TN 89-24 Effective Date 7/1/89
Supersedes TN _____ Approval Date 2/22/90

9

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

3. Public Notice

42 CFR 447.253(f)
As corresponding changes in State regulations were made, the reimbursement methodology change for inpatient hospital services has met the public notice requirements.

4. Related Information

42 CFR 447.255
The average rate per discharge for state FY 1989 was $2,825.00. The estimated average rate per discharge for state FY 1990 was $3,279.00. The difference between 1989 and 1990 represents a 16.1% increase in rates.

For special hospitals (defined according to Section 1.0000, z, of MS-89-23) payment is based upon a percentage of charges on an interim basis with a cost settlement. The average payment is 100% of charges and no changes are expected.

For hospitals designated as disproportionate share hospitals (defined according to Section 1.0000, o, of MS-89-23) the disproportionate share payment can not be readily merged into the two existing payment systems (for general and special hospitals) since the disproportionate share payments are not made upon the basis of discharge, per diem or cost settlement. The average disproportionate share payment per disproportionate share hospital was $31,820 in state FY 1989, and $156,175 in state FY 1990) 390.8% increase).

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Refers to MS-89-24.

Transmittal # 89-24 Effective Date 7/1/89
Supersedes TN: _____ Approval Date 2/22/90

10

5. Provider Appeals

42 CFR 447.253(c)
The State assures that an appeals procedure (which allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of such issues as the agency determines appropriate) is provided for payment rates.

6. Rates Paid

447.253(g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Sincerely,

Winston Barton
Secretary

WB:JWA:SA:plk
cc: L. Kathryn Klassen
Steve Otto
Carl Hawkins

Refers to MS-89-24.

89-24 7/1/89
2/22/90

11

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

September 26, 1989

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

Administrative Services
J. S. DUNCAN
Commissioner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance/ Medical Services
JOHN ALQUEST
Commissioner

Mental Health/ Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABE FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

Mr. William R. Blake, Jr.
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Blake:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for general hospital services. This letter supersedes all previous assurance letters concerning inpatient hospital reimbursement. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-89-23 regarding the change to a DRG reimbursement methodology.

1. Payment Rates

42 CFR 447.272(b)
The State of Kansas assures that the payments to State operated facilities, when considered separately, do not exceed the Medicare upper payment limit.

42 CFR 447.253(b)(1)(i)
The State of Kansas pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to P.L. 100-203, Section 4112.

Refers to MS-89-23.

State Plan TN# 89-23 Effective Date 7/1/89
Supersedes TN#_____ Approval Date 2/20/90

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

42 CFR 447.253(b)(1)(ii)(C)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.253(b)(2)
The State assures that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital, return on equity, and acquisition and settlement costs) due solely to a change in ownership which occur on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(0) of the Act.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. This system uses a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of depreciation which affects the 1981 base year shall result in a change in the provider's current rate.

For the period July 1, 1983, to January 18, 1987, the reimbursement system for outpatient hospital services was based on the lesser of reasonable cost or customary charges, with the exception of laboratory and radiology services which were paid on a fee-for-service basis beginning 10-01-84 and 07-01-86, respectively. We assured that reasonable costs were adjusted to reflect any recapture of depreciation for the lesser of reasonable cost or customary charges payment methodology.

Refers to MS-89-23.

State Plan No. S-23 Effective Date 7/1/89
Supersedes TN# _____ Approval Date 2/22/89

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

3. Public Notice

42 CFR 447.253(f)
As corresponding changes in State regulations were made, the reimbursement methodology change for inpatient hospital services has met the public notice requirements.

4. Related Information

42 CFR 447.255
The average rate per discharge for state FY 1989 was $2,825.00. The estimated average rate per discharge for state FY 1990 was $3,279.00. The difference between 1989 and 1990 represents a 16.1% increase in rates.

Both the short-term and long-term effect of this change are estimated:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

5. Provider Appeals

42 CFR 447.253(c)
The State assures that an appeals procedure (which allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of such issues as the agency determines appropriate) is provided for payment rates.

Refers to MS-89-23.

State Plan TN# 89-24 Effective Date 7/1/89
Supersedes TN#_____ Approval Date 12/15

6. Rates Paid

447.253(g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Sincerely,

Winston Barton
Secretary

WB:JWA:SA:plk
cc: L. Kathryn Klassen
Steve Otto
Carl Hawkins

Refers to MS-89-23.

State Plan TN# [illegible] Effective Date 10/1/89
Supersedes TN# _____ Approval Date 3/20/90

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

MIKE HAYDEN
Governor

DENNIS TAYLOR
Acting Secretary

December 7, 1990

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

We are submitting a small revision to Attachment 4.19-D, Subsection U. Omnibus Budget Reconciliation Act (OBRA) of 1987 - Nursing Home Reform Act Requirement. The details are explained in the letter from L. Kathryn Klassen.

In accordance with 42 CFR 447.253, the Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payments for long term care services in adult care homes. The requirements set forth in paragraphs (b) through (g) of this section are being met, the related information required by subsection 447.225 of this subpart is furnished herewith and the agency complies with all other requirements.

1. **42 CFR 447.253 (b) State Findings**
   The State of Kansas makes findings to insure that the rates used to reimburse providers satisfy the requirements of paragraph 447.253(b)(1)(i).

2. **42 CFR 447.253(b)(1)(i) Payment Rates**
   The State of Kansas continues to pay nursing facilities and ICFs/MR for long term care services in accordance with a Medicaid State Plan formula established through consultation with representatives of the adult care home provider groups. The rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

Refers to MS-90-42.

State Plan TN# 90-42 Effective Date 10/1/90

Supersedes TN#_____ Approval Date 1/31/91

3. **42 CFR 447.253(b)(2) Upper Limits**
The State of Kansas assures that it has findings that the estimated average proposed Medicaid payment rate is reasonably expected to pay no more in the aggregate for long term care facility services than the amount that the agency reasonably estimates would be paid for services under the Medicare principles of reimbursement.

4. **42 CFR 447.253(c) Provider Appeals**
The State of Kansas, in accordance with the federal regulations and with the Kansas Administrative Regulations, provides a fair hearing or exception procedure that allows for an administrative review and an appeal by the provider as to its payment rates before the Administrative Hearing Section for the agency.

5. **42 CFR 447.253(d) Uniform Reporting**
Nursing facility and ICF/MR providers are required to file annual cost reports with the Medicaid agency within three months following the end of their fiscal year in accordance with Kansas Administrative Regulation 30-10-17.

6. **42 CFR 447.253(e) Audit Requirements**
The State of Kansas performs a desk review on all cost reports within six months after receipt, and provides for periodic field audits of the financial and statistical records of the participating providers.

7. **42 CFR 447.253(f) Public Notice**
Appropriate public notice has been given for the changes included in this amendment.

8. **42 CFR 447.253(g) Rates Paid**
The rates paid through the State of Kansas have been determined in accordance with methods and standards specified in an approved Medicaid State Plan.

9. **42 CFR 447.272(b) Application of Upper Limit**
The State of Kansas assures that it has findings that the State-operated facilities do not exceed a payment amount that can reasonably be estimated would have been paid under Medicare payment principles.

10. **42 CFR 447.255 Related Information**

	SNF	ICF	Combined (NF)
Estimated Average Rate 10/01/89	$52.01	$41.52	$41.66
Estimated Average Rate 10/01/90			$42.33

Refers to MS-90-42.

State Plan TN# 90-42 Effective Date 10/1/90
Supersedes TN# _____ Approval Date 1/31/91

Estimated Per Diem Increase Due to OBRA 87	Affected Facility Per Diem	Aggregate Per Diem	Aggregate Cost
Resident Assessments	$.11	$.11	$ 500,000
Medical Directors	$.20	$.17	$ 739,200
24 Hour Nursing	$.49	$.11	$ 500,000
Social Worker	$.29	$.02	$ 94,500
Combining SNF/ICF	$.26	$.26	$1,141,000
Nursing Aide Training	0	0	0
Resident Rights	0	0	0
Quality Assessment Committee	0	0	0
Estimated Aggregate Per Diem Increase		$.67	
Average Percent Increase		1.6%	

Both the short-term and long-term effects of these changes are estimated:

1. To maintain the availability of services on a statewide and geographic area basis. There are approximately 417 licensed nursing facilities and ICFs/MR in the State of Kansas with at least one in every county. Of these, approximately 396, or 95%, are also certified to participate in the Medicaid Program. Beds are available in every area of the State and close coordination with the local and area SRS offices allows the agency to keep close track of vacancies.

2. To maintain or improve the type of care furnished.

3. To maintain the extent of provider participation. Ninety-seven percent of the available providers are active providers in the program.

The State of Kansas assures that its payment methodology is not reasonably expected to result in an increase in payments based solely on a change of ownership in excess of the increase that would result from application of Section 1902(a)(13)(c) of the Social Security Act.

Sincerely,

Dennis R. Taylor
Acting Secretary

DRT:JWA:brj
Enclosures

Refers to MS-90-42.

State Plan TN# 90-42 Effective Date 10/1/90
Supersedes TN# _____ Approval Date 1/31/91

① PL ②

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

March 23, 1989

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

Administrative Services
J. S. DUNCAN
Commissioner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance Medical Services
JOHN ALQUEST
Commissioner

Mental Health Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABE FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

Mr. William R. Blake, Jr.
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Blake:

In response to your letter of February 17, 1989, the following information is submitted.

1. The assurance letter dated December 5, 1988, is amended to include the assurance that "payment to State-operated facilities, when considered separately, do not exceed the Medicare upper payment limit". Please see attached amended assurance letter Page 1.

2. The information requested in this section was sent previously on December 16, 1988 (copy attached). However, the assurance letter text has been amended to incorporate this information. Please see attached assurance letter, Page 3.

3. The information requested in this section was sent December 16, 1988 (copy attached). However, the assurance letter text has been amended to incorporate this information. Please see attached assurance letter, Page 3.

4. A. MS-88-42 transmits Page 9.b. of Attachment 4.19-A which was previously transmitted using the MS-88-12 number. However, the accompanying assurance letter for MS-88-42 was dated December 5, 1988 (subsequently amended by a letter dated December 16, 1988). The attached new assurance letter dated March 15, 1989, supersedes the assurance letters of October 21 and 24, 1988, which accompanied MS-88-27.

TN#MS-88-42 Approval Date 5/2/89 Effective Date 10/1/88 Supersedes TN#MS-88-27

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

December 16, 1988

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

Administrative Services
J. S. DUNCAN
Commissioner

Adult Services
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ANDREW O'DONOVAN
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Mental Health/ Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABE FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

Mr. William R. Blake, Jr.
Associate Regional Administrator for Program Operations
Room 242, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Blake:

In response to Carl Hawkins' telephone call of December 14, 1988, the following information is being sent as additions to the inpatient hospital assurance letter dated October 21, 1988, relating to MS-88-12. Page three, part 4, Related Information, should have added to it:

The average rate per day for state FY 1988 was $355.92. The difference between 1988 and 1989 represents a 4.99% increase in rates.

Both the short-term and long-term effect of this change are estimated:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

This additional information is pursuant to 42 CFR 447.255.

If there are further questions they may be directed to Sally Adams, (913)296-3981.

Sincerely,

L. Kathryn Klassen

L. Kathryn Klassen, R.N., M.S.
Director
Division of Medical Programs

LKK:SA:plk
cc: Carl Hawkins

B. Public notice for the change in hospital reimbursement methodology concerning liver transplants was provided on June 30, 1988, in the Kansas Register. A copy of this is attached for your reference. The effective date of MS-88-42 is still requested to be October 1, 1988.

Further questions may be directed to Sally Adams in the Division of Medical Programs.

Sincerely,

Winston Barton
Secretary

WB:JWA:SA:plk

TN#MS-88-42 Approval 5/2/89 Effective Date 10/1/88 Supersedes TN#MS-88-27

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

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March 23, 1989

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
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Rehabilitation Services
GABE FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

Mr. William R. Blake, Jr.
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Blake:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for general hospital services. This letter supersedes our previous letters dated December 28, 1984, February 12, 1985, July 1, 1985, September 20, 1985, June 23, 1987, June 23, 1988, October 21, 1988, October 24, 1988, December 5, 1988 and December 16, 1988. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-88-42 regarding the change the inpatient hospital reimbursement methodology relating to liver transplants.

1. Payment Rates

42 CFR 447.272(b)
The State of Kansas assures that the payments to State operated facilities, when considered separately, do not exceed the Medicare upper payment limit.

42 CFR 447.253(b)(1)(i)
The State of Kansas based the prospective payment system on the Medicare standards applicable in 1981. Through negotiations with the Kansas Hospital Association, it was agreed that a level of inflation would be added to these costs annually. This method was applied to both low and high cost hospitals. The change in rates which may affect high cost hospitals only results in a small portion of days being paid at a "lower" rate. This lower rate is not significantly different from the average cost of all Kansas hospitals. Therefore, the lower rate is reasonable and adequate.

Refers to MS-88-42.

The prospective payment system is reasonable and adequate except for liver transplants. A new reimbursement methodology for liver transplants has been developed to insure this reasonableness and adequacy. Rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
Hospitals are determined to be disproportionate share hospitals according to P.L. 100-203, Section 4112. A payment adjustment for disproportionate share hospitals is made based upon P.L. 100-203, Section 4112.

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

42 CFR 447.253(b)(1)(ii)(c)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.253(b)(2)
The State assures that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital, return on equity, and acquisition and settlement costs) due solely to a change in ownership which occur on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(0) of the Act.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. This system uses a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of

depreciation which affects the 1981 base year shall result in a change in the provider's current rate.

For the period July 1, 1983, to January 18, 1987, the reimbursement system for outpatient hospital services was based on the lesser of reasonable cost or customary charges, with the exception of laboratory and radiology services which were paid on a fee-for-service basis beginning 10-01-84 and 07-01-86, respectively. We assured that reasonable costs were adjusted to reflect any recapture of depreciation for the lesser of reasonable cost or customary charges payment methodology.

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

3. Public Notice

42 CFR 447.253(f)
As changes in State regulations, the reimbursement methodology for liver transplants and the prospective payment system have met the public notice requirements.

4. Related Information

42 CFR 447.255
The estimated average rate per day for state FY 1989 is $373.69. The average rate per day for state FY 1988 was $355.92. The difference between 1988 and 1989 represents a 4.99% increase in rates.

Both the short-term and long-term effect of this change are estimated:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Refers to MS-88-42.

5. Provider Appeals

42 CFR 447.253(c)
The State assures that an appeals procedure (which allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of such issues as the agency determines appropriate) is provided for payment rates.

6. Rates Paid

447.253(g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Sincerely,

Winston Barton
Secretary

WB:JWA:SA:plk
cc: L. Kathryn Klassen
Steve Otto
Carl Hawkins

Refers to MS-88-42.

Sally A.

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

March 23, 1989

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

Administrative
rvices
. S. DUNCAN
Commissioner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug
Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance/
Medical Services
JOHN ALQUEST
Commissioner

Mental Health/
Retardation Services
AL NEMEC
Commissioner

Rehabilitation
Services
GABE FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

Mr. William R. Blake, Jr.
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Blake:

In response to your letter of February 17, 1989, the following information is submitted.

1. The assurance letter dated December 5, 1988, is amended to include the assurance that "payment to State-operated facilities, when considered separately, do not exceed the Medicare upper payment limit". Please see attached amended assurance letter Page 1.

2. The information requested in this section was sent previously on December 16, 1988 (copy attached). However, the assurance letter text has been amended to incorporate this information. Please see attached assurance letter, Page 3.

3. The information requested in this section was sent December 16, 1988 (copy attached). However, the assurance letter text has been amended to incorporate this information. Please see attached assurance letter, Page 3.

4. A. MS-88-42 transmits Page 9.b. of Attachment 4.19-A which was previously transmitted using the MS-88-12 number. However, the accompanying assurance letter for MS-88-42 was dated December 5, 1988 (subsequently amended by a letter dated December 16, 1988). The attached new assurance letter dated March 15, 1989, supersedes the assurance letters of October 21 and 24, 1988, which accompanied MS-88-27.

B. Public notice for the change in hospital reimbursement methodology concerning liver transplants was provided on June 30, 1988, in the Kansas Register. A copy of this is attached for your reference. The effective date of MS-88-42 is still requested to be October 1, 1988.

Further questions may be directed to Sally Adams in the Division of Medical Programs.

Sincerely,

Winston Barton
Secretary

WB:JWA:SA:plk

STATE DEPARTMENT OF
SOCIAL & REHAB. SERVICES
JUN 30 1988
RECEIVED
LEGAL SERVICES

KANSAS REGISTER

State of Kansas

BILL GRAVES
Secretary of State

Vol. 7, No. 26 | June 30, 1988 | Pages 1207-1242

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State of Kansas

DEPARTMENT OF ADMINISTRATION
STATE EMPLOYEES HEALTH CARE COMMISSION

NOTICE OF COMMENCEMENT OF NEGOTIATIONS FOR A STATE HEALTH CARE BENEFITS PROGRAM

Notice is hereby given of the commencement of negotiations for contracts for the state health care benefits program to be effective January 1, 1989.

The Kansas State Employees Health Care Commission will receive proposals until 5 p.m. Monday, August 1, from those firms responding to the commission's request for proposal HCC-89A, dated July 1, 1988.

A special public meeting for all representatives interested in submission of a proposal will be held at 2 p.m. Thursday, July 14, in conference room 106, Landon State Office Building, 900 S.W. Jackson, Topeka.

Those interested in attending the conference can contact the commission's administrative office at (913) 296-7483 by July 8 to confirm attendance. Questions from potential responders concerning the project will be addressed only at this public meeting.

H. EDWARD FLENTJE
Chairman

Doc. No. 006754

ate of Kansas

SOCIAL AND REHABILITATION SERVICES

NOTICE OF BASIC MAXIMUM DAILY RATE OF CHARGE FOR STATE INSTITUTIONS

In compliance with K.S.A. 59-2006b(a), the following per patient day costs for fiscal year 1989 will be the basic maximum daily rate of charge, effective July 1, 1988, for the following state institutions:

Parsons State Hospital and Training Center	$127.50
Winfield State Hospital and Training Center	$185.60
Kansas Neurological Institute	$129.81
Norton State Hospital	$225.44

In compliance with K.S.A. 59-2006(b), the following state institutions are hereby authorized to compute an individual patient charge on the basis of rates for services based on costs incurred by such state institutions as determined by application of generally acceptable hospital accounting principles: Topeka State Hospital; Osawatomie State Hospital; Larned State Hospital, including the State Security Hospital; and Rainbow Mental Health Facility.

WINSTON BARTON
Secretary of Social and Rehabilitation Services

oc. No. 006770

State of Kansas

SOCIAL AND REHABILITATION SERVICES

NOTICE OF CHANGE IN MEDICAID REIMBURSEMENT METHOD

In accordance with 42 *Code of Federal Regulations* 447.205, public notice is given concerning a change in the method of Medicaid reimbursement for inpatient general hospitals determined to be disproportionate share hospitals and for those hospitals performing liver transplants for Kansas Medicaid recipients.

1. For hospitals determined in accordance with the criteria in Public Law 100-203, Section 4112, to be disproportionate share hospitals, a payment adjustment shall be made. This payment adjustment shall be the greater amount determined by either of the two options contained in Public Law 100-203, Section 4112, Subsections (b)(1)(A) and (b)(1)(B). Qualification for determination as a disproportionate share hospital shall be made on an annual basis for the duration of a one year period of time. An appeal procedure is available. This is estimated to cost an additional $733,600 to $1,433,115 annually. This change is being made to comply with Public Law 100-203, Section 4112 (Omnibus Budget Reconciliation Act).
2. For hospitals performing liver transplants for Kansas Medicaid recipients, reimbursement to the inpatient general hospital shall be based upon cost, not to exceed $100,000 per transplant surgery, contingent upon transplant surgery and excluding procurement of the organ. An interim payment based upon 80 percent of allowable charges may be made prior to the final cost settlement. If transplant surgery is not performed, reimbursement shall be made according to the Kansas Medicaid prospective payment system methodology. This is estimated to cost an additional $552,000 annually. This change is being made to expand the scope of medical assistance to better meet the needs of recipients.

These proposed changes are available for public review by writing to Sally Adams, Division of Medical Programs, Kansas Department of Social and Rehabilitation Services, Room 628-S, Docking State Office Building, 915 Harrison, Topeka 66612.

Written comments may be sent and reviewed by the public if directed to Sally Adams at the address above.

WINSTON BARTON
Social and Rehabilitation Services

Doc. No. 006771

© Kansas Secretary of State, 1988

Approved in error by the feds. This letter was amended by and superseded by one dated 03-23-89.

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

December 5, 1988

Mr. William R. Blake, Jr.
Associate Regional Administrator
for Financial Operations
Room 242, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

Administrative Services
S. DUNCAN
ommissioner

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JAN ALLEN
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Alcohol and Drug Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance/ Medical Services
JOHN ALQUEST
Commissioner

Mental Health/ Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABE FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

Dear Mr. Blake:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for general hospital services. This letter supersedes our previous letters dated December 28, 1984, February 12, 1985, July 1, 1985, September 20, 1985, June 23, 1987, June 23, 1988, October 21, 1988 and October 24, 1988. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-88-42 regarding the change the inpatient hospital reimbursement methodology relating to liver transplants.

1. Payment Rates

42 CFR 447.253(b)(1)(i)
The State of Kansas based the prospective payment system on the Medicare standards applicable in 1981. Through negotiations with the Kansas Hospital Association it was agreed that a level of inflation would be added to these costs annually. This method was applied to both low and high cost hospitals. The change in rates which may affect high cost hospitals only results in a small portion of days being paid at a "lower" rate. This lower rate is not significantly different from the average cost of all Kansas hospitals. Therefore, the lower rate is reasonable and adequate. The prospective payment system is reasonable and adequate except for liver transplants. A new reimbursement methodology for liver transplants has been developed to insure this reasonableness and adequacy. Rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
Hospitals are determined to be disproportionate share hospitals according to P.L. 100-203, Section 4112. A payment adjustment for disproportionate share hospitals is made based upon P.L. 100-203, Section 4112.

Refers to MS-88-42. State Plan TN# 88-42 Effective Date 10/1/88
Supersedes TN# _____ Approval Date 5/2/89

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

42 CFR 447.253(b)(1)(ii)(c)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.253(b)(2)
The State assures that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital, return on equity, and acquisition and settlement costs) due solely to a change in ownership which occur on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(O) of the Act.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. This system uses a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of depreciation which affects the 1981 base year shall result in a change in the provider's current rate.

For the period July 1, 1983, to January 18, 1987, the reimbursement system for outpatient hospital services was based on the lesser of reasonable cost or customary charges, with the exception of laboratory and radiology services which were paid on a fee-for-service basis beginning 10-01-84 and 07-01-86, respectively. We assured that reasonable costs were adjusted to reflect any recapture of depreciation for the lesser of reasonable cost or customary charges payment methodology.

Refers to MS-88-42.

State Plan TN# 88-42 Effective Date 10/1/88
Supersedes TN# _____ Approval Date 5/2/89

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

3. Public Notice

42 CFR 447.253(f)
As changes in State regulations, the reimbursement methodology for liver transplants and the prospective payment system have met the public notice requirements.

4. Related Information

42 CFR 447.255
The estimated average rate per day for state FY 1989 is $373.69.

5. Provider Appeals

42 CFR 447.253(c)
The State assures that an appeals procedure (which allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of such issues as the agency determines appropriate) is provided for payment rates.

6. Rates Paid

447.253(g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Sincerely,

Winston Barton
Secretary

WB:JWA:SA:plk
cc: L. Kathryn Klassen
Steve Otto

Attachment

Refers to MS-88-42.

State Plan TN# 88-42 Effective Date 10/1/88
Supersedes TN# _____ Approval Date 5/2/89

MS-88-27

STATE OF KANSAS

MIKE HAYDEN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

WINSTON BARTON, SECRETARY

DOCKING STATE OFFICE BUILDING
TOPEKA, KANSAS 66612-1570

October 24, 1988

Mr. Edward M. Brennan
Associate Regional Administrator
for Program Operations
Room 220, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brennan:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for general hospital services. This letter supersedes our previous letters dated December 28, 1984, February 12, 1985, July 1, 1985, September 20, 1985, June 23, 1987, ~~and~~ June 23, 1988. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-88-~~12~~ 27 regarding ~~the reimbursement methodology for liver transplants and the inclusion of~~ payment adjustments for ~~hospitals determined to be disproportionate share hospitals~~ change of ownership on the inpatient hospital reimbursement methodology.

1. Payment Rates

42 CFR 447.253(b)(1)(i)
The State of Kansas based the prospective payment system on the Medicare standards applicable in 1981. Through negotiations with the Kansas Hospital Association it was agreed that a level of inflation would be added to these costs annually. This method was applied to both low and high cost hospitals. The change in rates which may affect high cost hospitals only results in a small portion of days being paid at a "lower" rate. This lower rate is not significantly different from the average cost of all Kansas hospitals. Therefore, the lower rate is reasonable and adequate. The prospective payment system is reasonable and adequate except for liver transplants. A new reimbursement methodology for liver transplants has been developed to insure this reasonableness and adequacy. Rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
Hospitals are determined to be disproportionate share hospitals according to P.L. 100-203, Section 4112. A payment adjustment for disproportionate share hospitals is made based upon P.L. 100-203, Section 4112.

Refers to MS-88-~~12~~ 27.

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

42 CFR 447.253(b)(1)(ii)(c)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.253(b)(2)
The State assures that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital, return on equity, and acquisition and settlement costs) due solely to a change in ownership which occur on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(O) of the Act.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. This system uses a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of depreciation which affects the 1981 base year shall result in a change in the provider's current rate.

For the period July 1, 1983, to January 18, 1987, the reimbursement system for outpatient hospital services was based on the lesser of reasonable cost or customary charges, with the exception of laboratory and radiology services which were paid on a fee-for-service basis beginning 10-01-84 and 07-01-86, respectively. We assured that reasonable costs were adjusted to reflect any recapture of depreciation for the lesser of reasonable cost or customary charges payment methodology.

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

3. Public Notice

42 CFR 447.253(f)
As a change in State regulations, the prospective payment system has met the public notice requirements.

4. Related Information

42 CFR 447.255
The estimated average rate per day for state FY 1989 is $373.69

5. Provider Appeals

42 CFR 447.253(c)
The State assures that an appeals procedure (which allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of such issues as the agency determines appropriate) is provided for payment rates.

6. Rates Paid

447.253(g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Sincerely,

Winston Barton
Secretary

WB:JWA:SA:jm

Attachment

cc: L. Kathryn Klassen
Steve Otto

27.

Refers to MS-88-~~12~~.

Assurance : MS 88-12

STATE OF KANSAS

MIKE HAYDEN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

WINSTON BARTON, SECRETARY

DOCKING STATE OFFICE BUILDING
TOPEKA, KANSAS 66612-1570

October 21, 1988

Mr. Edward M. Brennan
Associate Regional Administrator
for Program Operations
Room 220, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brennan:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for general hospital services. This letter supersedes our previous letters dated December 28, 1984, February 12, 1985, July 1, 1985, September 20, 1985, June 23, 1987, and June 23, 1988. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-88-12 regarding the reimbursement methodology for liver transplants and the inclusion of payment adjustments for hospitals determined to be disproportionate share hospitals.

1. Payment Rates

42 CFR 447.253(b)(1)(i)
The State of Kansas based the prospective payment system on the Medicare standards applicable in 1981. Through negotiations with the Kansas Hospital Association it was agreed that a level of inflation would be added to these costs annually. This method was applied to both low and high cost hospitals. The change in rates which may affect high cost hospitals only results in a small portion of days being paid at a "lower" rate. This lower rate is not significantly different from the average cost of all Kansas hospitals. Therefore, the lower rate is reasonable and adequate. The prospective payment system is reasonable and adequate except for liver transplants. A new reimbursement methodology for liver transplants has been developed to insure this reasonableness and adequacy. Rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
Hospitals are determined to be disproportionate share hospitals according to P.L. 100-203, Section 4112. A payment adjustment for disproportionate share hospitals is made based upon P.L. 100-203, Section 4112.

Supp. Plan No. 88-12 Effective Date 7/1/88
Supersedes No. _____ Approval Date 1/18/89

Refers to MS-88-12.

MS 88-12

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

42 CFR 447.253(b)(1)(ii)(c)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

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State Plan TN# 88-12 Effective Date 7/1/88
Supersedes TN# _____ Approval Date 1/18/89
Refers to MS-88-12.

MS88-12

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

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42 CFR 447.253(f)
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447.253(g)
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Sincerely,

Winston Barton
Secretary

WB:JWA:SA:jm

Attachment

cc: L. Kathryn Klassen
Steve Otto

State Plan TN# 88-12 Effective Date 7/1/88
Supersedes TN# _____ Approval Date 1/18/89

Refers to MS-88-12.

STATE OF KANSAS

MIKE HAYDEN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

WINSTON BARTON, SECRETARY

DOCKING STATE OFFICE BUILDING
TOPEKA, KANSAS 66612-1570

June 23, 1988

Mr. Edward M. Brennan
Associate Regional Administrator
for Program Operations
Room 220, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brennan:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for general hospital services. This letter supersedes our previous letters dated December 28, 1984, February 12, 1985, July 1, 1985, September 20, 1985 and June 23, 1987. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-88-11 regarding the reimbursement methodology for liver transplants and the inclusion of payment adjustments for hospitals determined to be disproportionate share hospitals.

1. Payment Rates

42 CFR 447.253(b)(1)(i)
The State of Kansas based the prospective payment system on the Medicare standards applicable in 1981. Through negotiations with the Kansas Hospital Association it was agreed that a level of inflation would be added to these costs annually. This method was applied to both low and high cost hospitals. The change in rates which may affect high cost hospitals only results in a small portion of days being paid at a "lower" rate. This lower rate is not significantly different from the average cost of all Kansas hospitals. Therefore, the lower rate is reasonable and adequate. The prospective payment system is reasonable and adequate except for liver transplants. A new reimbursement methodology for liver transplants has been developed to insure this reasonableness and adequacy. Rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
Hospitals are determined to be disproportionate share hospitals according to P.L. 100-203, Section 4112. A payment adjustment for disproportionate share hospitals is made based upon P.L. 100-203, Section 4112.

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

42 CFR 447.253(b)(1)(ii)(c)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.253(b)(2)
The State assures that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital, return on equity, and acquisition and settlement costs) due solely to a change in ownership which occur on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(O) of the Act.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. This system uses a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of depreciation which affects the 1981 base year shall result in a change in the provider's current rate.

For the period July 1, 1983, to January 18, 1987, the reimbursement system for outpatient hospital services was based on the lesser of reasonable cost or customary charges, with the exception of laboratory and radiology services which were paid on a fee-for-service basis beginning 10-01-84 and 07-01-86, respectively. We assured that reasonable costs were adjusted to reflect any recapture of depreciation for the lesser of reasonable cost or customary charges payment methodology.

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

3. Public Notice

42 CFR 447.253(f)
As a change in State regulations, the prospective payment system has met the public notice requirements.

4. Related Information

42 CFR 447.255
The average estimated rate per day for state FY 1984 was $275. This compared to an average cost in state FY 1983 of $287.90. This reduction is in part due to the prospective nature of the payment system, which guarantees a set payment with no cost settlement, thereby eliminating some previous areas of concern (and expense) of providers.

This change (MS-85-32, Attachment 4.19-A, Page 9, Q.) is expected to increase the average payment rate to hospitals by $31.50 for the first day, for a total overall expenditure of $1,000,000.

	FY 1985	FY 1986 First Day Rate With Intensity Allowance	FY 1986 First Day Rate Without Intensity Allowance
All hospitals estimated daily rate	$278.00	$349.50	$318.00

This short-term effect (the long-term effect is not calculable) will:

1. increase the availability of services on a statewide and geographic area basis,

2. expand the type of care furnished,

3. encourage the extent of provider participation, and

4. have no effect on the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs as there are no hospitals so determined in Kansas.

5. Provider Appeals

42 CFR 447.253(c)
The State assures that an appeals procedure (which allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of such issues as the agency determines appropriate) is provided for payment rates.

6. Rates Paid

447.253(g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Sincerely,

Winston Barton
Secretary

WB:JWA:SA:bss

Attachment

cc: L. Kathryn Klassen
Steve Otto

assurances
MS87-16

STATE OF KANSAS

MIKE HAYDEN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

DOCKING STATE OFFICE BUILDING
TOPEKA, KANSAS 66612-1570

June 23, 1987

Mr. Edward M. Brennan
Associate Regional Administrator
for Program Operations
Federal Office Building, Room 225
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brennan:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for general hospital services. This letter supersedes our previous letters dated December 28, 1984, February 12, 1985, July 1, 1985 and September 20, 1985. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-87-01 regarding the calculation of the rate structure of all general hospital reimbursement (not merely "lower cost" hospitals).

1. Payment Rates

42 CFR 447.253(b)(1)(i)
The State of Kansas based the prospective payment system on the Medicare standards applicable in 1981. Through negotiations with the Kansas Hospital Association it was agreed that a level of inflation would be added to these costs annually. This method was applied to both low and high cost hospitals. The change in rates which may affect high cost hospitals only results in a small portion of days being paid at a "lower" rate. This lower rate is not significantly different from the average cost of all Kansas hospitals. Therefore, the lower rate is reasonable and adequate. Rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
There are no Kansas general hospitals which serve a disproportionate number of low income patients with special needs.

TN#MS-87-16 Approval Date AUG 05 1987 Efffective Date 4/1/87 Supercedes TN#MS-85-32A

Assurances

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

42 CFR 447.253(b)(1)(ii)(c)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.253(b)(2)
The State assures that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital, return on equity, and acquisition and settlement costs) due solely to a change in ownership which occur on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(O) of the Act.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. This system uses a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of depreciation which affects the 1981 base year shall result in a change in the provider's current rate.

For the period July 1, 1983, to January 18, 1987, the reimbursement system for outpatient hospital services was based on the lesser of reasonable cost or customary charges, with the exception of laboratory and radiology services which were paid on a fee-for-service basis beginning 10-01-84 and 07-01-86, respectively. We assured that reasonable costs were adjusted to reflect any recapture of depreciation for the lesser of reasonable cost or customary charges payment methodology.

Assurances

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

3. Public Notice

42 CFR 447.253(f)
As a change in State regulations, the prospective payment system has met the public notice requirements.

4. Related Information

42 CFR 447.255
The average estimated rate per day for state FY 1984 was $275. This compared to an average cost in state FY 1983 of $287.90. This reduction is in part due to the prospective nature of the payment system, which guarantees a set payment with no cost settlement, thereby eliminating some previous areas of concern (and expense) of providers.

This change (MS-85-32, Attachment 4.19-A, Page 9, Q.) is expected to increase the average payment rate to hospitals by $31.50 for the first day, for a total overall expenditure of $1,000,000.

	FY 1985	FY 1986 First Day Rate With Intensity Allowance	FY 1986 First Day Rate Without Intensity Allowance
All hospitals estimated daily rate	$278.00	$349.50	$318.00

This short-term effect (the long-term effect is not calculable) will:

1. increase the availability of services on a statewide and geographic area basis,

2. expand the type of care furnished,

3. encourage the extent of provider participation, and

4. have no effect on the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs as there are no hospitals so determined in Kansas.

Assurances

5. Provider Appeals

42 CFR 447.253(c)
The State assures that an appeals procedure (which allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of such issues as the agency determines appropriate) is provided for payment rates.

6. Rates Paid

447.253(g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Sincerely,

Robert C. Harder
Secretary

RCH:SA:bss
Attachment

cc: L. Kathryn Klassen
Steve Otto

Substituted by 9/20/85 letter

STATE OF KANSAS

JOHN CARLIN, Governor

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

INCOME MAINTENANCE AND MEDICAL SERVICES

ROBERT C. HARDER, Secretary

STATE OFFICE BUILDING
TOPEKA, KANSAS 66612

September 20, 1985

Assurances #2
MS 85-32

Mr. Dean R. Mordy
Associate Regional Administrator
for Program Operations
Federal Office Building, Room 225
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Mordy:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for inpatient hospital services. This letter supersedes our previous letters dated December 28, 1984, February 12, 1985, and July 1, 1985. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-85-32 regarding the calculation of the rate structure of all hospital reimbursement (not merely "lower cost" hospitals).

1. Payment Rates

42 CFR 447.253(b)(1)(i)
The State of Kansas based the prospective payment system on the Medicare standards applicable in 1981. To these costs a level of inflation was added through negotiations with the Kansas Hospital Association. This method was applied to both low and high cost hospitals. The change in rates which may affect high cost hospitals only results in a small portion of days being paid at a "lower" rate. This lower rate is not significantly different from the average cost of all Kansas hospitals. Therefore, the lower rate is reasonable and adequate. Rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
There are no Kansas hospitals which serve a disproportionate number of low income patients with special needs.

State Plan TN# KS85-32A Effective Date 7/1/85
Supersedes TN# MS-83-34 Approval Date 10/3/85

Assurances for MS 85-32

Substituted by 9/20/85 letter

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

42 CFR 447.253(b)(1)(ii)(c)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.253(b)(2)
The State assures that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital, return on equity, and acquisition and settlement costs) due solely to a change in ownership which occur on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(O) of the Act.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. This system uses a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of depreciation which affects the 1981 base year shall result in a change in the provider's current rate.

Since July 1, 1983, the reimbursement system for outpatient hospital services is based on the lesser of reasonable cost or customary charges. We assure that reasonable costs shall be adjusted to reflect any recapture of depreciation.

Assurances for MS85-32 Substituted by 9/20/85 letter

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

3. Public Notice

42 CFR 447.253(f)
As a change in State regulations, the prospective payment system has met the public notice requirements.

4. Related Information

42 CFR 447.255
The average estimated rate per day for state FY 1984 was $275. This compared to an average cost in state FY 1983 of $287.90. This reduction is in part due to the prospective nature of the payment system, which guarantees a set payment with no cost settlement, thereby eliminating some previous areas of concern (and expense) of providers.

This change (MS-85-32, attachment 4.19-A, Page 9, Q.) is expected to increase the average payment rate to hospitals by $31.50 for the first day, for a total overall expenditure of $1,000,000.

	FY 1985	FY 1986 First Day Rate With Intensity Allowance	FY 1986 First Day Rate Without Intensity Allowance
All hospitals estimated daily rate	$ 278.00	$ 349.50	$ 318.00

This short-term effect (the long-term effect is not calculable) will:

1. increase the availability of services on a statewide and geographic area basis,

2. expand the type of care furnished,

3. encourage the extent of provider participation, and

4. have no effect on the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs as there are no hospitals so determined in Kansas.

State Plan TN# KS 85-32A Effective Date 7/1/85
Supersedes TN# _____ Approval Date 10/3/85

Assurances
MS85-32
Substituted by 9/20/85 letter

5. Provider Appeals

42 CFR 447.253(c)
The State assures that an appeals procedure (which allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of such issues as the agency determines appropriate) is provided for payment rates.

6. Rates Paid

447.253(g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Sincerely,

Robert C Harder

Robert C. Harder
Secretary

RCH:plk
Attachment
cc: L. Kathryn Klassen
Steve Otto

#343

State Plan TN# 85-32A Effective Date 4/1/85
Supersedes TN#_____ Approval Date 10/3/85

STATE OF KANSAS

JOHN CARLIN, Governor

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Otto
BS
JF

KS MS 84-37
&
KS 84-37

INCOME MAINTENANCE AND
MEDICAL SERVICES

ROBERT C. HARDER, Secretary

STATE OFFICE BUILD
TOPEKA, KANSAS 6

FEB 21 11 12 AM '85

February 12, 1985

Steve Otto, Medicaid Operations Specialist
Division of Program Operations
State & Contractor Operations Branch
Health and Human Services
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Otto:

Regarding your letter of February 5, 1985, in the first point, the citations have been checked. Those quoted appear correct when compared to the Federal Register, Vol. 48, #244, December 19, 1983. We regret that the citations in our letter of December 28, 1984, were incorrect, and we agree that the citations you cited apply to our assurances.

The second point, recapture of depreciation in hospital payment methodology, has also been considered. In accordance with section 1861(v)(1)(O), we are clarifying our previous assurances.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. This system uses a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of depreciation which affects the 1981 base year shall result in a change in the provider's current rate.

Since July 1, 1983, the reimbursement system for outpatient hospital services is based on the lesser of reasonable cost or customary charges. We assure that reasonable costs shall be adjusted to reflect any recapture of depreciation.

If this additional clarification is insufficient, please advise us immediately.

Sincerely yours,

Robert C. Harder,
Secretary

RCH:plk
cc: L. Kathryn Klassen
Anita Favors
2825M

State Plan TN# MS 84-37 Effective Date 10/1/84
Supersedes TN# MS 83-34 Approval Date 3/25/85

assurance
MS 84-37

DEC 28 12 18 PM '84

~~BS~~
SP-4

STATE OF KANSAS

JOHN CARLIN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

INCOME MAINTENANCE AND MEDICAL SERVICES

ROBERT C. HARDER, SECRETARY

STATE OFFICE BUILDING
TOPEKA, KANSAS 6661

December 28, 1984

KS 84-37A

Mr. Dean R. Mordy
Associate Regional Administrator
for Program Operations
Room 225, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Mordy:

In accordance with Section 1902 (a)(13)(B) of the Social Security Act, the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for inpatient hospital services. This assurance relates to MS-84-37 regarding change of ownership and the calculation of hospital reimbursement.

1. Payment Rates

42 CFR 447.252 (a)(i)
The State of Kansas based the prospective payment system on the Medicare standards applicable in 1981. To these costs a level of inflation was added through negotiations with the Kansas Hospital Association. This method is applied to both low and high cost hospitals. The change in rates which may affect high cost hospitals only results in a small portion of days being paid at a "lower" rate. This lower rate is not significantly different from the average cost of all Kansas hospitals. Therefore, the lower rate is reasonable and adequate. Rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and federal laws, regulations, and quality and safety standards.

42 CFR 447.252(a)(3)(i)
There are no Kansas hospitals which serve a disproportionate number of low income patients with special needs.

42 CFR 447.252(a)(3)(ii)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

State Plan TN# MS 84-37 Effective Date 10/1/84
Supersedes TN# MS 83-34 3/25/85

Assurances MS84-37

State Plan TN# MS84-37 Effective Date 10/1/84
Supersedes TN# MS83-34 Approval Date 3/25/85

42 CFR 447.252(a)(3)(iii)
Since the State pays reasonable costs under 42 CFR 447.252(a)(1) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.252(b)
The State has found that the rates paid satisfy the requirements of 42 CFR 447.252 (a)(1) and (a)(3). In using the nursing differential that was in effect in 1981, the State is using this method as it applied to Medicaid at the time. There is no additional cost being considered over the costs as settled in 1981. The nursing differential resulted in higher average cost for Medicare but provided a slight reduction in cost to all other payors (using the same methodology, including Medicaid). This method is retained by using 1981 as the base year. This usage of the nursing differential in this manner would not affect whether the Medicare upper limit requirement is met.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital and return on equity) resulting from a change in ownership will not increase payments to providers in the aggregate more than the amount which would be recognized under Section 1861 (v)(1)(O) of the Act. This does not apply to changes in ownership prior to July 18, 1984. This assurance relates to MS - .

2. Uniform Reporting and Audit Requirements

42 CFR 252(f)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

3. Public Notice

42 CFR 447.254
As a change in State regulations, the prospective payment system has met the public notice requirements.

4. Average Payment Rate

The average estimated rate per day for State FY 1984 was $275. This compared to an average cost in State FY 1983 of $287.90. This reduction is in part due to the prospective nature of the payment system, which guarantees a set payment with no cost settlement, thereby eliminating some previous areas of concern (and expense) of providers.

Therefore the change is considered to have no impact on the availability of services, type of care, extent of provider participation, or the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs. All hospitals are likely to remain under the prospective payment system, thereby providing services throughout the State as needed.

Sincerely,

Robert C. Harder
Secretary

RCH:plk
Attachment
cc: L. Kathryn Klassen

2607M/1-3

State Plan TN# 77584-37 Effective Date 10/1/84
Supersedes TN# 77583-34 Approval Date 3/25/85

Assurances MS 88-12

STATE OF KANSAS

MIKE HAYDEN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

WINSTON BARTON, SECRETARY

DOCKING STATE OFFICE BUILDING
TOPEKA, KANSAS 66612-1570

October 21, 1988

Mr. Edward M. Brennan
Associate Regional Administrator
for Program Operations
Room 220, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brennan:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurance related to Kansas Medicaid payment for general hospital services. This letter supersedes our previous letters dated December 28, 1984, February 12, 1985, July 1, 1985, September 20, 1985, June 23, 1987, and June 23, 1988. New material in this letter is indicated by lines in the left margin. This assurance relates to MS-88-12 regarding the reimbursement methodology for liver transplants and the inclusion of payment adjustments for hospitals determined to be disproportionate share hospitals.

1. Payment Rates

42 CFR 447.253(b)(1)(i)
The State of Kansas based the prospective payment system on the Medicare standards applicable in 1981. Through negotiations with the Kansas Hospital Association it was agreed that a level of inflation would be added to these costs annually. This method was applied to both low and high cost hospitals. The change in rates which may affect high cost hospitals only results in a small portion of days being paid at a "lower" rate. This lower rate is not significantly different from the average cost of all Kansas hospitals. Therefore, the lower rate is reasonable and adequate. The prospective payment system is reasonable and adequate except for liver transplants. A new reimbursement methodology for liver transplants has been developed to insure this reasonableness and adequacy. Rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
Hospitals are determined to be disproportionate share hospitals according to P.L. 100-203, Section 4112. A payment adjustment for disproportionate share hospitals is made based upon P.L. 100-203, Section 4112.

State Plan TN 88-12 Effective Date 7/1/88
Supersedes TN _____ Approval Date 1/18/89

Refers to MS-88-12.

42 CFR 447.253(b)(1)(ii)(B)
If it is determined through the utilization review process that hospital patients received services at an inappropriate level of care, no reimbursement is made and/or previous payments are recovered as appropriate.

42 CFR 447.253(b)(1)(ii)(c)
Since the State pays reasonable costs under 42 CFR 447.253(b)(1)(i) and there are hospitals serving all areas of Kansas, recipients have reasonable access to facilities. Hospitals must meet Medicare standards for quality which ensures that recipients receive inpatient hospital services of adequate quality. Monitoring is provided by the Department of Health and Environment.

42 CFR 447.253(b)(2)
The State assures that the estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for inpatient hospital services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Deficit Reduction Act of 1984, Section 2314
In accordance with Section 2314 of the Deficit Reduction Act of 1984, the Medicaid revision in Section 1902 (a)(13)(B), the Department of Social and Rehabilitation Services submits this assurance for inpatient hospital payment methodology. Capital related costs (depreciation, interest on capital, return on equity, and acquisition and settlement costs) due solely to a change in ownership which occur on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(0) of the Act.

Prior to July 1, 1983, the State of Kansas assures that it shall recapture depreciation in accordance with Medicare cost principles which were in effect at the time. The reimbursement system for inpatient hospital services was changed as of July 1, 1983. This system uses a hospital's fiscal year ending in 1981 as a base for rate setting. Therefore, we assure that any recapture of depreciation which affects the 1981 base year shall result in a change in the provider's current rate.

For the period July 1, 1983, to January 18, 1987, the reimbursement system for outpatient hospital services was based on the lesser of reasonable cost or customary charges, with the exception of laboratory and radiology services which were paid on a fee-for-service basis beginning 10-01-84 and 07-01-86, respectively. We assured that reasonable costs were adjusted to reflect any recapture of depreciation for the lesser of reasonable cost or customary charges payment methodology.

State Plan TN# 88-12 Effective Date 7/1/88
Supersedes TN# _____ Approval Date 1/18/89
Refers to MS-88-12.

MS 88-12

2. Uniform Reporting and Audit Requirements

42 CFR 253(d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

3. Public Notice

42 CFR 447.253(f)
As a change in State regulations, the prospective payment system has met the public notice requirements.

4. Related Information

42 CFR 447.255
The estimated average rate per day for state FY 1989 is $373.69

5. Provider Appeals

42 CFR 447.253(c)
The State assures that an appeals procedure (which allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of such issues as the agency determines appropriate) is provided for payment rates.

6. Rates Paid

447.253(g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Sincerely,

Winston Barton

Winston Barton
Secretary

WB:JWA:SA:jm

Attachment

cc: L. Kathryn Klassen
Steve Otto

State Plan TN# 88-12 Effective Date 7/1/88
Supersedes TN# _____ Approval Date 1/18/89

Refers to MS-88-12.

Refer to:
FMB:MS
KS SPA 94-19

FEB 15 1996

Ms. Janet Schalansky
Deputy Secretary
Department of Social and Rehabilitation Services
Docking State Office Building
Room 603 North
915 Harrison Street
Topeka, Kansas 66612

Dear Ms. Schalansky:

We have completed our review of Kansas State plan amendment (SPA) 94-19 including the revisions you submitted on November 11, 1995 and February 13, 1996. This amendment incorporates the one percent Medicaid utilization requirement into the State's definition of disproportionate share hospitals (DSHs) and imposes spending limits for public DSH providers.

You have now provided the additional explanation and revised State plan material we requested in our October 31, 1995 letter. Specifically, you have furnished the assurances relating to DSH payments that were missing from the initial submission. You also revised the plan material to clarify that all DSH providers will have a Medicaid inpatient utilization rate of at least one percent as required by section 1923(d)(3) of the Social Security Act (the Act). Furthermore, you revised the limit for public hospitals to clarify that any payments made by uninsured patients will be subtracted from the cost of services they receive. You also made various other miscellaneous clarifying changes to your proposal.

Based on the assurances and related rate information you submitted and on the additional clarifying information mentioned above, we have approved Kansas SPA 94-19 for incorporation into the official Kansas State Medicaid plan, effective July 1, 1994. If you have any questions, please call Mary Stuart at 816-426-6466.

Sincerely,

Robert L. Epps
Acting Associate Regional Administrator
for Medicaid

cc: Ann Koci

FILE COPY

Stuart\mm\February 14, 1996\KS94-19

Office	Signature	Date	Office	Signature	D
WPD					
MFMB	[signature]	2/15/96			
MFMD	[signature]	2/15/96			
MDD	[signature]	2/15/96			

Substitute per letter dated 11-7-95

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

November 9, 1995

Mr. Richard P. Brummel
Health Care Financing Administration
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances to Kansas Medicaid payments for general hospital services. This assurance relates to MS-94-19 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253(b)(1)(i)
Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiency and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4.19A, Section 6.0000.

42 CFR 447.253(b)(1)(ii)(B)
Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

42 CFR 447.253(b)(1)(ii)(C)
The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

42 CFR 447.272(c)
Aggregate disproportionate share payments do not exceed the disproportionate share base allotment. Disproportionate share payments to public facilities will not exceed the limits imposed by section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993).

Eff 7/1/94

App FEB 15 1996

Refers to MS-94-19

Social Security Act, Section 1902(a)(13)(B)
Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change of ownership which occurs on or after July 18, 1994, in excess of the amount that would be permitted under the provision of Section 1816(v)(2)(0) of the Act.

2. Upper Payment Limits

42 CFR 447.253(b)(2)
The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

The State assures that aggregate payments made to each group of State-operated facilities, when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles as required by 42 CFR 447.272(b)

3. Provider Appeals

42 CFR 447.253(e)
The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

4. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253(f) and (g)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

5. Public Notice

42 CFR 447.253(h)
The reimbursement methodology change for inpatient hospital services has met the public notice requirements by publication in the Kansas Register.

6. Rates Paid

42 CFR 447.253(i)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Refers to MS-94-19

Eff 7/1/94 App FEB 15 1996

7. Related Information

42 CFR 447.255
The average payment rate is expected to be $3,150 per discharge in FFY 1995. This is an increase of less than 1% from FFY 1994 primarily due to continued reductions in length of stay. All hospitals received increases in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts, as well as the cost of Medicaid/MediKan services, about 100% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments. This is based on the best information available from the Medicare cost reports and Medicaid/MediKan paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

Janet Schalansky

Janet Schalansky
Deputy Secretary

JKS:AEK:mas

cc: Jim Nash

Eff 7/1/94

App FEB 15 1995

mrB

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

March 31, 1994

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Health Care Financing Administration
601 East 12th Street
Room 235
Kansas City, Missouri 64106

HHS
HCFA-MEDICAID
REGION VII
94 APR -4 AM 10:43

Dear Mr. Brummel:

Kansas assures services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area based on rates that are effective July 1, 1994, for obstetrical practitioners. The attached listing of rates is based upon the average payment rate for each procedure code in FY '93.

The results of a comparison of licensed obstetrical providers participating in the Medicaid program, by SRS catchment areas, is attached. Obstetricians, family and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment. These results substantiate that access is available in these areas.

We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing obstetrical care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

Sincerely,

Joyce C. Sugrue, R.N.
Director
Division of Medical Services

JCS:TAH:pm
cc: Steve Otto

TN#MS-94-04 Approval Date MAY 04 1994 Effective Date APR 01 1994 Supersedes TN#MS-93-07

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

March 31, 1994

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Health Care Financing Administration
601 East 12th Street
Kansas City, Missouri 64106

HHS
HCFA-MEDICAID
REGION VII
94 APR -4 AM 10:4

Dear Mr. Brummel:

Kansas assures services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area based on rates effective July 1, 1994, for Pediatrician Practitioners. The attached listing of rates is based upon the average payment rate for each procedure code in FY '93.

The results of a comparison of licensed and enrolled pediatric providers participating in the Medicaid program, by SRS catchment areas, is attached. Pediatricians, family and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program, by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment. These results substantiate that access is available in these areas.

We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing pediatric care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

Sincerely,

Joyce C. Sugrue, R.N.
Director
Division of Medical Services

JCS:TAH:pm
cc: Steve Otto

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

TN#MS-94-05 Approval Date MAY 04 1994 Effective Date APR 01 1994 Supersedes TN#MS-93-08

MD3

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

HHS
HCFA-MEDICAID
REGION VII
93 APR 29 AM 8:22

April 14, 1993

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

The State of Kansas, in accordance with the State Medicaid Manual 6305.2 and 42 CFR 447.333, submits this assurance regarding Medicaid reimbursement for prescribed drugs.

The State of Kansas assures that the Medicaid payment rate for multiple source drugs does not exceed, in the aggregate, upper limit payment levels established by the Health Care Financing Administration (HCFA) per 42 CFR 447.332(a).

The State of Kansas also assures that the Medicaid payment rate for other drugs (defined as brand name drugs certified as medically necessary by a physician or drugs other than multiple source drugs) does not exceed, in the aggregate, the lower of either the estimated acquisition costs (average wholesale price less 10%) plus reasonable dispensing fees or the provider's usual and customary charges to the general public per 42 CFR 447.332 (b) and (c).

The State of Kansas assures that necessary findings support these assurances.

Sincerely,

Donna L. Whiteman

Donna L. Whiteman
Secretary

DLW:RLE:TAH:pm

cc: Steve Otto

TN#MS-93-09 Approval Date MAY 03 1993 Effective Date APR 01 1993 Supersedes No Numbe

10:57

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

November 14, 1989

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

Administrative Services
J. S. DUNCAN
Commissioner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance/ Medical Services
JOHN ALQUEST
Commissioner

Mental Health/ Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABE FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

Mr. William R. Blake, Jr.
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Blake:

The State of Kansas, in accordance with the State Medicaid Manual 6305.2 and 42 CFR 447.333, submits this assurance regarding Medicaid reimbursement for prescribed drugs. The State submits this assurance in addition to the Methods and Standards for Establishing Payment Rates for Prescribed Drugs as contained within Attachment 4.19-B, #12.a. of the Kansas Medicaid State Plan.

The State of Kansas assures that the Medicaid payment rate for multiple source drugs does not exceed, in the aggregate, upper limit payment levels established by the Health Care Financing Administration (HCFA) per 42 CFR 447.332(a).

The State of Kansas also assures that the Medicaid payment rate for other drugs (defined as brand name drugs certified as medically necessary by a physician or drugs other than multiple source drugs) does not exceed, in the aggregate, the lower of either the estimated acquisition costs (average wholesale price less 10%) plus reasonable dispensing fees or the provider's usual and customary charges to the general public per 42 CFR 447.332 (b) and (c).

The State of Kansas assures that necessary findings support these assurances.

Sincerely,

Winston Barton
Secretary

WB:JWA:SA:plk

cc: Steve Otto

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

March 14, 1989

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

Administrative Services
J. S. DUNCAN
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Mr. William R. Blake, Jr.
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Blake:

The State of Kansas, in accordance with the State Medicaid Manual 6305.2 and 42 CFR 447.333, submits this assurance regarding Medicaid reimbursement for prescribed drugs. The State submits this assurance in addition to the Methods and Standards for Establishing Payment Rates for Prescribed Drugs as contained within Attachment 4.19-B, #12.a. of the Kansas Medicaid State Plan.

The State of Kansas assures that the Medicaid payment rate for multiple source drugs does not exceed, in the aggregate, upper limit payment levels established by the Health Care Financing Administration (HCFA) per 42 CFR 447.332.(a).

The State of Kansas also assures that the Medicaid payment rate for other drugs (defined as brand name drugs certified as medically necessary by a physician or drugs other than multiple source drugs) does not exceed, in the aggregate, the lower of either the estimated acquisition costs plus reasonable dispensing fees or the provider's usual and customary charges to the general public per 42 CFR 447.332 (b) and (c).

The State of Kansas assures that necessary findings support these assurances.

Sincerely,

Winston Barton

Winston Barton
Secretary

WB:JWA:SA:mrw

TN# MS-89-05 Approval Date 3/28/89 Effective Date 1/1/89 Supersedes TN# MS-87-44A

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

December 12, 1995

Mr. Richard P. Brummel
Health Care Financing Administration
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances to Kansas Medicaid payments for general hospital services. This assurance relates to MS-95-16 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253(b)(1)(i)
Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiency and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4.19A, Section 6.0000.

42 CFR 447.253(b)(1)(ii)(B)
Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

42 CFR 447.253(b)(1)(ii)(C)
The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

42 CFR 447.272(c)
Aggregate disproportionate share payments do not exceed the disproportionate share base allotment. Disproportionate share payments to public facilities will not exceed the limits imposed by section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993).

Subst. per letter dated 12/13/95

Refers to MS-95-16

Eff 7/1/95 App JAN 27 1997

Social Security Act, Section 1902(a)(13)(B)
Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change of ownership which occurs on or after July 18, 1994, in excess of the amount that would be permitted under the provision of Section 1816(v)(2)(0) of the Act.

2. Upper Payment Limits

42 CFR 447.253(b)(2)
The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

The State assures that aggregate payments made to each group of State-operated facilities, when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles as required by 42 CFR 447.272(b)

3. Provider Appeals

42 CFR 447.253(e)
The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

4. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253(f) and (g)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

5. Public Notice

42 CFR 447.253(h)
The reimbursement methodology change for inpatient hospital services has met the public notice requirements by publication in the Kansas Register.

6. Rates Paid

42 CFR 447.253(i)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Subst per letter dated 12/16/96

Eff 7/1/95

App JAN 27 1997

7. Related Information

42 CFR 447.255
The average payment rate is expected to be $3,150 per discharge in FFY 1995. This is an increase of less than 1% from FFY 1994 primarily due to continued reductions in length of stay. All hospitals received increases in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts, as well as the cost of Medicaid/MediKan services, about 100% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments. This is based on the best information available from the Medicare cost reports and Medicaid/MediKan paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

Janet Schalansky

Janet Schalansky
Deputy Secretary

JKS:AEK:TAH:mas

cc: Jim Nash

Substitute per letter dated 12/12/95

Eff 7/1/95 App JAN 27 1997

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

December 22, 1995

Mr. Richard P. Brummel
Health Care Financing Administration
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances to Kansas Medicaid payments for general hospital services. This assurance relates to MS-95-21 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253(b)(1)(i)
Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiency and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4.19A, Section 6.0000.

42 CFR 447.253(b)(1)(ii)(B)
Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

42 CFR 447.253(b)(1)(ii)(C)
The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

42 CFR 447.272(c)
Aggregate disproportionate share payments do not exceed the disproportionate share base allotment. Disproportionate share payments to ~~public facilities~~ all hospital will not exceed the limits imposed by section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993).

Refers to MS-95-21

App FEB 27 1997

Social Security Act, Section 1902(a)(13)(B)
Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change of ownership which occurs on or after July 18, 1994, in excess of the amount that would be permitted under the provision of Section 1816(v)(2)(0) of the Act.

2. Upper Payment Limits

42 CFR 447.253(b)(2)
The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

The State assures that aggregate payments made to each group of State-operated facilities, when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles as required by 42 CFR 447.272(b)

3. Provider Appeals

42 CFR 447.253(e)
The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

4. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253(f) and (g)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

5. Public Notice

42 CFR 447.253(h)
The reimbursement methodology change for inpatient hospital services has met the public notice requirements by publication in the Kansas Register.

6. Rates Paid

42 CFR 447.253(i)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Refers to MS-95-21

App FEB 27 1997

7. Related Information

42 CFR 447.255
The average payment rate is expected to be $3,200 per discharge in FFY 1996. This is an increase about 1% from FFY 1995 primarily due to continued reductions in length of stay. Most hospitals received increases in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts, as well as the cost of Medicaid/MediKan services, over 95% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments. This is based on the best information available from the Medicare cost reports and Medicaid/MediKan paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

Janet Schalansky

Janet Schalansky
Deputy Secretary

JKS:AEK:mas

cc: Jim Nash

App [illegible]

"Substitute per letter dated 3/19/01"

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

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Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

1.0000 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

1.0000 continued

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

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

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

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

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

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

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Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

1.0000 continued

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

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

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

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

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

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

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

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1.0000 continued

z. "Readmission" means the subsequent admission of a recipient as an inpatient into a hospital within 30 days of discharge as an inpatient from the same or another hospital participating in the DRG reimbursement system.

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

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

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

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

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

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

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

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

2.1000 Hospital Participation Effective Date

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

2.2000 Billing Requirements

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

2.2100 General Billing

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

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2.2200 Transfer Billing

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

2.2300 Interim Billing

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

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

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

- The final interim bill at the time of discharge.

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

2.3000 Hospital Grouping

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

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2.3000 continued

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

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

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

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

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

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

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

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

2.4000 The DRG Reimbursement System Components

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

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385 Short stay neonates died or transferred (2 day maximum)
386 through 388 No longer used
389 Birth weight > 2000 grams, full term with major problems
390 Birth weight > 2000 grams, full term with other problems
391 Birth weight > 2000 grams, premature or full term, without complicating diagnoses
801 Birth weight < 1000 grams
802 Birth weight 1000 - 1499 grams
803 Birth weight 1500 - 2000 grams
804 Birth weight > 2000 grams, w/ respiratory distress syndrome
805 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 December 29, 2006, 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's 385 and 456.
- 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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- claims with unusually low cost data for the given DRG, or other abnormal data.

2.4120 Claims Modified Before Including in the Data Base

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

2.4200 Determination of the Costs of Claims

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

2.4210 Cost Reports

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

2.4220 Cost Data

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

2.4230 Cost Determination

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

2.4240 Hospital Specific Adjustments

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

2.4250 Example to Illustrate Cost Determination

Data

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

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2.4250 continued

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

Computations

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

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

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2.4250 continued

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

Analysis

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

2.4260 Inflation of the Cost and Charge Data

Due to the variety of cost report time periods and discharge dates, the schedule below was used to inflate routine and ancillary data. These were applied to the final costs as shown in the example in Subsection 2.4250 above.

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- Section 2.4260 continued

	Routine	Ancillary
7/31/99		3.83%
8/31/99		3.60%
9/30/99	5.40%	3.38%
10/31/99	5.18%	3.15%
11/30/99	4.95%	2.93%
12/31/99	4.73%	2.70%
1/31/00	4.50%	0.00%
2/28/00	4.28%	0.00%
3/31/00	4.05%	0.00%
4/30/00	3.83%	0.00%
5/31/00	3.60%	0.00%
6/30/00	3.38%	0.00%
7/31/00	3.15%	0.00%
8/31/00	2.93%	0.00%
9/30/00	2.70%	0.00%
10/31/00	2.48%	0.00%
11/30/00	2.25%	0.00%
12/31/00	2.03%	0.00%

Dates for routine are based on the hospital FYE and for ancillary are based upon the discharge date.

These amounts are applied to routine data, ancillary charges had already been increased by hospitals at their discretion as newer claims data was submitted. Based upon a comparison of the cost to charge ratios used for ancillaries, ancillary cost to charge ratios have generally declined or held steady. Therefore, the adjustment for ancillary charges should only be from the date of the service rather than from the cost report.

The inflation used was based upon a review of various price indices, changes in utilization, changes in case mix, and other relevant information. The inflation rate specifically considers the use of newer cost reports and the continued anticipated decline in average lengths of stay which reduce the cost of the average Medicaid stay.

"Substitute per letter dated 3/19/01"

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2.4300 Identification of Outlier Claims in the Data Base

2.4310 Mean Costs and Mean Lengths of Stay

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

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

2.4320 Establishment of Outlier Limits

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

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

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

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

*Substitute per letter dated 3/19/01

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2.4330 Example of Identifying Outliers

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

Computations

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

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

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

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

Analysis

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

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2.4330 continued

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

2.4400 DRG Relative Weights

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

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

2.4410 Data Base Adjustments for DRG Weight Computations

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

2.4420 Determination of Kansas Medicaid-Specific DRG Relative Weights

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

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

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

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

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

"Substitute per letter dated 3/19/01 "

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

Data

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

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

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

Computations

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

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

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

$$= .6881$$

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2.4430 continued

Analysis

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

2.4440 Modification of Relative Weights for Low-Volume DRGs

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

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

2.4450 Modification of Relative Weights for Selected DRG Pairs

In cases of DRG "pairs" - one DRG with complications and co-morbidity (CC's) and the other DRG without CC's - if the DRG without CC's was weighted higher than the DRG with CC's, the relative weights of both DRG's were replaced with the weighted average of the two relative weights.

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 15% was applied to the group payment rates effective December 29, 2006 as a budget neutrality factor.

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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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2.4520 Example of Group Rate Computation

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

Data

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

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

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

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2.4600 DRG Daily Rates

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

2.4700 Hospital Specific Medicaid Cost to Charge Ratios

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

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

These ratios will be used in the DRG reimbursement system to estimate costs of claims for determining whether the claims meet the cost outlier criteria (subsection 2.5110), and also to compute payment for cost outliers (subsection 2.5310). Please note these ratios should not be confnsed 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.

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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 in patient 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 admited, 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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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.

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Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

2.5100 Identification of Outlier Claims.

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

2.5110 Test for Cost Outlier

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

2.5120 Testing for Day Outlier

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

2.5130 Example of Testing for Outlier

Data

Hospital Data:	Group Payment Rate	$ 2,836
	Cost to Charge Ratio	.78
Claim Data:	Covered Charges	$39,760
	Covered Length of Stay	50 days
DRG Data:	DRG Weight	4.2294
	Cost Outlier Limit	$32,899
	Day Outlier Limit	67 days
	Daily Rate	$ 503
	Adjustment Percentage	.75

Computation/Comparison

Testing for Cost Outlier

Estimated Cost of Claim	=	Covered Charges x Ratio	
	=	$39,760	x .78
	=	$31,013	
Compare With Cost Outlier Limited		$32,899	

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

Section 2.5130 continued

Testing for Day Outlier:

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

Analysis

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

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

2.5200 Standard DRG Payment

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

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

Example of Standard DRG Payment Calculation:

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

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

2.5300 Payment for Outlier Claims

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

2.5310 Cost Outlier Payment

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

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

2.5310 continued

Example of Computing Cost Outlier Payment:

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

Computations						
Estimated Cost	=	Covered Charges	x	Hospital Ration		
	=	$45,980	x	.78		
	=	$35,864				
Payment for Cost Outlier Portion	=	Estimated (Cost	-	Cost Outlier Limit)	x	DRG Adj. Percentage
	=	($35,864	-	$32,899)	x	.75
	=	$ 2,224				
Total Payment	=	Std. DRG Pymt	+	Outlier Pymt.		
	=	$11,995	+	$2,224		
	=	$14,219				

2.5320 Day Outlier Payment

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

Example of Day Outlier Payment Computation:

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

Computations									
Payment for Day Outlier Portion	=	Covered [Length of Stay	-	Day Outlier] Limit]	x	DRG Daily Rate	x	DRG Adjustment Percentage
	=	(73	-	67)	x	$503	x	.75
	=	$2,264							

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

Section 2.5320 continued

Total Claim Payment	=	Standard DRG Payment	+ Outlier Payment
	=	$11,995	+ $2,264
	=	$14,259	

2.5330 Simultaneous Cost and Day Outlier Payment

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

Example of Payment for Simultaneous Cost and Day Outlier:

Data

Total Claim Payment for Cost Outlier....$14,219 (subsection 2.5310)
Total Claim Payment for Day Outlier.....$14,259 (subsection 2.5320)

Analysis

The higher of the two amounts, $14,259, will be the reimbursement amount for the claim which meets both cost outlier and day outlier criteria.

2.5340 Pay No More Than Charges

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

2.5400 Payment for Transfers

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

2.5410 Transferring Hospital(s)

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

2.5420 Discharging Hospital

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

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2.5430 Transfer To or From a non DRG Hospital

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

2.5440 Example of Payment Determination in Transfers

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

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

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

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

Data Used for this example:

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

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

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

*Substitute per letter dated 3/19/01 *

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

Section 2.5440 continued

Data Used for this example:

DRG Weight	.6515
Group 1 Rate	$2836

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

2.5500 Payment for Re-admission

2.5510 Readmission to the Same Hospital

If a recipient is readmitted to the same hospital within 30 days of discharge, and if the readmission is determined to have resulted from an inappropriate discharge; the reimbursement will be made only for the first admission.

2.5520 Readmission to a Different Hospital

If a recipient is readmitted to a different hospital within 30 days of discharge, and if the readmission is determined to have resulted from an inappropriate discharge; payment will be made only to the second hospital to which the patient was readmitted. Payment made to the first hospital for the original (first) admission will be recouped.

2.5530 Determination of Payment for Re-admission

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

Substitute per letter dated 3/19/01

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2.5600 Recipient Eligibility Changes

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

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

2.5700 Payment for Interim Billings

Hospitals will be allowed to submit interim bills for inpatient stays longer than 180 days. Each interim bill must cover 180 or more continuous days of service except the discharge billing and the federal fiscal year end cut-off billing, each of which may include less than 180 days as the situation may be.

2.5710 Payment for First Interim Billing

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

2.5720 Payment for Second and Subsequent Interim Billings

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

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

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

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2.6000 Settlements and Recoupments

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

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

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

lump sum payment. Final cost settlement will be issued upon receipt of the finalized Medicare cost report. CAHs are required to file a copy of the finalized Medicare cost report, including completed Medicaid fee-for-service worksheets, with Kansas Medicaid upon receipt of the finalized Medicare cost report from the Medicare Administrative Contractor. Underpayments will be issued to the CAH. Overpayments will be recouped from the CAH through offset or billed to the CAH . The CAH must repay the overpayment within 60 days of determination.

4.0000 Reimbursement for Inpatient Services in State Operated Psychiatric and Large Public Kansas Teaching Hospitals

Reimbursement for inpatient services in state operated psychiatric hospitals shall be based upon the lesser of reasonable costs or customary charges for covered services rendered to eligible individuals. These costs shall include Medicare allowable costs, including but not limited to malpractice, capital, physician services, and education as allowed under federal law. Reimbursement for inpatient services in large public Kansas teaching hospitals shall be paid as a percentage of charges with a maximum of 100%. Payment rates shall be established based upon a review of the cost reports and the federal upper payment limit to insure that no more than 100% of charges is paid as well as no more than the federal upper payment limit is paid. A review of their cost report shall also be made to estimate reasonable cost. This would not include physician costs, but would include all other costs that were identified in the state operated psychiatric hospitals above. The minimum payment rate that would be made would be the lesser of the billed charges and 85% of the estimated reasonable cost.

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

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

6.0000 Disproportionate Share Payment Adjustment

The Kansas Medical Assistance Program shall make a reimbursement adjustment for disproportionate share hospitals which are either located in the State of Kansas or located outside of the State of Kansas but operates a hospital that is located within the State of Kansas. The reimbursement adjustment for disproportionate share hospitals shall be made for hospitals eligible under either criteria contained in 6.1000 or 6.2000 below.

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

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

6.1000 Option 1

If determined eligible for disproportionate share payment adjustment according to P.L. 100-203, Section 4112, Subsection (b)(1)(A), and the Medicare Catastrophic Coverage Act, (eligibility shall be determined for a maximum of one year per determination), a hospital shall be reimbursed for disproportionate share according to the following. The mean Medicaid/MediKan inpatient utilization rate for Kansas hospitals receiving Medicaid/MediKan payments plus one standard deviation shall be subtracted from each hospital's Medicaid/MediKan inpatient utilization rate. If the remainder is greater than zero, the remainder shall be divided by 2, 2.5% shall be added, and the result shall represent the percentage payment adjustment. This percentage payment adjustment shall be multiplied by the Kansas Medicaid/MediKan annual payment for inpatient hospital services made for the state fiscal year ending two years prior to the year of the administration of a disproportionate payment adjustment. For example, 1995 state fiscal year payment adjustment shall be based upon the state fiscal year 1993 Kansas Medicaid/MediKan annual payment. The mean Medicaid/Medikan inpatient utilization rate shall include Medicare days allowed by Medicaid. In order to be eligible, the hospital must have a minimum medical utilization of 1%, as determined in Option 1. Medicaid/MediKan utilization shall be based upon the Medicare cost report which must be available as of four months prior to the start of the state fiscal year for which payments are to be made.

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6.2000 Option 2

Hospitals are determined to be eligible under the low-income utilization rate if, based upon the computations below, line C1 exceeds 25%. Hospitals shall be sent a form specifying the eligibility criteria prior to the start of each state fiscal year. Eligibility shall be determined for a maximum of one year per determination. Only hospitals returning the form may be potentially eligible for Option 2. This form shall be compared with the Medicare cost report (CMS-2552-96), paid Medicaid/MediKan claims summary and other information as necessary in order to verify the data submitted. The Medicare cost report must be available no later than four months prior to the start of the state fiscal year for which payments are being made.

All data below, except where specifically noted, should only include inpatient hospital data. SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory surgical center, hospice, rural health clinic, or non-reimbursable cost centers shall not be considered. Although specific references are given to the Medicare cost report, other line numbers may also be applicable where the hospital uses a blank line and adds an alternative title to the hospital cost report forms.

A1. Medicaid/MediKan inpatient payments for hospital fiscal year with a Medicare cost report available as of four months prior to the start of the state fiscal year, excluding disproportionate share payments.

A1a Medicaid/MediKan outpatient payments for the same time period as A1. Outpatient payments only includes payments made to 0hospitals for hospital outpatient services.

A2. Other state and local government income from Medicare Worksheet G-3, Governmental appropriations (Line 23), excluding Disproportionate share payments. Other sources may be used if equivalent and described by the hospital.

A3. Total Medicaid/MediKan, State and local government funds (A1+A1a+A2).

A4. Inpatient Revenues from Medicare worksheet G-2, Column 1, Total inpatient routine care services (line 16) + ancillary (line 17) + outpatient (line 18) - swing bed (lines 4 & 5) - SNF (line 6) - ICF (line 7) - LTCU (line 8) - other equivalent and appropriate lines.

A5. Total patient revenues from Medicare Worksheet G-2, Column 3 (line 25).

A6. Ratio of inpatient revenues to total patient revenues (A4 / A5).

A7. Contractual allowances and discounts from Medicare Worksheet G-3 (line 2).

A8. Inpatient share of contractual allowances and discounts (A6 x A7).

A9. Net inpatient revenue (A4 - A8).

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

6.2000 continued

A10. Ratio of Medicaid/MediKan, State, and local government funds to net inpatient revenue (A3 / A9).

B1. Charity care is considered to be any unpaid charge made directly to a patient where a reasonable effort has been made to collect the charge. This would include spend down incurred by a Medicaid recipient, the deductible on insured patients, and the entire charge of private pay patients, providing a reasonable attempt to collect the amount due has been made. This should also include the portion of any sliding fee scale which is not billed to the patient. It would not include any amount billed but not paid by a third party, such as Medicaid, Medikan, Medicare, or insurance (contractual allowances) or third party or employee discounts. Charity care charges would also not include bad debts unless the amounts meet the definitions given above. Information to support this number must be maintained by the hospital and is subject to review. This information is submitted by the hospital.

B1a. Inpatient charity care charges less total payments received related to inpatient charity care charges.

B1b. Outpatient charity care charges less total payments received related to outpatient charity care charges.

B2. Other State and local government funds (A2).

B3. Ratio of inpatient revenues to total patient revenues (A6).

B4. Inpatient portion of State and local government funds (B2 X B3).

B5. Hospital Costs (Medicare Worksheet B Part I, Total Column, subtotal (Line 95)-SNF (Line 34) - ICF (Line 35) - LTCU (Line 36) - Rural Health Clinic (Line 63) - Self care home dialysis (Line 64) - Line 65 (Ambulance) - DME (Line 66 & 67) - CORF, CMHC, OPT, OOT, OSP (Line 69) - Unapproved Teaching (Line 70) - HHA (Line 71) - UR-Hosp. Based SNF (Line 89) - ASC (Line 92) - Hospice (Line 93) - Other Special Purpose Cost Center (Line 94). This includes Kansas provider assessment expenditures incurred by the hospital.

B6. Hospital revenue (Medicare worksheet G2, Column 3, Total Patient Revenue (Line 25) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU (Line 8) - RHC (Line 18.50) - FQHC (Line 18.51) - HHA (Line 19) - Ambulance (Line 20) - CORF (Line 21) - ASC (Line 22) - Hospice (Line 23) - Other (Line 24)

B7. Cost to revenue ratio (B5 / B6).

B8. Hospital revenue attributable to the inpatient portion of State and local government funds (B4 / B7).

B9. Unduplicated charity care charges (B1a + B1b-B8). If this is negative, use 0).

B10. Ratio of unduplicated charity care to total inpatient revenue (B9 / A4).

C1. Low-Income utilization rate (A10 + B10). If the low-income utilization rate (C1) exceeds 25%, then Section D below applies.

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6.2000 continued

Da. Medicaid Inpatient Days.

Db. Total Inpatient Days.

Dc. Medicaid Inpatient Utilization Percentage (Da / Db).

D1. Hospital Specific DSH Limitation: All Hospitals are limited to no more than their Uncompensated Care Cost (UCC). UCC is the uncompensated cost of care to the uninsured and the uncompensated cost of care to Medicaid participants. This limitation is computed by Medicaid below.

D1a. Uninsured Hospital Inpatient Payment: Include all self-pay payments received during your fiscal year for uninsured inpatients. Uninsured inpatient payments should be based on actual collections received during the fiscal year regardless of service date. Do not include any individual payments or 3rd party payments on deductibles and co-insurance on Commercial and Medicare accounts. Also exclude collections on non-hospital services: Skilled Nursing Facility (SNF), Nursing Facility (NF), Rural Health Clinic (RHC), Federal Qualified Health Clinic (FQHC),and non-hospital clinics (i.e. clinics not reported on Worksheet "C" Part I). This information is submitted by the hospital.

D2a. UCC Uninsured Inpatients (Hospital Cost report inpatient cost to charge ratio x inpatient uninsured charges, less inpatient uninsured revenue).

D2aa. Uninsured Hospital Outpatient Payments: Include all self-pay payments received during your fiscal year for uninsured outpatients. Uninsured outpatient payments should be based on actual collections received during the fiscal year regardless of service date. Do not include any individual payments or 3rd party payments on deductibles and co-insurance on Commercial and Medicare accounts. Also exclude collections on non-hospital services: Nursing Facility (NF), Rural Health Clinic (RHC), Federal Qualified Health Clinic (FQHC), and non-hospital clinics (i.e.clinics not reported on Worksheet "C" Part I).

D2b. UCC Uninsured Outpatients (Hospital cost report outpatient cost to charge ratio x outpatient uninsured charges, less outpatient uninsured revenue).

D3. Kansas Medicaid Inpatient Days in last available fiscal year of hospital.

D4. All Medicaid Inpatient Days in last available fiscal year of hospital.

D5. Kansas portion of Medicaid inpatient days (D3 /D4).

D6a. Kansas portion of Uninsured Inpatient Uncompensated Cost (D2a X D5).

D6b. Kansas portion of Uninsured Outpatient Uncompensated Cost (D2b X D5).

D7a. UCC Kansas Medicaid Inpatients (Hospital cost report inpatient cost to charge ratio x allowed Medicaid inpatients charges, less all payments related to allowed Medicaid inpatient charges).

D7b. UCC Kansas Medicaid Outpatients (Hospital cost report outpatient cost to charge ratio x allowed Medicaid outpatient charges, less all payments related to allowed Medicaid outpatient charges).

D8. Estimated Disproportionate Share Payments prior to federal allotment (D6a + D6b + D7a + D7b).

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An example of both the eligibility and payment adjustment computations are attached.

6.3000 Simultaneous Option 1 and Option 2 Eligibility

If a hospital is eligible under both 6.1000 and 6.2000 the disproportionate share payment adjustment shall be the greater of these two options.

6.4000 Request for Review

If a hospital is not determined eligible for disproportionate share payment adjustment according to 6.1000 or 6.2000, a hospital may request in writing a review of the determination within 30 days from the notification of the final payment adjustment amount. Any data supporting the redetermination of eligibility must be provided with the written request.

6.5000 Payment Limitations

If the payments determined exceed the allotment determined by CMS in accordance with section 1923(f) (1) (C) of the Social Security Act, then all hospitals eligible for disproportionate share shall have their disproportionate share payments reduced by an equivalent percentage which will result in an aggregate payment equal to the allotment determined by CMS.

All hospitals are limited to no more than the Kansas Medicaid inpatient portion of 100% of the cost of the uninsured plus the difference between the cost of the Kansas Medicaid inpatient and outpatient services and the payments for Kansas Medicaid inpatient and outpatient services. Data for both the uninsured and Medicaid cost and payments shall be based upon the Medicare cost report which must be available as of the start of the state fiscal year for which payments are to be made. The Kansas Medicaid inpatient portion is the ratio of Kansas Medicaid/MediKan inpatient days divided by total Medicaid/MediKan inpatient days. A cost determination of both the uninsured and the Kansas Medicaid inpatient costs shall be made upon receipt of an appropriate cost report.

(Reserved for future use).

(Reserved for future use).

(Reserved for future use).

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

7.0000 Change of Ownership

7.1000 Department Notification and Provider Agreements

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

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

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

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

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

7.1000 continued

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

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

7.2000 Certification Surveys

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

7.3000 Cost Limitations

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

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

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

8.0000 Audits

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

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

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

10.0000 Medical Education Payments

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

The hospital specific medical education rate has two components, direct medical education (DME) rate and indirect medical education (IME) rate. These are computed as follows:

- Direct Medical Education Percent = Lesser of total direct medical education cost or aggregate approved cost divided by the total cost of the hospital. This data is from the most recent available Medicare cost report as of the start of each State fiscal year.

- Indirect Medical Education Percent = 2.23 x ((1 + ratio of full time equivalent interns and residents to hospital beds excluding nursery)$^{0.405}$ – 1). This data is from the most recent available Medicare cost report as of the start of each State fiscal year.

- Hospital Specific Medical Education Rate = Medicaid hospital DRG Group rate x (1 + DME Percent + IME Percent).

- Medical Education Payment Amount = Hospital Specific Medical Education Rate x number of discharges of all Medicaid paid claims for that hospital x hospital specific average case mix weight.

- Average case mix weight = sum of DRG weights for all Medicaid paid discharges divided by the number of all Medicaid paid discharges.

- Payments shall be made at least quarterly based upon the discharges and case mix weights determined from claims that are applicable to this section of the State Plan that have not previously been reimbursed for medical education.

Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

Narrative Explanation of Reimbursement Formula

Under the Medicaid program, the State of Kansas pays psychiatric residential treatment facilities (PRTFs) for care and treatment provided to residents who are eligible for Medicaid benefits. The narrative explanation of the PRTF reimbursement formula is divided into six sections. The sections are: Cost Reports, Inflation Factors, Base Rate Determination, Quarterly Acuity Index Calculation, Owner/Operator Upper Payment Limits, and Comparable Private Pay Rates.

1) Cost Reports

The PRTF Financial and Statistical Report is the uniform cost report. It organizes the commonly incurred business expenses of PRTFs into five reimbursable cost centers (administration; facility operating; property; room, board and support; and treatment). There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the PRTFs' accounting records. All PRTFs that have operated as PRTFs for 12 or more months on June 30th shall file a cost report for each year end June 30th. Cost reports are due to the Department by September 30th each year.

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

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

Change of Owner/Provider:

When a non-arms length change of provider takes place or an owner of the real estate assumes the operations from a lessee, the PRTF will be treated as an on-going operation. In this situation, the related provider or owner shall be required to file the year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator for the months during the year ending June 30th in which the new operator was not involved in running the PRTF. The cost report information from the old and new operators shall be combined to prepare a 12-month cost report.

Initial Cost Reports and Rate Setting:

Initially PRTF cost reports will not be available to set the base reimbursement rate for PRTFs. Therefore, initially costs reports from Level VI Residential Facilities (Level VIs), the predecessors of PRTFs, which operated for 12 months or more on June 30, 2006 will be used. In addition, the facility operating and room, board, and support cost centers from the cost reports from Level V Residential Treatment facilities (Level Vs) that will be converting to PRTFs July 1, 2007 will also be used. In some cases federal and state

rules require PRTFs to provide a higher level of service than is currently provided by Level Vs and Level VIs. The cost reports will be desk reviewed and compared to PRTF service requirements to ensure each cost report includes all required services. Should the desk review identify costs not included in the facility's cost report which are required by the residents, the cost report will be adjusted to include the additional service costs.

2) Inflation Factors

Inflation will be applied to the allowable reported costs. Inflation will be applied to the midpoint of each cost report period to the midpoint of the rate payment period. The inflation will be based on the Data Resources, Inc., National Skilled Nursing Facility Market Basket Without Capital Index (DRI Index).

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

The inflation factor will not be applied to the following costs:

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

3) Rate Determination

Rates for Existing PRTFs

Medicaid rates for PRTFs are established by determining the average per diem costs for all PRTFs for the administrative, property, and treatment cost centers. The average is determined from the inflated cost report data for these cost centers. Only data submitted for the current state fiscal year will be used to determine average costs.

The total inflated allowable historic costs for these cost centers for all PRTFs are divided by the total number of reported allowable resident days for all PRTFs to arrive at an average per diem per cost center. The averages of these cost centers are summed resulting in the base reimbursement rate for PRTFs for these cost centers. The base reimbursement rate for these cost centers are adjusted based on the acuity indices of the residents in each facility as described below. The facility's per diem rate for facility operating and room, board, and support cost centers are added resulting in the facility's rate that will be effective January 1st each year.

Rates for New PRTFs

The per diem rate for a new PRTF will be the base average reimbursement rate determined for all PRTFs' for the first quarter of operating. Thereafter, the administrative, property, and treatment cost centers will be adjusted for acuity as described below and the average of all PRTFs' facility operating cost center and room, board, and support cost center until the next rate setting period in which the facility reports full year costs.

4) Quarterly Acuity Index Calculation

Acuity Rate Adjustments

A uniform assessment will be completed for each resident upon admission to the PRTF. The uniform assessment, assessment instructions, and the scoring of the assessment are contained in Attachment 2. Each resident will be assigned a severity index score. The severity index scores for each resident enrolled in the PRTF will be compiled quarterly and averaged. All PRTF average acuity indices will be arrayed. The base reimbursement rate for administration, property, and treatment cost centers will be adjusted for each facility based on where the facility's acuity index falls in the array as shown below:

Percentiles	Adjustment to Administration, Property, and Treatment Cost Centers
75th to 100th	5% Increase
50th to 74th	0% Increase
25th to 49th	5% Decrease
0 to 24th	10% Decrease

The cut off dates and the effective date for each acuity adjustment is shown below:

Cut-Off Date:	Rate Effective Date:
May 31st	July 1st
August 31st	October 1st
November 30th	January 1st
February 28th	April 1st

The resident listings will be mailed to PRTFs prior to the dates the quarterly acuity adjusted rates are determined. This will allow the PRTFs time to review the resident listings and make corrections before they are notified of new rates.

Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

Narrative Explanation of Reimbursement Formula

Initial Rates

Acuity indices of newly admitted residents will not be available for the initial rate setting period. Therefore, for the first six months, actual reported costs will be used as a proxy for the average acuity index. The state fiscal year 2006 per diem costs of all facilities will be arrayed and grouped as described for the average acuity indices above. The base reimbursement rate will be adjusted for each PRTF based on where their per diem costs fall in the array. Uniform acuity assessments will be completed on all newly admitted PRTF residents and acuity indices will be used for the quarter beginning six months after the start of this state plan.

5) Owner/Related Party/Director/Co-Director Limits Upper Payment Limits

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

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

6) Comparable Private Pay Rates

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

MAR - 7 2007

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State of Kansas
Department of Social & Rehabilitation Services (SRS)

ATTACHMENT 1: INSTRUCTIONS FOR COMPLETING THE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FINANCIAL AND STATISTICAL REPORT (FORM HCP-PRTF-01)

PURPOSE

The purpose of this report is to obtain the resident-related costs incurred by psychiatric residential treatment facilities (PRTF) in providing services according to applicable state and federal laws, and quality and safety standards.

SUBMITTAL INSTRUCTIONS

One blank Form HCP-PRTF-01 on CD, Psychiatric Residential Treatment Facility Financial and Statistical Report, will be sent by the SRS/Health Care Policy (HCP), Management Operations (MO) to each PRTF in the Kansas Medical Assistance Program before the end of the state's fiscal year.

Send the completed form HCP-PRTF-01 and form HCP-PRTF-09 (Census Summary) for each month of the reporting period on CD or submit the forms electronically, along with two printed and signed copies of Declaration Page of the HCP-PRTF-01 to the following address:

Social and Rehabilitation Services
Health Care Policy/Management Operations
915 SW Harrison, 10th Floor
Topeka, Kansas 66612-1570

All inquires on completion of these forms should be directed to the SRS/HCP/MO at (785) 291-3202.

GENERAL

The cost report is organized by the following sections. Not all expense lines are within each section. A separate cost report must be completed for each PRTF.

General Information
Schedule A, Facility Administrative Cost Center
Schedule A, Treatment Facility Operating Cost Center
Schedule A, Facility Property Cost Center
Schedule A, Room, Board, and Support Cost Center
Schedule A, Treatment Cost Center
Schedule A, Non-Reimbursable/Non-Resident Related Expense Items
Schedule B, Expense Reconciliation
Schedule C, Statement of Owners and Related Parties
Schedule D, Statement Related to Interest on All Bonds, Loans, Notes and Mortgages Payable
Schedule E, Revenue Statement
Schedule F, Fixed Asset, Depreciation & Amortization Questionnaire
Declaration of Preparer and Declaration of Owner, Partner, or Office of Corporation

1. Complete the forms accurately and legibly. Any report that is incomplete or is not legible shall be promptly returned to the provider. Failure to submit a complete cost report shall result in penalties as described in #9.

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2. All amounts must be rounded to the nearest dollar and sum to the total.

3. **DO NOT** add lines to the forms. Use "OTHER" lines for resident-related expenses not designated on the Expense Statement, Schedule A. Attach a schedule if necessary.

4. **DO NOT** cross out or re-title lines on the forms. **DO NOT** include more than one amount per line. If more than one amount or journal entry is combined, submit an attachment with explanation. The attachment should be **sorted by cost report expense lines** and should include subtotals.

5. Use the accrual method of accounting in reporting financial data. Revenues are reported in the period when **earned**, and not when received, and expenses are reported when **incurred**, not when paid. If financial data for year ending June 2006 is only available on a cash basis, then that data will be accepted.

7. Estimates of revenues and expenses are not acceptable.

8. All cost reports must be for a period of 12 consecutive months beginning with July 1.

9. All state fiscal year cost reports shall be received by the agency no later than the close of business on the last working day of September. The provider may request a one-month extension of the due date by submitting the request in writing to the address in the submittal instructions within the time period allowed for filing the original cost report.

   A one-month extension of the due date for the filing of a cost report may be granted by the agency when the cause for delay is beyond the control of the provider. Delays beyond the control of the provider that may be considered by the agency in granting an extension shall include:

   a. disasters that significantly impair the routine operations of the facility or business
   b. destruction of records as a result of a fire, flood, tornado, or another accident that is not reasonable foreseeable
   c. computer viruses that impair the accurate completion of cost report information

   The provider shall make the request in writing and it shall be received by the agency on or before the due date of the cost report. Requests received after the due date shall not be accepted.

   The extension will be granted if the agency determines that the provider has shown good cause.

   NOTE: IF A COST REPORT IS RECEIVED AFTER THE DUE DATE WITHOUT AN APPROVED TIME EXTENSION, THE PROVIDER IS SUBJECT TO THE PENALTIES.

   Each provider filing a cost report after the due date shall(may) be subject to the following penalties:

   a. All further payments to the provider shall be suspended until the complete cost report has been received. A complete cost report shall include all the required documents listed in the cost report.
   b. Failure to submit the cost report within one year after the end of the cost report period shall be cause for termination from the Kansas medical assistance program

10. Each PRTF must maintain adequate accounting and/or statistical records. Inadequate record keeping is cause for suspension of payments. If PRTF program expenses have been co-mingled with the

non-PRTF expenses, see the instructions for provider adjustments on Schedule A, Expense Schedule.

11. Copies of the State Medicaid Plan, the cost report form and related instructions governing PRTF reimbursement may be obtained from the web site. NOTE: SINCE THE COST REPORT INSTRUCTIONS MAY BE CHANGED, THE PREPARER OF THE COST REPORT SHOULD CAREFULLY REVIEW THE MOST RECENT VERSION PRIOR TO COMPLETING THE FORM HCP-PRTF-01 FOR SUBMISSION.

Definitions

1. Accrediting agency – Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Service for Families and Children, or the Commission on Accreditation of Rehabilitation Facilities.

2. Adequate financial cost data – Cost data shall be in accordance with state and federal Medicaid requirements and general accounting rules and based on the accrual basis of accounting. Estimates of costs are not be allowable.

3. Central Office – A central office is an expense center that provides administrative support to more than one program or service unit including the PRTF.

4. Cost and other accounting information – adequate financial data about the PRTF operation, including source documentation, that is accurate, current, and sufficiently detailed to accomplish the purposes for which it is intended. Source documentation, including petty cash payout memoranda and original invoices, shall be valid only if the documentation originated at the time and near the place of the transaction. In order to provide the required cost data, the provider shall maintain financial and statistical records in a manner that is consistent from one period to another. This requirement shall not preclude a beneficial change in accounting procedures when there is a compelling reason to effect a change of procedures.

5. Costs not related to resident care – means costs that are not appropriate, necessary, or proper in developing and maintaining the PRTF operation and activities. These costs shall not be allowed in computing reimbursable costs.

6. Costs related to resident care – necessary and proper costs, arising from arm's-length transactions in accordance with general accounting rules, that are appropriate and helpful in developing and maintaining the operation of resident care facilities and activities.

7. Fiscal Year – The state fiscal year of July 1 through June 30 shall be the fiscal year for the cost report.

8. Non-working owners – any individual or organization having five percent or more interest in the provider who does not perform a resident-related function for the PRTF

9. Non-working related party or director – any related party, as defined in these definitions, who does not perform a resident-related function for the PRTF

10. Owner – the person or legal entity that has the rights and interest of the real and personal property used to provide the PRTF services.

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11. Related parties – two or more parties with a relationship in which one party has the ability to influence another party to the transaction in the following manner:

    a. when one or more of the transacting parties might fail to pursue the party's or parties' own separate interest fully;
    b. when the transaction is designed to inflate the Kansas medical assistance program costs; or
    c. when any party considered a related party to a previous owner or operator becomes the employee, or otherwise functions in any capacity on behalf of a subsequent owner or operator. Related parties shall include parties related by family, business, or financial association or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arm's-length negotiations.

12. Resident assessment instruments – the pre-admission assessment tool, resident assessment protocols, Community Based Service Team (CBST) Plan, and the plan of care including re-assessments.

13. Reimbursable Day: A resident must be present at 11:59 pm to receive payment for that day. If the resident is not there at 11:59 pm the resident can not be counted as present and the PRTF can not bill for that day unless the resident is on approved absent days. Approved absent days is defined as follows:

    Visitation days when indicated in the resident's treatment plan (within the total number of days approved for the resident's stay). The PRTF can bill for a maximum of 7 days per visit. The frequency, duration, and location of the visits must be a part of the resident's individual case plan developed by the facility prior to the visitation. An approved visitation plan must be documented in the resident's official record at the facility.

    If a resident is absent from the facility for a short time due to circumstances needing the resident's immediate attention (deaths, weddings, personal business), or the resident leaves the facility without permission, the facility can bill up to five days unless the resident's placement is terminated sooner.

14. Routine services and supplies – services and supplies that are commonly stocked for use by or provided to any resident. The services and supplies may include, but not be limited to the following:

    a. Facial tissues & toilet paper
    b. First-aid ointments and similar ointments
    c. Gloves, rubber or plastic
    d. Ice bags and hot water bottles
    e. Laundry, including personal laundry
    f. Laxatives
    g. Lotions, creams, and powders, including baby lotion, oil and powders
    h. Mouthwash, shampoo,
    i. Over-the-counter vitamins
    j. Over-the-counter analgesics and antacids taken for the occasional relief of pain or discomfort
    k. Skin antiseptics, including alcohol
    l. Thermometers
    m. All over-the-counter drugs, supplies and personal comfort items that are available without a prescription at a commercial pharmacy or medical supply outlet and are provided by the PRTF as a reasonable accommodation for individual needs and preferences.

15. Sale-leaseback – a transaction in which an owner sells a facility to a related or non-related purchaser and then leases the facility from the new owner to operate as the provider.

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16. Working trial balance – A list of the account balances in the general ledger order that was used in completing the cost report. The working trial balance shall contain account numbers, descriptions of the accounts, the amount of each account and the cost report expense line on which the account was reported. Revenues and expenses shall be grouped separately and totaled on the working trial balance and shall reconcile to the applicable cost report schedules. A schedule that lists all general ledger accounts grouped by cost center and line description shall be attached.

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COST REPORT INSTRUCTIONS

COVER PAGE

Complete all items on the cover page.

Check the type of business organization which most accurately describes your provider status or explain on the line labeled Other. Limited Liability Companies should check the box that matches their declaration for tax purposes. Please check only one.

PRTF Beds:

Lines A - E: The number of beds available multiplied by the calendar days in the reporting period = Total Bed Days Available during reporting period.

Enter beginning and ending dates, the number of beds available and the number of calendar days covered by the beginning and ending dates. The beds available multiplied by the number of calendar days = bed days at this bed count. If a change in the number of beds has occurred during the reporting period, show the increase or decrease on a separate line, the date of the change, the new bed count, and the bed days at that count.

Line F: Total days during the reporting period = column total of # of Calendar Days. This should equal 365.

Line G: Total Beds available during reporting period = column total of Bed Days @ this Bed Count

Example of Bed Days calculation:
Assume a home of 20 beds was increased on March 16 to 25 beds, the number of bed days for the period would be determined as follows:

July 1 to March 15 - 258 days x 20 beds =	5,160 bed days
March 16 to June 30 - 107 days x 25 beds =	2,675 bed days
	7,835 bed days for fiscal year

NOTE: Lines H, I and J should match totals on census form HCP-PRTF-09.

Line H: Enter the number of Medicaid Reimbursable Days, excluding Absent Days (See definitions)

Line I: Enter the number of Medicaid Reimbursable Absent Days = (See definitions)

Line J: Enter the number of "Other Funded" Days Reimbursed = (Reimbursed = days during reporting period that beds were filled and payment source is not Medicaid)

Line K: Total Days Beds were Reimbursed = total of line H, I & J

Line L: Total Vacancy = 100% less (Total Days Beds Reimbursed/Total Beds Available)

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SCHEDULE A - EXPENSE STATEMENT

Attach a copy of the working trial balance used to prepare the cost report.

All costs shall be reported on the designated expense lines. If all expense classifications are not addressed, report the amount on the line and in the cost center that most nearly describes the expense. For example, telephone expense is included in the Facility Administrative cost center. Therefore, the expense for telephone lines to the treatment units' station shall **not** be reported in the Treatment cost center. See specific line instructions for more detail. **DO NOT CROSS OUT OR USE A LINE DESIGNATED FOR A PARTICULAR TYPE OF EXPENSE FOR SOME OTHER TYPE OF EXPENSE.**

Total Annual Hours Paid - Column 1 - Enter the total hours paid to the employees on each of the salary lines for the reporting period. For any employee whose time is divided across multiple work functions within a facility and performs for less than a full-time-equivalent work week, defined as 40 hours per week, the work time and compensation shall be prorated on each function within a facility or within all facilities, but shall not exceed 100 percent of that person's total work time.

Per Working Trial Balance (Books) or Federal Tax Return (if un-audited) - Column 2 - Report the expenses reflected in the accounting records under the appropriate cost center (i.e., Facility Administrative, Treatment Facility Operating, Facility Property, Room, Board and Support, Treatment, and Non-reimbursable and Non-resident Related). The total of all the expense lines (Column 2) shall reconcile to the accounting records or income tax return. (For exceptions, see instructions for Schedule B.)

Provider Adjustments - Column 3 - Enter the necessary adjustments to the expenses reported in Column 2 that are not resident-related or offset expense recoveries reported in the Revenue Statement, Schedule E. Attach a schedule if necessary.

PRTF Related Expense - Column 4 - Enter the difference between Column 2 and Column 3. Please complete Column 4 even if no adjustments were made in Column 3.

State Adjustments/Adjusted Resident Related Expenses - Columns 5 & 6 - Leave blank - FOR AGENCY USE ONLY

Expense Lines

The specific instructions do not cover each line item of the expense statement. They are designed to cover items that may require additional explanation or examples.

Accounting and Data Processing - Report accounting expense on this line, except fees paid to owner/related party firms or individuals which must be reported on the owners compensation. Data processing expense related to financial management (i.e., accounting, payroll, budgeting, etc.) shall be reported on this line.

Advertising & Recruitment- Report allowable advertising and recruitment expense on this line. This line shall be used for fees paid to employment agencies, employment advertisements and ads in telephone directories. Fund raising, public relations, advertising for resident utilization and sponsorships are **not allowable** and shall be reported in the Non-reimbursable & Non-resident Related expense section of Schedule A.

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Allocations - All providers with pooled administrative costs shall report allocated costs.

All facilities, including the central office, must use the same reporting period. **Attach a detailed schedule listing the allocation type and method of allocation to each facility. Failure to submit detailed central office expenses and allocations methods shall result in an incomplete cost report.**

Guidelines for central office costs

Allocation of central office costs shall be reasonable, conform to general accounting rules, and is allowed only to the extent that the central office is providing a service normally available in the PRTF. Central office costs shall not be recognized or allowed to the extent that they are unreasonable in excess of similar PRTFs in the program. The burden of furnishing sufficient evidence to establish a reasonable level of costs shall be on the provider.

All expenses reported as central office costs shall be limited to the actual resident-related costs of the central office.

The provider shall report cost of ownership or the arm's length lease expense, utilities, maintenance, property taxes, insurance, and other plant operating costs of the central/regional office space for resident-related activities as central office costs.

The provider shall report all administrative expenses incurred by central/regional offices as central office costs. The administrative expenses reported as central office costs shall not be directed to individual facilities operated by the provider or reported on any other line of the cost report.

Non-reimbursable costs, cost limitations and the revenue offsets shall apply to central/regional office costs.

Salaries of employees performing the duties for which they are professionally qualified shall be allocated to the direct treatment cost center or the appropriate cost center for the duties performed. Professionally qualified employees shall include licensed and registered nurses, dietitians, therapists, and others.

Salaries of chief executives, corporate officers, department heads, and other employees who may meet the specifications of owner or related parties, as specified in the definitions above, shall report these salaries as owner's compensation in the facility administrative cost center or the appropriate cost center if providing resident-related services, subject to owner/related party salary limitations.

Salaries of all other central/regional office personnel performing resident-related administrative functions in the facility administrative cost center.

Allowable central office costs are subject to the following conditions:

1. Only expense allocations related to Kansas facilities will be allowed.
2. Purchases from related-party vendors - Costs of resident-related goods and services supplied to the central office by related parties will be allowed at the lower of the cost to the vendor or the charge to the central office;
3. Costs directly attributable to a specific provider or non-provider activity must be allocated directly to the entity for which they were incurred;
4. Central office bulk purchases of PRTF supplies - These expenses may be allocated to the supplies lines in the appropriate cost centers, if the allocation method is adequately documented; and
5. Consultants – Costs that are incurred generally for the corporation.

Amortization of Leasehold Improvement - Report only amortization of leasehold improvements on this line.

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Leasehold improvements are defined as betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

Consultants - Report fees paid to professionally qualified non-salaried consultants hired generally to meet the needs of the facility or residents in general. List the titles of consultants reported.

Also, see Management Consultant Fees.

Contracted Labor - These lines shall be used to report all contract labor for services that would normally be provided by employees listed in the cost center.

Criminal Background Check - Report the amount expended for criminal background checks for all employees.

Depreciation Expense – Facility - This amount must be computed by the straight-line method. Such amounts must be reconciled to a detailed depreciation schedule. The determination of capitalized property must be in conformity with Generally Accepted Accounting Principles. **Attach a detailed depreciation schedule to the cost report.**

Depreciation Expense – Equipment - This amount must be computed by the straight-line method. Such amounts must be reconciled to a detailed depreciation schedule. The determination of capitalized property must be in conformity with Generally Accepted Accounting Principles. **Attach a detailed depreciation schedule to the cost report.**

Employee Benefits - Allocate employee benefits to the benefit lines in each cost center based on the percentage of gross salaries or the actual amount of expense incurred in each center. Employee benefits, if offered to substantially all employees may include, but are not limited to:

1. Employer's share of payroll taxes
2. State and federal unemployment contributions
3. Workers' compensation insurance
4. Group health and life insurance
5. Employee "non-cash" gifts
6. Moving/relocation expenses
7. Employee retirement plans
8. Employee parties - except alcoholic beverages
9. Profit sharing
10. Physical examinations
11. Malpractice insurance that specifically protects employees. This shall be specifically identified on the insurance bill from the agent.
12. Employee Uniforms
13. Employee Meals

Employee benefits shall not include:

1. Employee cash bonuses and/or incentive awards - these payments shall be considered additional compensation and be reported on salary lines.
2. Benefits given to owner/related parties - these benefits shall be reported on the owner/related party employee benefits lines in the appropriate cost center.

Employee benefits with restrictions include:

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1. Employee benefits offered to select non-owner/related party employees shall be reported as a benefit in the cost center in which the salary is reported.

Food - Report all food costs. The provider shall be required to keep records on the total number of meals served to residents, employees, guests, and outside programs. If the food expense for the employees, guests, and outside programs is included in the HCP-PRTF-01 expenses, the expense should be offset against the dietary cost center as follows:

1. Dietary Salaries
   a. Dietary Portion Employee Benefits
   b. Dietary Owner/Related Party Compensation
   c. Dietary Consultant
   d. Food
   e. Dietary Supplies
   f. Other
   g. Total Dietary Cost ÷ Total Number of Meals Served = Cost Per Meal

2. Cost per meal x number of meals served to employees, guests, and outside programs = amount of offset

3. The cost of free employee meals shall be allocated and reported on employee benefit lines. If employees pay less than the cost for a meal, the difference between the meal revenue and cost may be reported as an employee benefit.

Insurance - Liability - Report liability insurance expense on this line.

Insurance – Other - Report insurance expense on this line. Workers' compensation and employee health and life insurance expense shall be reported on employee benefit lines. Facility insurance should be reported in the Treatment Facility Operating cost center. Insurance premiums on lives of owners and related parties are not an allowable expense, and shall be in the Non-reimbursable & Non-resident Related expense section of Schedule A.

Interest - Report the interest expense related to operating loans. Interest on loans for real and personal property and equipment shall be reported in Property cost center. The interest expense shall be incurred on indebtedness established with either of the following:

1. Lenders or lending organizations not related to the borrower; or

2. Partners, stockholders, home office organizations, or related parties, if the following conditions are met:
   a. The terms and conditions of payment of the loans shall resemble terms and conditions of an arm's-length transaction by a prudent borrower with a recognized, local lending institution with the capability of entering into a transaction of the required magnitude. A signed promissory note and loan amortization schedule shall be submitted with the cost report. Allowable interest expense shall be limited to the annual expense submitted on the loan amortization schedule, unless the loan principal is retired before the end of the amortization period.
   b. The provider shall demonstrate, to the satisfaction of SRS, a primary business purpose for the loan other than increasing the per diem rate.
   c. The transaction shall be recognized and reported by all parties for federal income tax purposes.

3. When the general fund of a PRTF "borrows" from a donor-restricted fund, this interest expense shall

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be an allowable cost. In addition, if a PRTF operated by members of a religious order borrows from the order, interest paid to the order shall be an allowable cost.

4. The interest expense shall be reduced by the investment income from restricted or unrestricted idle funds or funded reserve accounts, except when that income is from gifts and grants, whether restricted or unrestricted, that are held in a separate account and not commingled with other funds. Income from the provider's qualified pension fund shall not be used to reduce interest expense.

5. Interest earned on restricted or unrestricted reserve accounts of industrial revenue bonds or sinking fund accounts shall be offset against interest expense and limited to the interest expense on the related debt.

6. Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost or the cost basis recognized for program purposes shall not be considered to be reasonably related to resident care.

Interest on Equipment – Report all interest expense incurred for the acquisition of equipment and furnishings.

Interest on Real Estate - Report all interest expense incurred for the acquisition or construction of real estate. Describe fully on Schedule D. Include amortization expense for loan costs. The interest for equipment and furnishings purchased along with the building shall be reported on a separate line.

Legal - Report allowable routine legal costs and other costs associated with litigation if the litigation is decided in the provider's favor, on this line. Costs related to resolving contested issues of title or disputes arising from the performance of contracts or agreements related to the purchase or sale of property or business is not allowable. Allowable fees paid to owner/related party firms or individuals must be reported as owner/related party compensation. Retainer fees and cost associated with claims against the state are not allowed.

Licenses, accreditation and dues - Report allowable licenses, accreditation fees and dues on this expense line. Costs of social, fraternal, civic and other organizations that concern themselves with activities unrelated to their members' professional or business activities are not allowable. Personal automobile club memberships are not allowable unless reported as compensation. Any dues paid for the cost of lobbying are not allowable. Cost of licenses for professional direct services staff is to be included in treatment cost center or the cost of licenses for facility maintenance staff is to be included in the treatment facility cost center.

Linen and Bedding Material - Report linen and bedding material expenses on this line.

Maintenance & Repairs - Report all maintenance and repair expenses for equipment and vehicle as related to administrative operating expenses in the Facility Administrative cost center, expenses applicable to the building and grounds in the Treatment Facility Operating cost center, and expenses applicable to equipment related to Room, Board and Support in the respective cost center. Vehicle maintenance and repairs expenses related to Resident Transportation should be included in the Resident Transportation line of the Treatment cost center.

Management Consultant Fees (Also, see Consultants) - Report fees paid to non-related party management consultants. If the management services company is owned or controlled by the company or person(s) that own or control the facility, actual cost of the management services company must be reported as central office costs and/or owner's compensation. See instructions for reporting central office costs.

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Consulting fees paid to owners and related parties are considered owner's compensation subject to the owner-administrator compensation limit. These fees should be reported on the Owners and Related Party Compensation line. No allowance shall be made for costs related to investigation of investment opportunities, travel, entertainment, goodwill, or administrative or managerial activities performed by owners or other related parties that are not directly related to resident care.

Other - "Other" or blank lines have been provided in the each cost center. Types of expense entered on these lines shall be identified and be applicable to the cost center unless further restricted. Attach a schedule to the cost report. **Failure to do so will cause the cost report to be deemed incomplete and subject to penalties (General Section, #9).**

For example, other may include miscellaneous expenses incidental to the operation and/or maintenance of the facility and grounds, i.e. trash hauling, snow removal, etc. in the Treatment Facility Operating Cost Center.

Other Health Care Costs - These are medically necessary services provided by outside medical providers to meet the needs of individual residents. Examples include: pharmaceuticals, laboratory tests, physician visits, etc.

Owners/Related Party Compensation - Record the amount earned and reported to IRS for owner/related parties. In order to be allowed, the compensation must be paid within sixty (60) days after close of the cost report period. The amount reported must be in agreement with entries made in Schedule C. Compensation may be included in allowable cost only to the extent that it represents reasonable remuneration, as limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions, for managerial and administrative functions, professionally qualified services and other services related to the operation of the PRTF, and was rendered in connection with resident care. All compensation paid to an owner/related party shall appear on the appropriate lines regardless of the label placed on the services rendered (See Kansas Medicaid State Plan).

Owners or related parties, as specified in the Definitions section, who actually perform a necessary function directly contributing to resident care, a reasonable amount shall be allowed for at the lesser of: 1) the cost that would have been incurred to pay a non-owner employee to perform the resident-related services, limited by a schedule of salaries and wages based on the state civil service salary schedule in effect when the cost report is processed; or, 2) the amount of cash and other assets actually withdrawn by the owner or related parties.

Allocation of owner or related party total work time for resident-related functions. When any owner or related party performs a resident-related function for less than a full-time-equivalent work week, defined as 40 hours per week, the compensation limit shall be prorated. The time spent on each function within a facility or within all facilities in which the owner or related party has an ownership or management interest shall be prorated separately by function, but shall not exceed 100 percent of that person's total work time. Time spent on other non-related business interests or work activities shall not be included in calculations of total work time. Owner or related parties performing resident-related functions must be licensed or certified by the state to perform services requiring such credentials.

Salaries paid to non-working owners or other related parties, as defined in the Definitions of the Cost Report Instructions, shall not be considered an allowable cost regardless of the name assigned to the transfer or accrual or the type of provider entity making the payment. Each payment shall be separately identified and reported as owner compensation in the non-reimbursable and non-resident-related expense section of Schedule A in the cost report.

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Rent or Lease Expense – Equipment – Report all recurring rent or lease expense for equipment such as computer leases, copier leases/ telephone equipment leases, etc.

Rent or Lease Expense – Facility - Report all recurring facility rent or lease expense

Resident Transportation - Report resident transportation expense incurred for non-emergency medical, shopping, activities, etc., in which the residents are the primary passengers. Mileage reimbursements for staff use of personal vehicles may be included if the primary passenger is a resident.

This includes fuel, vehicle lease, interest, depreciation (also include on Schedule D), insurance, vehicle repairs and maintenance or other vehicle-related expense. If transportation costs are allocated, trip logs must be kept to document the expense.

For allocation purposes, acceptable methods of allocating cost to Resident Transportation are as follows:

1. Allocated at a set rate per mile. The rate would be determined by dividing total vehicle expense, not restricted to another expense line, by the total miles. The IRS allowed rate per mile is acceptable because it includes factors for depreciation, insurance and repairs.

2. Allocated directly per the following formula:

3. $\frac{\text{Resident Travel Miles}}{\text{Total Miles}} \times$ Total Vehicle Expenses not Restricted to Another Expense Line = Resident Travel Expense

4. If private vehicles are used to transport residents, the entire amount of the reimbursement paid to the employee for use of the vehicle is allowable as Resident Transportation. The rate of reimbursement must, however, be reasonable.

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Salaries - Salaries are compensation paid for personal services that were reported to the Internal Revenue Service (IRS). These lines, plus the owner/related party compensation lines, shall reconcile to your working trial balance.

Report hours paid and the related salaries on the appropriate line for all salaries classifications.

Non-owner/related party administrator compensation shall be reported in the Administration Cost Center. Salaries and benefits of the administrator and co-administrator paid as central office costs shall be included as part of the central office allocated costs.

When any non-owner or non-related party performs a resident-related function for less than a full-time-equivalent work week, defined as 40 hours per week, the work time and compensation shall be prorated on each function within a facility or within all facilities, but shall not exceed 100 percent of that person's total work time. Time spent on other non-related business interests or work activities shall not be included in calculations of total work time.

Report the salaries of the Treatment Facility Operations Cost Center personnel, the salaries of Room, Board, and Support Cost Center personnel, and the salaries of Treatment Cost Center personnel on the appropriate lines in the respective cost center (see salaries classifications list below). **DO NOT REPORT CONSULTANTS ON THESE LINES.**

1. Salaries – Program Director
2. Salaries – Other Administrative Salaries
3. Salaries -- Maintenance Staff
4. Salaries – Housekeeping
5. Salaries – Dietary
6. Salaries -- Laundry
7. Salaries – Licensed Mental Health Professional (LMHP) – an individual who is licensed in the State of Kansas to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently such as:
    a. Licensed clinical psychologists,
    b. Licensed clinical marriage and family therapists,
    c. Licensed clinical professional counselors,
    d. Licensed specialist clinical social workers, or
    e. Licensed clinical psychotherapists.

    A LMHP also includes individuals licensed to practice under the supervision or direction of:
    a. Licensed masters marriage and family therapists,
    b. Licensed masters professional counselors,
    c. Licensed masters social workers, or
    d. Licensed master level psychologists.

    Supervision or direction must be provided by a person who is eligible to provide Medicaid services and who is licensed at the clinical level or is a physician.

9. Salaries – Mental Health Worker – An individual who is at least twenty-one (21) years of age and meets at least one of the following requirements:
    a. A bachelor's degree; at least 12 credit hours of education in psychology, sociology, social work, counseling, nursing, education, rehabilitation counseling, or theology; and one year of experience in mental health services.
    b. A licensed registered nurse (RN) and one year of experience in mental health

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services.

c. A high school diploma or equivalent and four years of experience in mental health services.
d. A licensed practical nurse (LPN) with one year of experience in mental health services.
e. A licensed mental health tech (LMHT) with one year of experience in mental health services.

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10. Salaries – Direct Care Staff – All direct care staff who are at least twenty-one (21) years of age and at least three (3) years older than the oldest resident; must have a high school diploma or its equivalent.
11. Salaries – Therapy – Other therapy salaries not covered in other classifications.

For owner/related party administrator compensation see the definition "Owner and Related Party Compensation".

Small Equipment - Equipment purchases of $1,000 to $5,000 that were not capitalized must be expensed on this line. Equipment purchases of $1 to $999 may be reported in the cost center of benefit as a supply expense.

Staff Training – Report the costs of fees, tuition, books, etc. for education or training seminars. Training must be pertinent to the job duties and not involve acquiring a degree. Travel, lodging and meals associated with the education/seminars may be reported on this line.

Supplies – Dietary - Report supplies expense directly related to the preparation and service of food to the residents unless further restricted by another expense line. Examples include but are not limited to paper goods, kitchen utensils, etc.

Supplies - Housekeeping - Report all supplies expense related to keeping the building clean and sanitary. Floor care supplies shall be expensed on this line.

Supplies - Laundry and Linen - Report all supplies expense directly related to laundry and linen services for the residents, unless restricted by another line.

Supplies - Nursing - Report expenses of all **routine** supplies directly related to the provision of nursing and/or health related services for residents, unless further restricted by another expense line.

Supplies – Office and Printing - Report all office supplies, postage, duplicating and printing expenses on this line. The printing and duplicating of forms are considered to be an administrative expense and shall **not** be reported in any other cost center.

Supplies - Operating - Report supplies expense incidental to the operation of the applicable cost center. and maintenance of the building, grounds, and equipment in the Treatment Facility Operating Cost Center.

Supplies - Resident Activity - Report the supplies expense involved in providing resident activities.

Taxes - Report all real and personal property taxes in the Treatment Facility Operating Cost Center. Federal income, excess profit taxes, state or local income and excess profits taxes, taxes on property that is not used providing covered services, and interest or penalties paid on any of these taxes are non-reimbursable costs and should be reported in the Non-reimbursable & Non-resident Related Cost Center.

Telephone and Other Communication - Report routine telephone and communications expense in the Administration Cost Center regardless of the department or cost center benefit.

Total Rate Costs - Enter the sum of the totals in the Facility Administrative, Treatment Facility Operating, Facility Property, Room, Board, and Support, and Treatment cost centers.

Travel - Report administrative, staff and consultant travel expenses that are related to resident care. Estimates shall not be acceptable. Exceptions:

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1. Long term or recurring vehicle lease expense for business purposes shall be reported on Rent or Lease Expense – Equipment Line or as applicable to treatment on the Resident Transportation Line.
2. Expenses associated with the personal use of a vehicle are not allowable unless reported within otherwise allowable limits of compensation.
3. Resident transportation expense shall be reported in the Treatment cost center outlined in the expense line explanation.

Utilities Except Telephone - Report expenses for gas, water, electricity, heating oil, trash hauling, etc. Cablevision may be considered a utility or resident activity expense.

Non-Reimbursable & Non-Resident Related Items

Provider adjustments must be made in column 3 that offset column 2 expenses in total. Column 4 will show zero expenses.

Costs not related to resident care shall be considered Non-reimbursable costs and reported in this section. In addition, the following expenses or costs shall not be allowed:

Fund Raising/Public Relations/Advertising for Resident Utilization -- Include non-allowable advertising expenses. See Advertising and Recruitment explanation under Expense Lines Section.

Education and Educational Related Expenses -- If a PRTF incurs costs related to school services for youth residing at the facility, these expenses should be included as non-reimbursable & non-resident related expense. These expenses include facility, property equipment and supplies, transportation related to school attendance and staff costs.

Insurance - Life – Premiums paid on the lives of owners or related parties.

Membership Fees or Dues – Costs of social, fraternal, civic and other organizations that concern themselves with activities unrelated to their members' professional or business activities.

Non-working Directors or Officers Fees – Fees paid to non-working directors and the salaries of non-working officers

Other – Expenses such as:

1. the inputted value of services rendered by non-paid workers and volunteers;
2. expenses reimbursed from other state or federal funds;
3. utilization review;
4. costs of social, fraternal, civic, and other organizations that concern themselves with activities unrelated to their members' professional or business activities;
5. vending machines and related supplies;
6. board of director costs;
7. penalties, fines, and late charges;
8. automobiles and related accessories in excess of $25,000.00 each. Buses and vans for resident transportation shall be reviewed for reasonableness and may exceed $25,000.00 in costs;
9. provider-owned or related party-owned, -leased, or -chartered airplanes and related expenses;
10. bank overdraft charges or other penalties;
11. personal expenses not directly related to the provision of long-term resident care in a PRTF;
12. management fees paid to a related organization that are not clearly derived from the actual cost of

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materials, supplies, or services provided directly to an individual PRTF;

13. business expenses not directly related to the care of residents in a long-term care facility including business investment activities, stockholder and public relations activities, and farm and ranch operations;
14. legal and other costs associated with litigation , unless the litigation is decided in the provider's favor;
15. lobbying expenses and political contributions; or
16. purchase discounts, allowances, and refunds shall be deducted from the cost of the items purchased. Refunds of prior years' expenses shall be deducted from the related expenses.

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Provision for Income Taxes – Federal income and excess profit taxes, state or local income and excess profit taxes, taxes from which exemptions are available to the provider, taxes on property that is not used in providing covered services; self-employment taxes applicable to individual proprietors, partners, or members of a joint venture, and any interest or penalties paid on these taxes. In addition, interest and penalties paid on federal and state payroll taxes should be included here.

Resident Purchases - Report the expense for items purchased for residents but not listed as routine services or supplies.

SCHEDULE B - EXPENSE RECONCILIATION

General: This schedule shall be used to reconcile the expenses reported on the PRTF Financial and Statistical Report (Form HCP-PRTF-01) to the provider's financial books and federal tax return.

Total Expenses Per Books or Federal Tax Return - Record each cost center total from Schedule A, Column 2.

Total Provider Adjustments - Record each cost center total from Schedule A, Column 3.

Total Resident Related Expenses – Record each cost center total from Schedule A, Column 4.

Total Expenses per Cost Report – Total each Column, lines A through F.

Expenses on Books or Federal Tax Return Not on Cost Report - Itemize each expense reflected in the books or federal tax return and not included in the cost report. These expenses should be recorded in the column 1 under books and/or federal tax return. Use an additional schedule if necessary to list expenses.

Total – Total lines G, H, and I. This total should equal working trial balance (books) or federal tax return.

SCHEDULE C - STATEMENT OF OWNERS AND RELATED PARTIES

General: List all owners of the provider entity with 5% or more ownership interest and all related parties. Fill out Schedule C completely and accurately. Attach an additional schedule if more explanation or space is needed. Providers shall base all allocations on reasonable factual information and make the information available on request. Such information shall include details of dates, hours worked, nature of work performed, how it relates to resident care and the Kansas Civil Service wage rates for such activities.

ENTER - Name, Social Security Number and Address

Column (1) - % of ownership (if applicable) or state the relationship to owner

Column (2) - % of time devoted to this facility per customary workweek

Column (3) - Total salaries, drawings, consulting fees, and other payments to owners and related parties.

Column (4) - List the titles, functions or descriptions of the jobs performed or transactions made with all owners and related parties. The job classes should correspond with those included in the Kansas Civil Service classifications for comparable positions.

Column (5) - Enter the distribution by cost report line item of the total compensation incurred for all job functions. Owner/related party compensation shall be reported on the owner compensation expense lines

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in the related cost centers in Schedule A.

Totals - The total compensation in Column 3 and Column 5 should agree. These two totals should also agree with the total of cost report line items titled Owner/related party compensation from Schedule A.

SCHEDULE D - STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE

Note: Failure to produce documentation of interest expense upon request is cause for disallowance. Schedules need to be submitted for related party loans showing the interest paid, check numbers and dates.

Column (1a & 1b) - Enter the original date and duration of the loan in months.

Column (2) - Enter the interest rate. If it is a variable rate, provide the range of the interest rates for the cost report period.

Column (3) - Enter the amount of the loan.

Column (4) - Enter the unpaid principal balance at the end of the cost report period. The total of Column 4 must agree with the Working Trial Balance.

Column (5) - Enter the total amount of interest and principal payments made during the cost report year.

Column (6) - Enter the total amount of interest incurred during the cost report year. The total of Column 6 must agree with the total interest reported on Schedule A.

Enter each lender's name, address and the items financed for each loan on a separate line. Indicate the cost center the interest expense was reported on of Schedule A. If interest expense on a loan is pro-rated to both lines, show the breakdown.

Enter the totals of Column 4 - Unpaid Balance and Column 6 - Interest Expense, (column 6 should match interest expense reported in Schedule A).

SCHEDULE E - REVENUE STATEMENT

A statement of revenue is required as part of the cost report. Revenue shall be reported in accordance with general accounting rules as recorded in the accounting records of the PRTF.

Revenue received for a service that is not related to client care shall be used to offset the cost of providing that service. The cost report line item which includes the non-resident related costs shall not be less than zero.

Expense recoveries credited to expenses accounts shall not be reclassified as revenue to increase the costs reported.

Column 1 - Enter the revenues from the general ledger accounts on the appropriate lines. Revenues from services not designated on this schedule must be identified and reported as Other.

Column 2 - Enter the amount of the offset to the appropriate expense accounts. **Note the Following:** The amount of the offset should be the cost of reimbursable expenses. Non-reimbursable items (i.e. Vending) are offset at cost.

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Column 3 - Enter the line number of the expense reported on the Expense Statement, Schedule A, against which the offset has been made. The amount of the offset must be entered in Column 3, Provider Adjustments, on the Expense Statement, Schedule A.

Other Revenue – Enter a description and if necessary to provide an explanation, attach an explanation.

Resident Purchases - Enter the total of all reimbursements for personal purchases, i. e. radios, snack items, school supplies, etc.

SCHEDULE F - FIXED ASSET, DEPRECIATION AND AMORTIZATION QUESTIONNAIRE

Each question shall be answered completely and accurately.

Lines 1 – 7 - Complex Capital Structures:

Attach a complete explanation of the ownership/management structure of the PRTF including owners with 5% or more interest in the property and/or business, related parties as specified in the definitions, and all relevant contracts, leases, and assignments. This information must be accurate and comprehensive enough to present a true and clear account of the ownership and control of the facility.

If the facility is leased, a copy of the original lease agreement and subsequent amendments and/or agreements shall be available upon request of the agency. A provider making payments under Industrial Revenue Bonds with a nominal purchase upon maturity shall report the cost of ownership versus lease expense.

Line 10 - A new provider that purchases a facility shall submit a statement outlining details of the purchase and have available upon request of the agency copies of the loan agreement(s), and any other pertinent information concerning the transaction.

Line 11 - Submit a copy of the detailed depreciation schedule with the cost report. Each asset shall be listed with the cost, date of purchase, life, salvage value, accumulated depreciation expense and current depreciation expense. Depreciation must be computed using the STRAIGHT LINE method.

ATTENTION

The cost report is not considered complete unless all required documents are submitted with the cost reports.

DECLARATION STATEMENT

Declaration by Owner; Partner; or Officer of the Corporation, City or County which is the Provider. The cost report is not considered complete unless signed by an owner or authorized agent of the facility and/or business and the preparer. If person signing is not an owner or partner, documentation or a resolution stating their authority to sign needs to be attached. If the facility/business owner and the preparer are the same individual, please sign both spaces. Print the names of the owner/authorized agent and preparer in the space provided. **PLEASE READ DECLARATION STATEMENT.**

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State of Kansas

Department of Social and Rehabilitation Services

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT

COVER PAGE

SEND TO: Social and Rehabilitation Services Health Care Policy/Management Operations 915 SW Harrison, 10th Floor TOPEKA, KANSAS 66612-1570	**AGENCY USE ONLY**

INSTRUCTIONS ARE AN INTEGRAL PART OF THIS REPORT. YOU MUST READ THEM BEFORE COMPLETING.

	EDS PROVIDER NUMBER (NEED 10 DIGITS)	**EMPLOYERS' FEDERAL ID NUMBER**
PROVIDER NAME (The person or business organization responsible for meeting requirements, providing services and receiving payments.)		**FACILITY NAME**

FACILITY ADDRESS (STREET, CITY, STATE, ZIP)

CONTACT PERSON'S NAME	**PHONE NUMBER**	**CONTACT EMAIL ADDRESS**	
		REPORT PERIOD _____ TO _____	**TYPE OF ACCREDITATION: Check One** _____ CARF _____ COA _____ JACHO Time Period Covered: _____ to _____
	FAX NUMBER	**FISCAL YEAR END**	

TYPE OF MOST RECENT AUDIT A-133 _____ GAS _____ Other (Specify) _____

CURRENT PRIVATE PAY RATE: _____

CHECK ONLY ONE

Sole Proprietorship ___ Partnership ___ Corp - Profit ___
Corp. - Non Profit ___ City Owned ___ County Owned ___
Other - Government Owned ___ Other (Specify): ___

PRTF BEDS

	TIME PERIOD					
	BEGINNING DATE/DATE OF CHANGE	ENDING DATE	# OF BEDS		# OF CALENDAR DAYS	BED DAYS AT THIS BED COUNT
A.						0
B.						0
C.						0
D.						0
E.						0
F.	TOTAL DAYS DURING REPORTING PERIOD				0	
G.	TOTAL BED DAYS AVAILABLE (TOTAL COLUMN J - LINES A THROUGH E)					0
H.	TOTAL MEDICAID REIMBURSABLE DAYS, EXCLUDING APPROVED ABSENT DAYS					0
I.	TOTAL MEDICAID APPROVED ABSENT DAYS					0
J.	TOTAL RESIDENT "OTHER FUNDED" BED DAYS REIMBURSED					0
K.	TOTAL REIMBURSABLE BED DAYS (TOTAL LINES H THROUGH J)					0
L.	VACANCY PERCENTAGE (1 MINUS K / G)					#DIV/0!

DO NOT CROSS OUT OR RETITLE LINES DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.	PROVIDER NAME EDS PROVIDER NUMBER

SCHEDULE A **EXPENSE STATEMENT**

FACILITY ADMINISTRATIVE COST CENTER (Costs for this facility's operation only)	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
SALARY - PROGRAM DIRECTOR						
SALARIES - OTHER ADMINISTRATIVE						
EMPLOYEE BENEFITS						
OWNER/RELATED PARTY ADMIN COMPENSATION - SCHEDULE C						
OWNER/RELATED PARTY EMPLOYEE BENEFITS						
STAFF TRAINING						
CONTRACTED LABOR						
MANAGEMENT CONSULTANT FEES						
SUPPLIES - OFFICE & PRINTING						
TELEPHONE & OTHER COMMUNICATION						
TRAVEL						
ADVERTISING AND RECRUITMENT						
LICENSES, ACCREDITATION & DUES						
ACCOUNTING & DATA PROCESSING						
INSURANCE - LIABILITY						
INSURANCE - OTHER						
INTEREST						
LEGAL						
CRIMINAL BACKGROUND CHECK						
TAXES (NOT REAL/PROPERTY)						
MAINTENANCE & REPAIRS						
SUPPLIES - OPERATING						
SMALL EQUIPMENT (SEE INSTRUCTIONS)						
OTHER (SPECIFY)						
OTHER (SPECIFY)						
OTHER (SPECIFY)						
ALLOCATIONS - ATTACH SCHEDULE						
ALLOCATIONS - CENTRAL OFFICE						
TOTAL FACILITY ADMIN COST CENTER	0	$ -	$ -	$ -	$ -	$ -

DO NOT CROSS OUT OR RETITLE LINES DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.				PROVIDER NAME EDS PROVIDER NUMBER		
SCHEDULE A	**EXPENSE STATEMENT**					
TREATMENT FACILITY OPERATING COST CENTER (Costs for this facility's operation only)	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
SALARIES - MAINTENANCE STAFF						
EMPLOYEE BENEFITS						
OWNER/RELATED PARTY COMPENSATION - SCHEDULE C						
OWNER/RELATED PARTY EMPLOYEE BENEFITS						
CONTRACTED LABOR						
STAFF TRAINING						
INSURANCE - FACILITY						
TRAVEL						
CONSULTANTS (SPECIFY)						
UTILITIES						
CONTRACTORS FEES						
MAINTENANCE & REPAIRS						
SUPPLIES - OPERATING						
TAXES - REAL AND PERSONAL PROPERTY						
LICENSES, ACCREDITATION & DUES						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
TOTAL TREATMENT FACILITY OPS COST CENTER	0	$ -	$ -	$ -	$ -	$ -

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DO NOT CROSS OUT OR RETITLE LINES DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.				PROVIDER NAME EDS PROVIDER NUMBER		
SCHEDULE A	**EXPENSE STATEMENT**					
FACILITY PROPERTY COST CENTER (Costs for this facility's operation only)	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
INTEREST - EQUIPMENT						
INTEREST - REAL ESTATE						
RENT/LEASE EXPENSE - EQUIPMENT						
RENT/LEASE EXPENSE - FACILITY						
AMORTIZED LEASEHOLD IMPROVEMENT						
DEPRECIATION EXPENSE - EQUIPMENT						
DEPRECIATION EXPENSE - FACILITY						
TOTAL FACILITY PROPERTY COST CENTER		$ -	$ -	$ -	$ -	$ -

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SCHEDULE A EXPENSE STATEMENT

ROOM, BOARD, AND SUPPORT COST CENTER (Costs for this facility's operation only)	ANNUAL HOURS PAID (1)	FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) RELATED EXPENSES (6)
SALARIES - HOUSEKEEPING						
SALARIES - DIETARY						
SALARIES - LAUNDRY						
EMPLOYEE BENEFITS						
OWNER/RELATED PARTY COMPENSATION - SCHEDULE C						
OWNER/RELATED PARTY EMPLOYEE BENEFITS						
STAFF TRAINING						
CONTRACTED LABOR						
CONSULTANT (SPECIFY)						
FOOD						
SUPPLIES - DIETARY						
LINEN & BEDDING MATERIAL						
SUPPLIES - LAUNDRY & LINEN						
SUPPLIES - HOUSEKEEPING						
SMALL EQUIPMENT						
MAINTENANCE & REPAIRS						
SUPPLIES - NURSING						
SUPPLIES - RESIDENT ACTIVITY						
RESIDENT TRANSPORTATION						
SUPPLIES - TREATMENT						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
TOTAL ROOM & BOARD COST CENTER	0	$ -	$ -	$ -	$ -	$ -

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SCHEDULE A	**EXPENSE STATEMENT**					
TREATMENT COST CENTER (Costs for this facility's operation only)	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
SALARIES - LICENSED MENTAL HEALTH PROFESSIONAL (LMHP)						
SALARIES - MENTAL HEALTH WORKER						
SALARIES - DIRECT CARE STAFF						
SALARIES - THERAPY						
PHYSICIANS, ARNP, PHYSICIAN ASSISTANT						
EMPLOYEE BENEFITS						
OWNER/RELATED PARTY COMPENSATION - SCHEDULE C						
OWNER/RELATED PARTY EMPLOYEE BENEFITS						
CONTRACT PHYSICIAN, ARNP, PHYSICIAN ASSISTANT						
OTHER CONSULTANTS (SPECIFY)						
CONTRACTED LABOR						
LICENSES, ACCREDITATION AND DUES						
STAFF TRAINING						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
TOTAL SUPPORT & TREATMENT COST CENTER		$ -	$ -	$ -	$ -	$ -
TOTAL	0	$ -	$ -	$ -	$ -	$ -

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DO NOT CROSS OUT OR RETITLE LINES DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.					PROVIDER NAME EDS PROVIDER NUMBER	
SCHEDULE A	**EXPENSE STATEMENT**					
NON-REIMBURSABLE & NON-RESIDENT RELATED EXPENSE ITEMS (Costs for this facility's operation only)	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
BAD DEBTS						
PROVISION FOR INCOME TAXES						
NONWORKING OWNERS/OFFICERS - SCHEDULE C						
MEMBERSHIPS FEES AND DUES						
FUND RAISING/PROMO & NON-REIMBURSABLE ADVERTISING						
LIFE INSURANCE - OWNERS/OFFICERS						
OTHER HEALTH CARE						
VENDING MACHINES						
BOARD OF DIRECTORS EXPENSE						
RESIDENT PURCHASES						
EDUCATION & EDUCATION RELATED EXPENSES						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
TOTAL NON-REIMBURSABLE		$ -	$ -	$ -	$ -	$ -
TOTAL		$ -	$ -	$ -	$ -	$ -

ATTACH A DETAILED DEPRECIATION SCHEDULE AND THE DETAILED WORKING TRIAL BALANCE USED TO PREPARE THIS COST REPORT

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SCHEDULE B EXPENSE RECONCILIATION

		PER BOOKS OR FEDERAL TAX RETURN (1)	PROVIDER ADJUSTMENTS (2)	RESIDENT RELATED EXPENSES (3)
A	TOTAL EXPENSES - FACILITY ADMINISTRATIVE COST CENTER	$ -	$ -	$ -
B	TOTAL EXPENSES - TREATMENT FACILITY COST CENTER	$ -	$ -	$ -
C	TOTAL EXPENSES - FACILITY PROPERTY COST CENTER	$ -	$ -	$ -
D	TOTAL EXPENSES - ROOM, BOARD, AND SUPPORT COST CENTER	$ -	$ -	$ -
E	TOTAL EXPENSES - TREATMENT COST CENTER	$ -	$ -	$ -
F	TOTAL EXPENSES - NON-REIMBURSEABLE	$ -	$ -	$ -
G	TOTAL EXPENSES PER COST REPORT	$ -	$ -	$ -
	EXPENSES ON BOOKS OR FEDERAL TAX RETURN NOT ON COST REPORT			
H	SPECIFY			
I	SPECIFY			
J	**TOTAL (SHOULD EQUAL SUPPORTING BOOKS OR FEDERAL TAX RETURN)**	$ -		

SCHEDULE C STATEMENT OF OWNERS AND RELATED PARTIES

LIST ALL OWNERS OF PROVIDERS WITH 5% OWNERSHIP INTEREST & ALL RELATED PARTIES.
SUMMARIZE THE AMOUNT AND NATURE OF TRANSACTIONS WITH ALL OWNERS & RELATED PARTIES.

ME, SSN, ADDRESS (CITY & STATE)	(1) % OWNERSHIP	(2) % TIME DEVOTED	(3) TOTAL AMT INCURRED	(4) TITLE, FUNCTION OR DESCRIPTION - TRANSACTION	(5) DISTRIBUTION AMOUNT	COST CENTER WHERE INCLUDED
TOTALS (SHOULD BE EQUAL)			$ -		$ -	

CALCULATIONS MUST EQUAL THE OWNER/RELATED PARTY LINES OF THE COST CENTERS

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SCHEDULE D **STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE**

(Costs for this facility's operation only)

PROVIDER NAME

EDS PROVIDER NUMBER

LENDER'S NAME	LENDER'S ADDRESS	ITEMS FINANCED	ORIGINATION DATE (1a)	DURATION (months) (1b)	INTEREST RATE (2)	ORIGINAL LOAN AMOUNT (3)	UNPAID BALANCE (4)	TOTAL ANNUAL PAYMENTS (5)	INTEREST EXPENSE (6)
TOTALS:							$0	$0	$0

TOTAL OF COLUMN 6 MUST AGREE WITH THE SUM OF INTEREST REPORTED IN THE FACILITY ADMINISTRATIVE COST CENTER AND FACILITY PROPERTY COST CENTER. ATTACH A COPY OF LOAN AGREEMEI AND AMORTIZATION SCHEDULES FOR ALL LOANS OF $5,000 OR MORE IF NOT ALREADY SUBMITTED.

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SCHEDULE D **STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE**

(Costs for this facility's operation only)

PROVIDER NAME

EDS PROVIDER NUMBER

LENDER'S NAME	LENDER'S ADDRESS	ITEMS FINANCED	ORIGINATION DATE (1a)	DURATION (months) (1b)	INTEREST RATE (2)	ORIGINAL LOAN AMOUNT (3)	UNPAID BALANCE (4)	TOTAL ANNUAL PAYMENTS (5)	INTEREST EXPENSE (6)
TOTALS:							$0	$0	$0

TOTAL OF COLUMN 6 MUST AGREE WITH THE SUM OF INTEREST REPORTED IN THE FACILITY ADMINISTRATIVE COST CENTER AND FACILITY PROPERTY COST CENTER. ATTACH A COPY OF LOAN AGREEMEI AND AMORTIZATION SCHEDULES FOR ALL LOANS OF $5,000 OR MORE IF NOT ALREADY SUBMITTED.

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		PROVIDER NAME EDS PROVIDER NUMBER		
IEDULE E REVENUE STATEMENT				
		REV PER BOOKS OR FED TAX RETURN (1)	ADJUSTMENT TO EXPENSE ACCOUNTS (2)	COST CENTER OF RELATED EXPENSE (3)
ROUTINE DAILY SERVICE:				
PRIVATE PAY				
MEDICAID RESIDENTS & PATIENT LIABILITY				
CONTRIBUTIONS AND DONATIONS				
OTHER RESIDENTS (SPECIFY)				
REVENUE FROM MEALS SOLD TO GUESTS & EMPLOYEES				
REVENUE FROM SALES OF SUPPLIES TO RESIDENTS				
PURCHASE DISCOUNTS, RETURNS, REFUNDS & ALLOWANCES				
OTHER SUPPLIES SOLD				
GRAM REIMBURSEMENTS & TAX CREDITS				
INVESTMENT/INTEREST INCOME				
VENDING MACHINE REVENUE				
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES REVENUE				
OTHER (SPECIFY)				
OTHER (SPECIFY)				
OTHER (SPECIFY)				
TOTALS		$0	$0	

Be Certain to Off-Set Expenses with Related Revenue Where Appropriate

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		PROVIDER NAME EDS PROVIDER NO

SCHEDULE F FIXED ASSET, DEPRECIATION & AMORTIZATION QUESTIONNAIRE

1	DOES THE PROVIDER LEASE OR RENT ANY PART OF THE PHYSICAL FACILITY FROM ANY OTHER ENTITY?.....	☐ YES	☐ NO
2	IF YES, DO ANY OWNERS OF THE PHYSICAL FACILITY HAVE AN INTEREST, DIRECTLY OR INDIRECTLY, IN THE PROVIDER?.....	☐ YES	☐ NO

IF YES, PROVIDE THE OWNERSHIP INFORMATION REQUESTED BELOW. IF NO, GO TO QUESTION 913.

	NAME OF OWNERS OF PHYSICAL FACILITY	% OF OWNERSHIP	DESCRIBE NATURE OF RELATIONSHIP WITH PROVIDER. IF NONE, WRITE "NONE"
3			
4			
5			
6			
7			

IF THE OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW THE INSTRUCTIONS FOR LINES 1-7 FOR COMPLEX CAPITAL STRUCTURES.

8	DOES THE LEASE CONTAIN AN OPTION TO PURCHASE THE LEASED PROPERTY?	☐ YES	☐ NO
	IS THE PHYSICAL FACILITY OWNED BY THE PROVIDER?	☐ YES	☐ NO
10	IF OWNED, WAS THE PURCHASE AN ARMS LENGTH TRANSACTION?..... (ATTACH A STATEMENT OUTLINING DETAILS OF THE PURCHASE)	☐ YES	☐ NO
11	WAS THE STRAIGHT LINE DEPRECIATION METHOD USED?.....	☐ YES	☐ NO
	IF NO, HAVE YOU RECALCULATED THE DEPRECIATION USING THE STRAIGHT LINE METHOD AND MADE THE APPROPRIATE ADJUSTMENTS TO THE DEPRECIATION EXPENSE REPORTED ON THE EXPENSE STATEMENT?	☐ YES	☐ NO

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DECLARATION OF PREPARER:

I HAVE COMPILED THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS PREPARED FOR

FOR THE COST REPORT PERIOD ENDING _____ , TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH WORKING TRIAL BALANCE (ATTACHED) AS EXPLAINED IN THE RECONCILIATION (SCHEDULE B); THAT I HAVE ALL SUPPORTING DOCUMENTATION OF EXPENSES REPORTED; THAT I HAVE REQUESTED ALL NECESSARY AND AVAILABLE MATERIAL; AND, THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PREPARER'S SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

PREPARER'S ADDRESS (STREET, CITY, STATE, ZIP)	PHONE NUMBER FAX NUMBER

PREPARER'S EMAIL ADDRESS

DECLARATION OF OWNER; PARTNER; OR OFFICER OF THE CORPORATION, CITY, OR COUNTY WHICH IS THE PROVIDER:

I HEREBY CERTIFY THAT I HAVE READ THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH WORKING TRIAL BALANCE (ATTACHED) AS EXPLAINED IN THE RECONCILIATION (SCHEDULE B); THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I CERTIFY THAT NO MATERIAL OR INFORMATION I HAVE ACCESS TO WOULD PRODUCE FINDINGS CONTRARY TO THOSE IN THE ACCOMPANYING COST REPORT INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

SIGNATURE AND TITLE OF OWNER, PARTNER, OR OFFICER OF THE CORPORATION, CITY OR COUNTY WHICH IS THE PROVIDER. IF PERSON SIGNING IS NOT AN OWNER OR PARTNER, PLEASE ATTACH DOCUMENTATION OR A RESOLUTION SHOWING THEIR AUTHORITY TO SIGN. (UNLESS ONE HAD BEEN PREVIOUSLY SENT AND ON FILE)

SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

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Attachment 2 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

Youth Psychiatric Residential
Behavior Severity Index

Social and Rehabilitation Services – Division of Health Care Policy
The Kansas Mental Health Authority
October 20, 2006

MAR - 7 2007

Attachment 2 to Instructions Regarding Methods and Standards for Establishing Payment Rates Psychiatric Residential Treatment Facilities

Instructions:
The Kansas Youth Psychiatric Residential Behavior Severity Index is an instrument use to record the extent to which a youth's behavior which results from a serious emotional disturbance will increase the utilization of resources required to manage that behavior. The tool is not intended to reflect causes or the dynamics underlying the youth's serious emotional disturbance but rather is intended to provide the degree to which the youth's behavior at present or in the recent past is disruptive to functioning.

This assessment should be completed immediately prior to admission to a Psychiatric Residential Treatment Facility (PRTF) by a person who is knowledgeable about the severity of the youth's present and recent behavior. The assessment will be the utilized throughout the youth's stay in the PRTF to determine the facility's acuity index. Completed assessments will be submitted to SRS or its designee for entry into the PRTF data base. The information in the assessment data base will be used to determine the quarterly acuity adjustment for each PRTF as specified in the state plan. In addition, the PRFT will provide assessment information upon each youth's discharge.

Assessment:
Unless otherwise instructed, for each question rate the behavior of the youth based on the degree of severity of the behavior and the frequency the behavior occurs. When scoring for the severity of a behavior use the following guidelines unless otherwise defined:

Behavior is not a problem: If the behavior is not considered a problem for the youth or those around him/her or if the behavior does not occur mark zero in both seriousness and frequency.
Behavior presents minimal slight problem: Causes some minor challenges to the youth's life, but is manageable using typical mild interventions or redirection.
Behavior presents moderate problem: Causes significant problems in the youth's life and prevents him/her from living independently and effectively interacting with others, but is manageable using targeted, planned interventions.
Behavior presents a serious problem: Causes bodily harm to the youth or others or serious but repairable property damage. The behavior must be managed using intensive planned interventions and treatment.
Behavior presents an extremely serious problem: Behavior, if left to occur without intervention, could cause death or irreparable property damage and is only managed with intensive staff supervision using planned interventions and treatment.

General Guidelines:

1. There are four subscales which are comprised of 17 questions within the assessment: Severity of Psychiatric Symptoms, Risk Factors, Complicating Factors, and Co-Morbidity. All subscales and all questions within those subscales are to be completed. If a subscale or question is not applicable, place a 0 as the score.
2. Use a literal approach to judging behavior. Use only the definitions provided for the behavior and assess only on factual information that is available to determine if the behavior manifested. Do not infer that a behavior has occurred based on another behavior or on the youth's diagnosis. As much as possible base the ratings on what you have observed or what has been reported by other informants.

Scoring:
Scoring begins on page 13. When scoring, use the scores from the right hand box of the assessment. The four subscales have been numbered with Roman numeral's. The scoring page has been broken out by subscales. You will fill in the scores according to the directions to receive a raw score which is placed in the right hand box for each subscale. The Risk Factors Subscale has been weighted which will result in a higher score for these questions. You will add the weighted scores in this subscale in the same manner as above to receive a raw score.

When all raw scores have been tabulated the final box will be completed. The first step is to add the multiplying factors to the raw score from Subscale III: Risk Factors. You will take the risk factor raw score found in the right had box under subscale III and multiple it by the cognitive functioning score (question 17) found in the Subscale Box V: Co-Morbidity. This will give you an adjusted raw score for Subscale III. Add this total score to the raw scores found in the right hand box for subscales II, IV, and V. The result is the total score for the youth which is recorded in the right hand box at the bottom of page 14.

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Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

Youth Psychiatric Residential
Behavior Severity Index
2007

SECTION I. IDENTIFICATION INFORMATION:

Youth's Name:_____ **Social Security #:**_____ **Sex:**___**DOB:** ___/_____/_____
Mo. Day Yr.

Address:_____
(Street and Apartment #) (City) (State) (Zip)

Name of Guardian:_____ **Address:**_____

Guardian's Phone #: (___)_____**Relationship** (check one): **Parent**___ **Self** ___ **SRS** ___ **JJA** ___

Race or Ethnic Group: #1 to #6 _____

1 = Asian/Asian American/Pacific Islander **2** = Black/African American
3 = First Nations/Native American/American Indian or Alaskan Native **4** = Hispanic/Latino/Mexican American
5 = White/Caucasian/European American **6** = Multiple Race/Ethnicity or Bi-Racial

Diagnosis:
Axis I _____ _____
Axis II _____ _____
Axis III _____ _____
Axis IV _____ _____
Axis V _____ **GAF:** _____

Prognosis: _____

Other Medically Intense Needs that would complicate treatment:_____
_____
_____
_____
_____

Name of Assessing Individual (include Qualifications):_____

CMHC / Facility: _____ **Phone #:** (___)_____

Initial Assessment Date (Mo/Day/Yr): __/__/__ **Discharge Assessment Date (Mo/Day/Yr):** __/__/__

Attachment 2 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

SECTION II. Severity of Psychiatric Symptoms:

1. Neuropsychiatric Disturbance. This dimension is used to rate symptoms of psychiatric disorders with a known neurological base. DSM-IV disorders included on this dimension are Schizophrenia, Psychotic disorders (unipolar, bipolar, NOS), Autism, and some encephalopathies. The common symptoms of these disorders include hallucinations, delusions, unusual thought processes, strange speech, bizarre/idiosyncratic behavior. 0 This youth has no evidence of thought disturbances. Both thought processes and content are within normal range. 1 This youth has evidence of mild disruption in thought processes or content. The youth may be somewhat tangential in speech or evidence somewhat illogical thinking (age inappropriate). This level also includes youth with a history of hallucinations but none currently. This category would be used for youth who are sub-threshold for one of the DSM diagnoses listed above. 2 This youth has evidence of notable disturbance in thought process or content. The youth may be somewhat delusional or have brief or intermittent hallucinations. The youth's speech may be, at times, quite tangential or illogical. This level would be used for youth who meet the diagnostic criteria for one of the disorders listed above. 3 This youth has a severe thought disorder. The youth frequently experiences symptoms of psychosis and frequently has no reality assessment. There is evidence of ongoing delusions or hallucinations or both. The youth may be experiencing command hallucinations. This level is used for extreme cases of the diagnoses listed above.	**Score 1:** _____
2. Emotional Disturbance. This dimension is used to rate symptoms of the follow psychiatric disorders as specified in DSM-IV: Depression (unipolar, dysthymia, NOS), Bipolar, Intermittent Explosive Disorder, Generalized Anxiety, Eating Disorders, Phobias. Symptoms included in this dimension are depressed mood, social withdrawal, anxious mood, sleep disturbances, weight/eating disturbances, loss of motivation. 0 This youth has no emotional problems. No evidence of depression or anxiety. 1 This youth has mild to moderate emotional problems. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to gross avoidance behavior. This level is used to rate either a mild phobia or anxiety problem or a sub-threshold level of symptoms for the other listed disorders. 2 This youth has a moderate to severe level of emotional disturbance. This could include major conversion symptoms, frequent anxiety attacks, obsessive rituals, flashbacks, hypervigilance, depression, or school avoidance. The youth has a diagnosis of anxiety or depression regardless of severity. This youth meets the criteria for an affective disorder listed above. 3 This youth has a very severe level of emotional disturbance. The youth stays at home or in bed all day due to anxiety or depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. More severe forms of anxiety or depressive diagnoses would be coded here (e.g., meeting criteria in excess of the diagnosis). This youth has an extreme case of one of the disorders listed above.	**Score 2:** _____

Attachment 2 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

SECTION II. Severity of Psychiatric Symptoms:

3. Conduct Disturbance. This dimension includes the symptoms of conduct disorder and oppositional behavior as specified in DSM-IV. These symptoms include antisocial behaviors like shoplifting, lying, vandalism, cruelty to animals, assault, and non-compliance with authority.

Score 3: _____

0 This youth has no evidence of behavior disorder.

1 This youth has a mild or moderate level of conduct problems. Some difficulties in school and home behavior. Problems recognizable but not notably deviant for age and sex and community. This might include occasional truancy, lying or petty theft from family. The youth is occasionally noncompliant to some rules or adult instructions

2 This youth has a moderate to severe level of conduct disorder. This could include episodes of planned aggressive or other anti-social behavior. The youth is frequently noncompliant with rules or adult instructions. The youth meets the criteria for a diagnosis of conduct disorder and/or oppositional defiant disorder.

3 This youth has a very severe conduct disorder. This could include frequent episodes of unprovoked, planned aggressive or other antisocial behavior. The youth is virtually always noncompliant with rules or adult instructions. The youth meets the criteria for a severe case of conduct disorder and/or oppositional defiant disorder.

4. Impulsivity. In addition to impulsive behavior, symptoms of Attention Deficit and Hyperactivity Disorder and Impulse Control Disorder would be rated here. Inattention/distractibility not related to opposition would also be rated here.

Score 4: _____

0 The youth has no evidence of impulse control problems.

1 This youth has with some evidence of mild problems with impulse control. This could be infrequent impulsive action that does not pose notable safety risk, but where the youth clearly did not consider consequences. Occasional tantrums or angry outbursts might be rated here.

2 This youth has considerable impulse control problems. Frequent impulsive behavior is observed or reported that carries some safety risk. The youth meets DSM-IV diagnostic criteria for ADHD or Impulse Control Disorder.

3 This youth has a severe impairment of impulse control. Frequent impulsive behavior is observed or noted that carries considerable safety risk (e.g. running into the street, dangerous driving or bike riding). The youth may have profound symptoms of ADHD or Impulse Control Disorder.

SECTION III. Risk Factors:

5. Self Harming Behavior: Youth attempts to injury self or actually injures self due to loss of self-control due to serious emotional disturbance.

A. Severity: **Score 5A:** _____

0 Not a problem
1 Youth has a known history of self-injurious behavior, suicide or ideation.
2 Youth experiences suicide ideation or preoccupation including expressing suicidal threats or ideation. With no history of actual attempts.
3 Youth experiences suicide ideation or preoccupation including expressing suicidal threats or ideation and with history of actual attempts.
4 Youth displays self-injurious behavior or attempts suicide if not closely supervised.

B. Frequency Score: **Score 5B:** _____

0 Problem never or hardly ever occurs
1 Behavior occurred in the last year
2 Behavior occurred several times in the last six months
3 Behavior occurs multiple times per month
4 Behavior occurs multiple times per week
5 Behavior occurs multiple times per day

Attachment 2 to Instructions Regarding
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SECTION III. Risk Factors:

6. Aggression to Others. Youth attempts to injure or actually injures others due to loss of self-control due to serious emotional disturbance.

A. Severity: — **Score 6A:** _____

0 Not a problem
1 Youth displays verbal but not physical aggression
2 Youth displays serious verbal aggression and some mild physical aggression.
3 Youth displays serious physical aggression which is not life threatening or expresses homicidal threats or ideation.
4 Youth displays physical aggression which is life threatening. Youth experiences command hallucination to kill or injure someone.

B. Frequency Score — **Score 6B:** _____

0 Problem never or hardly ever occurs
1 Behavior occurred in the last year
2 Behavior occurred several times in the last six months
3 Behavior occurs multiple times per month
4 Behavior occurs multiple times per week
5 Behavior occurs multiple times per day

7. Sexual Aggression. Youth engages in inappropriate sexual behavior including but not limited to: sexual behavior with persons unable to consent, public sexual behavior, predatory sexual behavior, etc.

A. Severity: — **Score 7A:** _____

0 Not a problem
1 Youth makes inappropriate sexual advances or fixates on inappropriate sexual behavior
2 Youth has engaged in inappropriate sexual behavior, but he/she did not or was not forced or coerced the sexual behavior.
3 Youth engaged in inappropriate sexual behavior which was coerced, but not physically forced
4 Youth is sexually aggressive and engaged in inappropriate sexual behavior which was physically forced

B. Frequency Score — **Score 7B:** _____

0 Problem never or hardly ever occurs
1 Behavior occurred in the last year
2 Behavior occurred several times in the last six months
3 Behavior occurs multiple times per month
4 Behavior occurs multiple times per week
5 Behavior occurs multiple times per day

8. Social Emotional. This assesses the extent to which the youth effectively interacts with others. — **Score 8:** _____

0 This youth has appropriate peer relations. He/she has at least one identifiable close friend and good relations with other peers.

1 This youth has mild to moderate dysfunction in peer relations. This may include an absence of any close friend, conflictual relationships, or withdrawal from peers.

2 This youth has serious dysfunction in peer relationships. The child may be a 'loner' with few social contacts or may have very conflictual relationships with most peers.

3 This youth has very severe dysfunction in peer relationships. This would include violence towards peers or a complete absence of meaningful social contact or exclusive association with a highly deviant peer group (e.g., gang involvement).

Attachment 2 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

SECTION IV. Complicating Factors:

9. Destruction of Property. Youth attempts to destroy or actually destroys or steals property due to loss of self-control due to serious emotional disturbance.

A. Severity: **Score 9A:** _____

0 Not a problem
1 Behavior present slight problem of minor property destruction, vandalism or theft under $50
2 Behavior presents moderate problem of property destruction, vandalism, or theft under $250
3 Behavior presents a serious problem of property destruction, vandalism or theft under $500
4 Behaviors including fire setting or arson, which presents an extremely serious problem associated with felonies

B. Frequency: **Score 9B:** _____

0 Problem never or hardly ever occurs
1 Behavior occurred in the last year
2 Behavior occurred several times in the last six months
3 Behavior occurs multiple times per month
4 Behavior occurs multiple times per week
5 Behavior occurs multiple times per day

10. Running Away. Youth attempts to run away or actually runs away from required monitoring and supervision due to serious emotional disturbance.

A. Severity:

0 Not a problem **Score 10A:** _____
1 Youth has no recent history of running away but has expressed an ideation about escaping current situation or treatment.
2 Youth threatens to run away and may do so occasionally if not supervised. This behavior occurs primarily during the day and the youth returns on his/her own accord or is easily found.
3 Youth ran away from home or treatment setting overnight. The youth does not voluntarily return and is difficult to find.
4 Youth runs away overnight, does not voluntarily return, is difficult to find and is engaging in behavior that places the youth at significant risk, i.e. approaching strangers, hitch hiking, panhandling, etc.

B. Frequency: **Score 10B:** _____

0 Problem never or hardly ever occurs
1 Behavior occurred in the last year
2 Behavior occurred several times in the last six months
3 Behavior occurs multiple times per month
4 Behavior occurs multiple times per week
5 Behavior occurs multiple times per day

11. Disruptive to Others. Youth actively interferes with others activities or intentions due to loss of self-control related to a serious emotional disturbance.

A. Severity:

0 Not a problem **Score 11A:** _____
1 Behavior present slight problem
2 Behavior presents moderate problem
3 Behavior presents a serious problem
4 Behavior presents an extremely serious problem

B. Frequency: **Score 11B:** _____

0 Problem never or hardly ever occurs
1 Behavior occurred in the last year
2 Behavior occurred several times in the last six months
3 Behavior occurs multiple times per month
4 Behavior occurs multiple times per week
5 Behavior occurs multiple times per day

Attachment 2 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

SECTION IV. Complicating Factors:

12. Social Offensive Behavior / Hygiene. Youth engages in socially offensive behavior due to loss of self-control related to a serious emotional disturbance. This includes spitting at others, urinating in inappropriate places, smearing feces.

A. Severity: **Score 12A:** _____

0 Not a problem

1 Behavior present slight problem

2 Behavior presents moderate problem

3 Behavior presents a serious problem

4 Behavior presents an extremely serious problem

B. Frequency: **Score 12B:** _____

0 Problem never or hardly ever occurs
1 Behavior occurred in the last year
2 Behavior occurred several times in the last six months
3 Behavior occurs multiple times per month
4 Behavior occurs multiple times per week
5 Behavior occurs multiple times per day

13. Medically Intense Needs. Youth has biologically based medical needs that complicate psychiatric treatment. This includes the youth's compliance with treatment of the medical needs such as taking non psychotropic medication.

A. Severity: **Score 13A:** _____

0 Not a problem
1 Behavior present slight problem
2 Behavior presents moderate problem
3 Behavior presents a serious problem
4 Behavior presents an extremely serious problem

B. Frequency: **Score 13B:** _____

0 Problem never or hardly ever occurs
1 Behavior occurred in the last year
2 Behavior occurred several times in the last six months
3 Behavior occurs multiple times per month
4 Behavior occurs multiple times per week
5 Behavior occurs multiple times per day

14. Reasoning and Age: The youth's reasoning skills have not developed due to the youth's age which presents a moderate to serious complication to psychiatric treatment: **Score 14:** _____

0 youth is 16 to 21 years old

1 youth is 13 to 15 years old

2 youth is 10 to 12 years old

3 youth is under the age of 9

Attachment 2 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

SECTION V. Co-Morbidity:

15. Substance Abuse. Youth abuses prohibited substances including but not limited to: alcohol, illegal drugs, prescription drugs, etc.

A. Severity: — **Score 15A:** _____

0 Not a problem

1 Youth has mild substance use problems which are not related to addiction and present no problems of living for the youth.

2 Youth has moderate substance abuse problems which may be related to addiction and presents problems of living to the person including intoxication, loss of money, reduced school performance or parental concern.

3 Youth has serious substance abuse problems which may be related to addiction that both requires treatment and interacts with and exacerbates the psychiatric illness.

4 Youth has serious substance abuse problems which may be related to addiction that consistently interferes with the ability to function and requires a structured setting.

B. Frequency Score — **Score 15B:** _____

0 Problem never or hardly ever occurs
1 Behavior occurred in the last year
2 Behavior occurred several times in the last six months
3 Behavior occurs multiple times per month
4 Behavior occurs multiple times per week
5 Behavior occurs multiple times per day

16. Eating Disorder (Anorexia / Bulimia): — **Score 16:** _____

0 There is no evidence of an eating disorder.

1 This youth has mild to moderate problems associated with an eating disorder. This can include inappropriate dieting, fasting, or excessive exercise. This level is used to rate either a mild or sub-threshold level of symptoms associated with an eating disorder.

2 This youth has a moderate to serious problems associated with an eating disorder. This could include self induced vomiting, misuse of laxatives, diuretics, or enema's which occur at least weekly and is placing the youth at risk for serious self harm. The youth has a diagnosis of anorexia or bulimia regardless of severity.

3 This youth has very severe problems associated with an eating disorder. This could include self induced vomiting, misuse of laxatives, diuretics, or enema's which occur to an extent that serious harm (including death) is imminent. More severe forms of eating disorder diagnoses would be coded here (e.g., meeting criteria in excess of the diagnosis).

17. Cognitive Impairment: — **Score 17:** _____

0 This level indicates a child with no evidence of any mental retardation, developmental delay, or Traumatic Brain Injury

1 This level indicates a child with diagnosed developmental delay, or a traumatic brain injury that results in impaired cognitive functioning and presents mild complications to psychiatric treatment: Child's IQ is expected to be greater than 85.

2 This level indicates a child with developmental delay or a traumatic brain injury that results in impaired cognitive functioning and presents moderate complications to psychiatric treatment: Child's IQ would be expected to be between 70 and 85.

3 This level indicates a child with mental retardation or a traumatic brain injury that results in impaired cognitive functioning and presents significant complications to psychiatric treatment: Child's has an IQ of less than 70.

Proceed to Scoring
NEXT PAGE

Attachment 2 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

SECTION VI. Scoring:

Section II: Severity of Psychiatric Symptoms:

1	Neuropsychiatric Disturbance	Score 1:_____
2	Emotional Disorder	Score 2:_____
3	Conduct Disturbance	Score 3:_____
4	Impulsivity	Score 4:_____

Add Scores 1 through 4 for the Raw Score:

II. Raw Score: _____

Section III: Risk Factors:

5	Self Harming Behavior		
	A. Severity	Score A:_____	
	B. Frequency	Score B:_____	
	Total (5A + 5B = ____ X 3 = _____)		Score 5:_____
6	Aggression to Others:		
	A. Severity	Score A:_____	
	B. Frequency	Score B:_____	
	Total (6A + 6B = ____ X 2 = _____)		Score 6:_____
7	Sexual Aggression		
	A. Severity	Score A:_____	
	B. Frequency	Score B:_____	
	Total (7A + 7B = ____ X 2 = _____)		Score 7:_____
8	Social /Emotional		Score 8:_____

Add Scores 5 through 8 for the Raw Score:

III. Raw Score: _____

Section IV: Complicating Factors:

9	Destruction of Property:		
	A. Severity	Score A:_____	
	B. Frequency	Score B:_____	
	Total (9A + 9B = ____)		Score 9:_____
10	Running Away:		
	A. Severity	Score A:_____	
	B. Frequency	Score B:_____	
	Total (10A + 10B =____)		Score 10:____
11	Disruptive to Others:		
	A. Severity	Score A:_____	
	B. Frequency	Score B:_____	
	Total (11A + 11B = ____)		Score 11:_____
12	Social Offensive Behavior / Hygiene		
	A. Severity	Score A:_____	
	B. Frequency	Score B:_____	
	Total (12A + 12B = ____)		Score 12:_____
13	Medically Intense Needs:		
	A. Severity	Score A:_____	
	B. Frequency	Score B:_____	
	Total (13A + 13B = ____)		Score 13:_____
14	Reasoning and Age:		Score 14:_____

Add Scores 9 through 14 for the Raw Score:

Scoring Continued on Next Page

IV. Raw Score: _____

MAR - 7 2007

Attachment 2 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

SECTION VI. Scoring:

Section V: Co-Morbidity: 15 Substance Misuse / Abuse: A. Severity Score A:_____ B. Frequency Score B:_____ Total (15A + 15B = ____) Score 15:_____ 16 Eating Disorder: Score 16:_____ 17 Cognitive Impairment: Score 17:_____ **Add Scores 15 through 17 for the Raw Score:**	**V. Raw Score:** _____
Multiplying Factors and Total Score: 1. Take Risk Factors Raw Score times the Cognitive Impairment Score for the total Risk Factor Score III Raw Score ____ X Score 17 _____ = adjusted Raw III:_____ (if score 17 is a 0 or 1, skip the above and use the III Raw Score) 2. **Add Raw Scores II, IV and V to adjusted III from above for the total severity index score:** Raw II:_____ Raw IV:_____ Raw V:_____	**Total Score:** _____

ATTACHMENT 4.19-B

Methods and Standards for Establishing Payment Rates
--Other Types of Care

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

December 22, 1995

Mr. Richard P. Brummel
Health Care Financing Administration
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances to Kansas Medicaid payments for general hospital services. This assurance relates to MS-95-21 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253(b)(1)(i)
Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiency and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4.19A, Section 6.0000.

42 CFR 447.253(b)(1)(ii)(B)
Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

42 CFR 447.253(b)(1)(ii)(C)
The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

42 CFR 447.272(c)
Aggregate disproportionate share payments do not exceed the disproportionate share base allotment. Disproportionate share payments to ~~public facilities~~ 447 hospitals will not exceed the limits imposed by section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993).

Refers to MS-95-21

App FEB 27 1997

Social Security Act, Section 1902(a)(13)(B)
Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change of ownership which occurs on or after July 18, 1994, in excess of the amount that would be permitted under the provision of Section 1816(v)(2)(0) of the Act.

2. Upper Payment Limits

42 CFR 447.253(b)(2)
The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

The State assures that aggregate payments made to each group of State-operated facilities, when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles as required by 42 CFR 447.272(b)

3. Provider Appeals

42 CFR 447.253(e)
The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

4. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253(f) and (g)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

5. Public Notice

42 CFR 447.253(h)
The reimbursement methodology change for inpatient hospital services has met the public notice requirements by publication in the Kansas Register.

6. Rates Paid

42 CFR 447.253(i)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Refers to MS-95-21

App FEB 27 1997

7. Related Information

42 CFR 447.255
The average payment rate is expected to be $3,200 per discharge in FFY 1996. This is an increase about 1% from FFY 1995 primarily due to continued reductions in length of stay. Most hospitals received increases in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts, as well as the cost of Medicaid/MediKan services, over 95% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments. This is based on the best information available from the Medicare cost reports and Medicaid/MediKan paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

Janet Schalansky

Janet Schalansky
Deputy Secretary

JKS:AEK:mas

cc: Jim Nash

App [illegible]

Substitute per letter dated 11-7-95

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

November 9, 1995

Mr. Richard P. Brummel
Health Care Financing Administration
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances to Kansas Medicaid payments for general hospital services. This assurance relates to MS-94-19 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253(b)(1)(i)
Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiency and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4.19A, Section 6.0000.

42 CFR 447.253(b)(1)(ii)(B)
Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

42 CFR 447.253(b)(1)(ii)(C)
The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

42 CFR 447.272(c)
Aggregate disproportionate share payments do not exceed the disproportionate share base allotment. Disproportionate share payments to public facilities will not exceed the limits imposed by section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993).

Eff 7/1/94.

Approved FEB 15 1996

Social Security Act, Section 1902(a)(13)(B)
Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change of ownership which occurs on or after July 18, 1994, in excess of the amount that would be permitted under the provision of Section 1816(v)(2)(0) of the Act.

2. Upper Payment Limits

42 CFR 447.253(b)(2)
The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

The State assures that aggregate payments made to each group of State-operated facilities, when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles as required by 42 CFR 447.272(b)

3. Provider Appeals

42 CFR 447.253(e)
The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

4. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253(f) and (g)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

5. Public Notice

42 CFR 447.253(h)
The reimbursement methodology change for inpatient hospital services has met the public notice requirements by publication in the Kansas Register.

6. Rates Paid

42 CFR 447.253(i)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Refers to MS-94-19

Eff 7/1/94 App FEB 15 1996

Substitute per letter dated 11-9-95

7. Related Information

42 CFR 447.255
The average payment rate is expected to be $3,150 per discharge in FFY 1995. This is an increase of less than 1% from FFY 1994 primarily due to continued reductions in length of stay. All hospitals received increases in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts, as well as the cost of Medicaid/MediKan services, about 100% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments. This is based on the best information available from the Medicare cost reports and Medicaid/MediKan paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

Janet Schalansky

Janet Schalansky
Deputy Secretary

JKS:AEK:mas

cc: Jim Nash

Eff 7/1/94

App FEB 15 1996

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

December 27, 1994

Mr. Richard P. Brummel
Health Care Financing Administration
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances to Kansas Medicaid payments for general hospital services. This assurance relates to MS-94-25 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253(b)(1)(i)
Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiency and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4.19-A, Section 6.0000.

42 CFR 447.253(b)(1)(ii)(B)
Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

42 CFR 447.253(b)(1)(ii)(C)
The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

Social Security Act, Section 1902(a)(13)(B)
Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change in ownership which occurs on or after July 18, 1994, in excess of the amount that would be permitted under the provision of Section 1861(v)(1)(O) of the Act.

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

Refers to MS-94-25

2. Upper Payment Limits

42 CFR 447.253(b)(2)
The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

The State assures that aggregate payments made to each group of State-operated facilities, when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles as required by 42 CFR 447.272(b).

3. Disproportionate Share Limit

42 CFR 447.272(c)
The aggregate disproportionate share hospital payments do not exceed the disproportionate share base allotment. Disproportionate share payments to public facilities will not exceed the limits imposed by section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93).

4. Provider Appeals

42 CFR 447.253(e)
The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

5. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253(f) and (g)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

6. Public Notice

42 CFR 447.253(h)
The reimbursement methodology change for inpatient hospital services has met the public notice requirements by publication in the Kansas Register.

7. Rates Paid

42 CFR 447.253(i)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Refers to MS-94-25

8. Related Information

42 CFR 447.255
The average payment rate is expected to be $3,150 per discharge in FFY 1995. This is an increase of less that 1% from FFY 1994 primarily due to continued reductions in length of stay. All hospitals received increased in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts, as well as the cost of Medicaid/MediKan services, about 100% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments in FY 1995 to hospitals eligible for disproportionate share payments. This is based on the best information available from the Medicare cost reports and Medicaid/MediKan paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

Donna L. Whiteman

Donna L. Whiteman
Secretary

DLW:RLE:TAH:mas

cc: Carol Finkle

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

December 27, 1993

HHS
HCFA-MEDICAID
REGION VII
93 DEC 28 AM 10:58

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payments for general hospital services. This assurance relates to MS-93-26 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253 (b)(1)(i)
Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253 (b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4.19-A, Section 6.0000.

42 CFR 447.253 (b)(1)(ii)(B)
Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

Refers to MS-93-26.

42 CFR 447.253 (b)(1)(ii)(C)
The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

Social Security Act, Section 1902(a)(13)(B)
Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change in ownership which occurs on or after July 18, 1984, in excess of the amount that would be permitted under the provision of Section 18161(v)(2)(0) of the Act.

2. Upper Payment Limits

42 CFR 447.253 (b)(2)
The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

3. Provider Appeals

42 CFR 447.253 (c)
The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

4. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253 (d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

5. Public Notice

42 CFR 447.253 (f)
The reimbursement methodology change for inpatient hospital services has met the public notice requirements by publication in the Kansas Register.

Refers to MS-93-26.

6. Rates Paid

42 CFR 447.253 (g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

7. Related Information

42 CFR 447.255
The average payment rate is expected to be $3,100 per discharge in FFY 1994. This is an increase of less than 1% from FFY 1993 primarily due to continued reductions in length of stay. All hospitals received increased in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts, as well as the cost of Medicaid/MediKan services, about 100% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments in Fy 1994 to hospitals eligible for disproportionate share payments. This is based upon the best information available from the Medicare cost reports and Medicaid/MediKan paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

Donna L. Whiteman
Secretary

DLW:RLE:TAH:pm
cc: Steve Otto
Refers to MS-93-26.

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

August 4, 1992

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payments for general hospital services. This assurance relates to MS-91-37 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253 (b)(1)(i)
Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253 (b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4,19-A, Section 6.0000.

42 CFR 447.253 (b)(1)(ii)(B)
Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

42 CFR 447.253 (b)(1)(ii)(C)
The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

Social Security Act, Section 1902(a)(13)(B)
Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change in ownership which occurs on or after July 18, 1984, in excess of the amount that would be permitted under the provision of Section 18161(v)(2)(0) of the Act.

2. Upper Payment Limits

42 CFR 447.253 (b)(2)
The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

Refers to MS-91-37.

3. Provider Appeals

42 CFR 447.253 (c)

The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

4. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253 (d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

5. Public Notice

42 CFR 447.253 (f)
The reimbursement methodology change for inpatient hospital services has met the public notice requirements.

6. Rates Paid

42 CFR 447.253 (g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

7. Related Information

42 CFR 447.255
The average payment rate is expected to be $2,637 per discharge in FY 1992. This is a decrease of 5.9% from FY 1991, primarily due to the rebasing and recalibration of the DRG system. Despite this reduction, the majority of hospitals received increases in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts as well as the cost of Medicaid/MediKan services, about 104% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments in FY 1992 to hospitals eligible for disproportionate share payments. This is based upon the best information available from the Medicare cost reports and Medicaid paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

Donna L. Whiteman
Secretary

DLW:RLE:pm
cc: Steve Otto
Refers to MS-91-37.

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

August 12, 1992

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In response to your letter dated December 2, 1991, regarding disproportionate share hospital payment methodology (MS-91-29), Kansas submits the following additional information.

1. 42 CFR 447.250ff.

Kansas assures that capital related costs due solely to a change of ownership which occurs on or after July 18, 1984, will not increase payment rates to providers in excess of the amount that would be permitted under the provision of Section 1861 (v)(1)(O) of the Act.

2. 42 CFR 447.253 (b)(2)(1).

Kansas assures that payment rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal Laws, regulations, and quality and safety standards.

3. 42 CFR 447.253 (b)(1)(ii)(B).

Kansas assures that services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

4. 42 CFR 447.253 (b)(1)(ii)(C).

Kansas assures that payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

5. 42 CFR 447.253 (b)(2) and 447.272.

Kansas assures that payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

6. Public Notice and Related Information.

Amendment MS-91-29 changes the State Plan by specifically excluding outpatient and including MediKan. Public notice of these changes was given on August 15, 1991. Therefore, the effective date of this plan is August 16, 1991.

During the time when the State Plan was being prepared, it was noticed that several hospitals had not filled in the forms for FY 1990 and FY 1991 completely. In particular, they left off the contractual allowances figure. Other hospitals submitted this figure, and it had been used in accordance with the Plan for FY 1990 and FY 1991. Verification was made to insure that an appropriate figure was to be included for the contractual allowances based upon the cost reports submitted to Medicare. The disproportionate share determinations were recomputed for FY 1990 and FY 1991 using this updated information and this is in process of being submitted to HCFA. With these new computations, the amount of disproportionate share based on a per hospital basis is expected to decline from FY 1991 to FY 1992. The decline is approximately 20%. While this may still seem like a substantial change, all computations are updated each year, using new Medicaid payment levels, contractual allowances, etc. Any changes in the data at individual hospitals certainly affect the amount of the disproportionate payment, but there was no methodology change which affects either how eligibility is determined or how the payment amount is determined.

7. Short or Long Term Effect on the Availability of Services.

This plan submittal will not change the availability of services as the methodology for computing disproportionate share payments has not changed. Without disproportionate share payments, services to low income and indigent clients would be affected.

8. Type of Care Furnished.

This plan submitted will not change the type of care furnished as the methodology for computing disproportionate share payments has not changed.

9. Extent of Provider Participation.

Disproportionate share funds are critical for the continued existence of hospitals which serve the low income, as these funds offset the costs of clients who cannot pay for their care.

10. Degree to which costs are covered in Hospitals that serve a Disproportionate number of Low Income Patients with Special Needs.

It is estimated that the continuation of the same methodology will result in the aggregate payment of 100% of the costs of low income patients with special needs at those hospitals eligible for disproportionate share.

11. Disproportionate Share Hospitals Formula Questions.

Federal law allows for variations in methodology, provided that at least all hospitals which meet the law requirements will also meet the State methodology. Kansas has made three adjustments to the specific formula in the law which continue to meet the law requirements. These changes are:

1. The exclusion of outpatient. By itself, this tends to reduce the likelihood of eligibility for any one hospital.

2. The inclusion of the MediKan program in addition to Medicaid. This was done as a better proxy (in addition to Medicaid) to identify which hospitals serve low income patients. By itself, this tends to increase the likelihood of eligibility for any one hospital.

3. The adjustment for contractual allowances in the formula. This adjustment was also made to identify which hospitals serve low income patients. By itself, this tends to increase the likelihood of eligibility for any one hospital.

Based upon a review of available data, the adjustments we have made would always result in our compliance with the law. In any case where there was any reduction due to the exclusion of the outpatient area, there is at least an equivalent increase due to the inclusion of MediKan and the contractual allowances adjustment. This question only affects the eligibility of hospitals and we are certain that out methodology does not result in any hospital being ineligible due to the changes which we have made.

Because of the above, we do not propose any changes in the formula such as you suggest. If the suggestions you made were included, and the other adjustments which we have made were retained, it would increase the amount of the payments which would be made for disproportionate share.

It is hoped that this additional information will expedite the approval of MS-91-29. Any further questions may be directed to Tina Hayes at 296-3981.

Sincerely,

Donna L. Whiteman
Secretary

DLW:RLE:JCS:TAH:pm

Attachment

cc: Steve Otto

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

JOAN FINNEY, *Governor*

January 14, 1992

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payments for general hospital services. This assurance relates to MS-92-03 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253 (b)(1)(i)
Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253 (b)(1)(ii)(A)
The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4.19-A, Section 6.0000.

42 CFR 447.253 (b)(1)(ii)(B)
Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

42 CFR 447.253 (b)(1)(ii)(C)
The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

Social Security Act, Section 1902(a)(13)(B)
Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change in ownership which occurs on or after July 18, 1984, in excess of the amount that would be permitted under the provision of Section 18161(v)(2)(0) of the Act.

2. Upper Payment Limits

42 CFR 447.253 (b)(2)
The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

Refers to MS-92-03.

State Plan TN#_____ Effective Date 01/01/92

Supersedes TN#_____ Approval Date 08/07/92

3. Provider Appeals

42 CFR 447.253 (c)

The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

4. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253 (d) and (e)
Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

5. Public Notice

42 CFR 447.253 (f)
The reimbursement methodology change for inpatient hospital services has met the public notice requirements.

6. Rates Paid

42 CFR 447.253 (g)
The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

7. Related Information

42 CFR 447.255
The average payment rate is expected to be $2,637 per discharge in FY 1992. This is a decrease of 5.9% from FY 1991, primarily due to the rebasing and recalibration of the DRG system. Despite this reduction, the majority of hospitals received increases in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts as well as the cost of Medicaid/MediKan services, about 104% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments in FY 1992 to hospitals eligible for disproportionate share payments. This is based upon the best information available from the Medicare cost reports and Medicaid paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability of services on a statewide and geographic area basis;

2. To maintain the type of care furnished;

3. To maintain the extent of provider participation; and

4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

Benna L. Whiteman
Secretary

DLW:RLE:brj

Refers to MS-92-03.

State Plan TN# _____ Effective Date 01/01/92

Supersedes TN# _____ Approval Date 08/07/92

Substitute per letter dated 08/14/91

KANSAS MEDICAID STATE PLAN

Attachment 4.19-B
#1
Replacement Page
Dated 08-15-91

Outpatient Hospital Services
Methods and Standards for Establishing Payment Rates

Payments to general and special hospitals for outpatient hospital services are based on the reimbursement methodologies for comparable services rendered by non-hospital providers.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

Effective January 1, 2001, rural health clinics enrolled in the Kansas Medicaid Program shall be reimbursed for covered services furnished to eligible beneficiaries under a prospective payment system (PPS) in accordance with the requirements of section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. An alternative payment system that assures the amount determined under the Medicaid PPS mandated by BIPA as minimum reimbursement, will also be available to providers at their option. A RHC will be reimbursed using the alternative methodology only if the provider agrees to it. Under both options, reimbursement for services covered by Medicare shall be made through an all-inclusive encounter rate determined by the Medicare intermediary for each qualified encounter.

When a rural health clinic furnishes "other ambulatory services", the Kansas Medicaid Program shall reimburse the provider using the methodologies utilized in paying for same services in other settings, provided all the requirements under the state plan are met. "Other ambulatory services" are those services which do not meet the Medicare definition of rural health clinic services, but are covered under the Medicaid state plan.

I. ENCOUNTER BILLING

A. Billable Visit or Encounter

A rural health clinic "visit" means a face-to-face encounter between a clinic patient and a clinic health care professional including a physician, physician assistant (PA), advanced registered nurse practitioner (ARNP), nurse-midwife, clinical psychologist, clinical social worker, and for Kan-Be-Healthy nursing assessments only, registered nurse. This may also include a visiting nurse provided all the conditions listed in I(D)(4) are fulfilled. Encounters with more than one certified health care professional or multiple encounters with the same health professional on the same day shall constitute a single visit.

B. More Than One Encounter on the Same Day

If the patient suffers illness or injury subsequent to the first visit on the same day, requiring additional diagnosis and treatment which are different from the first visit, the second encounter will qualify as an additional RHC visit.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

C. Health Care Professional Requirements

For services to be covered, the practitioner should either be an employee or an owner of the rural health clinic. A physician under contractual arrangement to receive compensation from the RHC also qualifies. The RN that performs KBH nursing assessments must be an employee of the RHC.

D. Place of Service Criteria

1. **Services at the Clinic:** Covered services provided at the clinic facility by practitioners defined in I(A) & I(B), excluding visiting nurse, may be billed as RHC visits. Services performed in the clinic are payable only to the clinic. Practitioners may not bill for these services under any other Medicaid provider number.
2. **Services Away from the Clinic:** Covered services provided at the patient's place of residence or elsewhere (e.g., at the scene of an accident) by an RHC practitioners excluding visiting nurse may be billed as a visit only if the practitioner is employed or compensated under agreement by the clinic for furnishing services to clinic patients in a location other than the clinic facility. These services are payable only to the RHC. The practitioner may not bill Medicaid for these services under any other provider number. If, on the other hand, the practitioner is NOT compensated by the RHC for provision of services in a location away from the clinic facility, services provided away from the clinic shall not constitute RHC services and the practitioner may bill Medicaid under a professional provider number. However, if these services are furnished during a time period for which he/she is compensated by the RHC, the clinic is required to carve out all expenditure associated with those services on the cost report.
3. **Services in a Hospital:** Services provided by a clinic practitioner in outpatient, inpatient, or emergency room of a hospital or swing-bed do not constitute RHC services under the Kansas Medicaid Program. These services may be billed under the practitioner's professional Medicaid provider number. However, if these services are provided by a clinic practitioner during time period for which he/she is compensated by the RHC, the clinic must carve out all expenditure associated with these services on the cost report.
4. **Visiting Nurse Services:** Part time or intermittent nursing care provided in a patient's place of residence may be billed as an encounter only if each of the following requirements is fulfilled:

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

(i) The RHC is located in an area designated by the Secretary of Health and Human Services as an area with a shortage of home health agencies;
(ii) the services are rendered to a homebound patient who is confined, either temporarily or permanently, to his or her place of residence as a result of a medical or health condition;
(iii) the "place of residence" may be a private home, a home for the aged, or other type of institution as long as it is NOT a hospital, long term facility, or skilled nursing facility (SNF) which is required to provide nursing care, rehabilitation, and other related services to inpatients as a condition for participation in Medicare & Medicaid SNF programs;
(iv) the services are furnished by a registered nurse (RN) or a licensed practical nurse (LPN) who is employed by or receives compensation from the RHC for providing these services;
(v) the services are furnished under a written plan of treatment established by a supervising physician, ARNP, or PA of the clinic. The treatment plan is:
- reviewed at least every 60 days by a supervising physician, and
- signed by a supervising physician, ARNP, or PA of the clinic;

(vi) the services consist of:
- nursing care that must be performed by an RN or LPN to assure the safety of the patient and to achieve the medically desired results; and
- personal care services to the extent covered under home health services. This does not include household & housekeeping services.

E. Content-of-Service

Content-of-service is a service or supply which does not constitute a billable encounter by itself, but its cost is included in the encounter rate. These should neither be billed as RHC encounter nor as a service under any other Medicaid provider number. Examples of services that are content-of-service:

1. Services furnished by the auxiliary health care staff employed by the clinic that are "incident to" the services provided by the certified health care professionals.
2. Administration of vaccine, immunization, or other injection.
3. Professional component of Radiology or EKG if performed by a clinic health care professional.
4. Drugs and biologicals which cannot be self-administered.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

F. Exclusions

Services & supplies, both direct and indirect, not related to patient care and not reasonable & necessary for the efficient delivery of health care services for diagnosis & treatment of clinic patients are not covered. These should neither be billed as RHC visits nor reported on the cost report as allowable RHC expenditure. In addition, the following are not covered as RHC benefit:

1. All services furnished by the auxiliary health care staff who are not employed by the clinic.
2. Services provided by the RHC's auxiliary health care employees without direct supervision of a clinic practitioner.
3. Technical components of Radiology and EKG.
4. Clinic diagnostic laboratory services including the six required lab tests for RHC certification.
5. Health care services performed by outside entities, including those entities which are owned by the clinic's owner or staff. These include but are not limited to Lab, Radiology, EKG, pharmacy, PT, and psychotherapy. The state plan requires that providers of these services bill Medicaid directly.

II. REIMBURSEMENT METHODS

Effective January 1, 2001, the Kansas Medicaid Program implemented the prospective payment system (PPS for rural health clinics to conform with BIPA 2000). There are no retroactive cost settlements under this system. As an alternative to the PPS, providers will be offered the opportunity for reimbursement under a modified cost-based system (CBS) on facility fiscal year basis. This methodology combines features of a cost-based system with the PPS payment level mandated by BIPA. Under this system, RHCs are paid the great of cost-based or PPS-based reimbursement through retroactive settlements. To receive reimbursement under the alternative system on a fiscal year basis, providers are required to submit a written request according to the schedule outlined in II.B.

This written request is only necessary once. By written request, providers may at any time change their choice of reimbursement methods in accordance with the schedule provided in II.B.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

A. **Definitions**

1. **Rate** - Payment for each qualified encounter or visit.
2. **Base Years or FY 1 & FY 2 - Current Providers** - Facility fiscal years 1999 and 2000.
3. **Base Years or FY 1 & FY 2 - New Providers** - Two facility fiscal years subsequent to the first year of business as a rural health clinic.
4. **Cost-Based Rate or Payment** - Based on the Medicare cost report.
5. **Baseline Rate** - Average of cost-based rates from the base years.
6. **MEI** - Percentage increase in the Medicare Economic Index for primary care services.
7. **PPS Rate or Payment** - Meets PPS requirements outlined in the BIPA 2000.
8. **Non-PPS Rate or Payment** - Does not meet BIPA requirements.
9. **Preliminary** - Derives from the Medicare cost report for only one base year.
10. **Final or Finalized** - Derived from Medicare cost reports for both base years.

B. **Criteria for Election of the Alternative Payment Option**

1. **For Facility Fiscal Years Beginning Prior to October 1, 2001** - The request must be received in our office no later than July 27, 2001 or as decided by the state at a later time
2. **For Facility Fiscal Years Beginning On or After October 1, 2001** - The request should be received in our office no later than forty five (45) days prior to the beginning of the facility fiscal year.
3. **No Request Received** - If no request for the alternative payment option is received timely for a facility fiscal year, the provider will be reimbursed under the PPS for that entire fiscal year with no settlement.

C. **Cost Reports**

RHC providers shall not be required to submit cost reports to Medicaid. The agency will use finalized cost reports received from Medicare intermediaries.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

III. PROSPECTIVE PAYMENT SYSTEM (PPS)

Under this methodology, rural health clinics shall be paid prospective rates based on an average of the reasonable costs of providing covered RHC services during the base years, with no retroactive settlement.

A. Determination of PPS Baseline Rate

1. **Methodology** - It will depend on the times frames covered by an availability of cost reports as follows:
   (i) Both Base Years Full Twelve-Month Periods: (FY 1 Cost-Based Rate + FY 2 Cost-Based Rate) /2.
   (ii) One or Both Base Years Less Than Twelve-Month Periods: [(FY 1 Cost-Based Rate x No. of Mo.)+(FY 2 Cost-Based Rate x No. of Mo.)] / Total No. of Months
   (iii) Only One Base Year Cost Report Available: Cost-based rate derived from the available cost report.
   (iv) No Base Year Cost Report Available: The lower of current rate (eff. On 12/31/2000) or average of baseline rates of other RHCs in the same Metropolitan Statistical Area (MSA) as defined by Department of Commerce.

2. **Frequency** - Once if the "final" rate is available at the time of initial rate setting, otherwise twice:
   (i) Initial Baseline Rate: After the approval of the SPA (for current providers) or at the time of enrollment (for new providers). This rate can be "preliminary" or "final" depending on the availability of cost reports.
   (ii) Final Baseline Rate: When Medicare cost reports for both base years become available.

B. Payment Procedure for January 1, 2001 to September 30, 2001

1. Prior to approval of this state plan, Medicaid has continued to pay interim rates effective 12/31/2000.
2. Upon SPA approval, initial PPS baseline rates will be computed using Medicare cost reports for facility fiscal years 1999 and 2000 received in our office before July 1, 2001.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

3. Interim payments will be reconciled to the initial baseline rates retroactive to January 1, 2001.
4. In cases where the initial baseline rate is "preliminary", interim payments will again be retroactively reconciled to the "final" baseline rate when it becomes available.

C. **Payment Procedure for October 1, 2001 to September 30, 2002**

1. PPS baseline rates effective on September 30, 2001 times the MEI index will be set as payment rates.
2. In cases where the baseline rate is preliminary", when the "final" baseline rate becomes available it will be adjust by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payment will be retroactively reconciled to the finalized rate.

D.

1. The PPS rates effective on the previous day (9/30 of the same year) shall be adjusted by the MEI index.
2. In cases where the baseline rate used for this rate setting is "preliminary", when the "final" baseline rate becomes available it will be adjusted by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.

E. **Baseline Rate for New Providers**

1. **If Historic Cost Reports Are Available:** If the facility is an established RHC, cost-based rates from Medicare cost reports from the two most recent fiscal years will be used to determine the initial PPS baseline rate. If it is available only from one fiscal year, that will be used for rate setting, provided it is at least a twelve-month period. Data covering the first year of business as a RHC will be excluded.
2. **If No Historic Cost Reports Are Available:** The payment rate shall be the average of the rates paid to other RHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

F. **Adjustment for Laboratory**

Effective July 1, 2002, clinical diagnostic lab services furnished by a clinic are no longer within the scope of RHC services under the Kansas Medicaid Program. A RHC that provides this service will be reimbursed on fee-for-service basis. Medicare implemented this change effective January 1, 2001. SRS will retroactively adjust PPS rates effective 7/1/02 to exclude all expenses associated with laboratory services after receiving relevant data that facilitates identification of these expenditures.

G. **Change in Scope of Services**

To receive a PPS rate adjusted for a proposed increase or decrease in the scope of covered RHC services in a future fiscal year as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. At a minimum, this shall include a description of the change, budgeted expenditures, and change in total number of visits. Any rate change would be implemented on the first of the month following the SRS decision.

IV. ALTERNATIVE PAYMENT METHODOLOGY - "MODIFIED COST-BASED SYSTEM" (CBS)

Under this reimbursement system, interim payments shall be reconciled to the higher of cost-based or PPS-based amount through fiscal year end retroactive cost settlements.

A. **Payment Rates Effective January 1, 2001 to September 30, 2001**

Prior to CMS approval of this state plan amendment, Medicaid has continued to pay rates that were effective on December 31, 2000. These will be changed to PPS baseline rates when they are computed (see III.B.2).

B. **Payment Rates Effective October 1, 2001 to September 30, 2002**

Baseline rates effective on September 30, 2001 times the MEI index.

C. **Payment Rates Effective Each October 1 After September 30, 2002**

The PPS rates effective on the previous day (September 30 of the same year) adjusted for the MEI index.

Methods & Standards for Establishing Payment Rates

Rural Health Clinics

D. Retroactive Cost Settlement

1. **Cost-Based Medicaid Cost:** It is total reasonable cost of covered services furnished to eligible Program beneficiaries during the facility fiscal year. It will be determined by applying the cost-based rate from the Medicare cost report to total covered Medicaid visits obtained from the fiscal agent records.
2. **PPS-Based Medicaid Cost:** It is the amount that the provider would have received for covered services furnished to eligible Program beneficiaries during the facility fiscal year under the PPS option. It will be determined by applying the PPS rate(s) to total covered Medicaid visits.
3. **Total Payment Received by Provider:** It consists of Medicaid payment and third party liability payments obtained from fiscal agent records; and any other related transaction.
4. **Overpayment or (Underpayment):** The greater of cost-based or PPS-based Medicaid cost minus total payment received by the provider will be the settlement paid to or (due from) the provider.

V. SERVICES FURNISHED UNDER CONTRACT WITH MANAGED CARE ENTITY (MCE)

If a RHC elects the alternative reimbursement option for a fiscal year, it will be eligible for a settlement on covered services provided to eligible Medicaid beneficiaries during that time period under a contract with a Medicaid managed care entity (MCE). The settlement will consist of the difference between the amount paid to the RHC by the MCE and the amount that would have been paid by Medicaid under the alternative methodology, Modified CBS, for the elected fiscal year.

A. Quarterly Supplemental Payments

The RHC shall send copies of the remittance advices received from the MCE to Medicaid after the end of each calendar quarter. Without these, the agency will not be able to make the supplemental payments. The remittances will be reviewed and the procedure-based payment data will be converted to "RHC encounters", making corrections if necessary (e.g., a payment not meeting the encounter definitions). The

state will compute "quarterly alternative amount" by applying the provider's Medicaid interim rate under the alternative system for the corresponding time period to total encounters. If it is less than the MCE payment, the agency will send the difference to the RHC no more than 90 days from the receipt of the remittance advices.

B. Fiscal Year End Settlement

When a fiscal year end final cost settlement is determined for Medicaid payments as described in section IV (Modified CBS), the state will also make a final settlement on services provided under the MCE contract during that FY. An "yearly alternative amount" will be computed using total encounters [obtained from the supplemental payment data] and the alternative system methodology. This amount will be compared with total payments received by the provider, i.e., MCE payments plus quarterly supplemental payments. If the computed alternative amount for the FY is higher than total payments, Medicaid shall pay the difference to the provider. If, on the other hand, the alternative amount is lower than total payments, the RHC shall refund the overpayment to the agency.

Methods & Standards for Establishing Payment Rates

Federally Qualified Health Centers

Effective January 1, 2001, Federally qualified health centers enrolled in the Kansas Medicaid Program shall be reimbursed for covered services furnished to eligible beneficiaries under a prospective payment system (PPS) in accordance with the requirements of section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. An alternative payment system that assures the amount determined under the Medicaid PPS mandated by BIPA as minimum reimbursement, will also be available to providers at their option. An FQHC shall be reimbursed using the alternative methodology only if the provider agrees to it. Under both options, reimbursement for services covered by Medicare plus dental services shall be made through an all-inclusive encounter rate determined by the agency for each qualified visit.

When a federally qualified health center furnishes "other ambulatory services" excluding dental services, the Kansas Medicaid Program shall reimburse the provider using the methodologies utilized in paying for same services in other settings, provided all requirements under the state plan are met. "Other ambulatory services" are those which do not meet the Medicare definition of federally qualified health center services, but are covered under the Medicaid state plan.

I. ENCOUNTER BILLING

The federally qualified health center program under the Kansas Medicaid Program complies with scope, definitions, criteria, and basis of payment for FQHC services under Medicare set forth in 42 CFR Part 405.2411 and 405.2446 through 405.2452, and Publication 27.

A. Billable Visit or Encounter

A federally qualified health center "visit" means a face-to-face encounter between a center patient and a center health care professional including a physician, physician assistant (PA), advanced registered nurse practitioner (ARNP), nurse-midwife, dentist, clinical psychologist, clinical social worker, and for Kan-Be-Healthy nursing assessments only, registered nurse. This may also include a visiting nurse provided all the conditions listed in I(D)(4) are fulfilled. Encounters with more than one certified health professional or multiple encounters with the same practitioner on the same day shall constitute a single visit.

B. More Than One Encounter on the Same Day

If the patient suffers illness or injury subsequent to the first visit on the same day, requiring additional diagnosis and treatment which are different from the first visit, the second encounter will qualify as an additional FQHC visit.

Methods & Standards for Establishing Payment Rates

Federally Qualified Health Centers

C. Health Care Professional Requirements

For services to be covered, the practitioner should be employed by, under arrangement to receive compensation from, or an owner of the FQHC. The RN that performs KBH nursing assessments must be an employee of the FQHC.

D. Place of Service Criteria

1. **Services at the Center:** Covered services provided at the center facility by practitioners defined in I(A) & I(B), excluding visiting nurse, may be billed as FQHC visits. Services performed in the center are payable only to the center. Practitioners may not bill for these services under any other Medicaid provider number.
2. **Services Away from the Center:** Covered services provided at the patient's place of residence or elsewhere (e.g., at the scene of an accident) by an FQHC practitioner excluding visiting nurse may be billed as a visit only if the practitioner is employed or in a location other than the center facility. These services are payable only to the center. The practitioner may not bill Medicaid for these services under any other provider number. If, on the other hand, the practitioner is NOT compensated by the FQHC for provision of services in a location away from the center facility, services provided away from the center shall not constitute FQHC services and the practitioner may bill Medicaid under a professional provider number. However, if these services are furnished during a time period for which he/she is compensated by the FQHC, the center is required to carve out all expenditure associated with these services on the cost report.
3. **Services in a Hospital:** Services provided by a center practitioner in outpatient, inpatient, or emergency room of a hospital or swing-bed do not constitute FQHC services under the Kansas Medicaid Program. These services may be billed under the practitioner's professional Medicaid provider number. However, if these services are provided by a center practitioner during a time period for which he/she is compensated by the FQHC, the center must carve out all expenditure associated with these services on the cost report.
4. **Visiting Nurse Services:** Part time or intermittent nursing care provided in a patient's place of residence may be billed as an encounter only if each of the following requirements is fulfilled:

   (i) The FQHC is located in an area designated by the Secretary of Health and Human Services as an area with a shortage of home health agencies;

(ii) the services are rendered to a homebound patient who is confined, either temporarily or permanently, to his or her place of resident as a result of a medical or health condition;

(iii) the "place of resident" may be a private home, a home for the aged, or other type of institution as long as it is NOT a hospital, long term facility, or skilled nursing facility (SNF) which is required to provide nursing care, rehabilitation, and other related services to inpatients as a condition for participation in Medicare & Medicaid SNF programs;

(iv) the services are furnished by a registered nurse (RN) or licensed practical nurse (LPN) who is employed by or receives compensation for providing these services from the FQHC;

(v) the services are furnished under a written plan of treatment established by a supervising physician, ARNP, or PA of the center which is
- reviewed at least every 60 days by a supervising physician, and
- signed by a supervising physician, ARNP, or PA of the center;

(vi) the services consist of:
- nursing care that must be performed by an RN or LPN to assure the safety of the patient and to achieve the medically desired results; and
- personal care services to the extent covered under home health services. This does not include household and housekeeping services.

E. Content-of-Service

Content-of-service is a service or supply which does not constitute a billable encounter by itself, but its cost is included in the encounter rate. These should neither be billed as an FQHC encounter nor as a service under any other Medicaid provider number. Examples of services that are content-of-service:

1. Services furnished by the auxiliary health care staff employed by the center that are "incident to" the services provided by the certified health care professionals.
2. Administration of vaccine, immunization, or other injection.
3. Professional component of Radiology or EKG if performed by a center health care professional.
4. Drugs and biologicals which cannot be self-administered.

F. Exclusions

Services & supplies, both direct and indirect, not related to patient care and not reasonable & necessary for the efficient delivery of health care services for diagnosis &

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Federally Qualified Health Centers

treatment of center patients are not covered. These should neither be billed as FQHC visits nor reported on the cost report as allowable FQHC expenditure. In addition, the following are not covered as FQHC benefit:

1. All services furnished by the auxiliary health care staff who are not employed by the center.
2. Services provided by the FQHC's auxiliary health care employees without direct supervision of a center practitioner.
3. Technical components of Radiology and EKG.
4. Clinical diagnostic laboratory services.
5. Health care services **performed by** outside entities, including those entities which are owned by the center's owner(s) or staff. These include but are not limited to Lab, Radiology, EKG, Pharmacy, PT, and psychotherapy. The State Plan requires that providers of these services bill Medicaid directly.

II. REIMBURSEMENT METHODS

Effective January 1, 2001, the Kansas Medicaid Program implemented the prospective payment system (PPS) for federally qualified health centers to conform with BIPA 2000. There are no retroactive cost settlements under this system. As an alternative to the PPS, providers are offered the opportunity for reimbursement under a modified cost-based system (CBS) on facility fiscal year basis. This methodology combines features of a cost-based system with the PPS payment level mandated by BIPA. Under this system, FQHCs are paid the greater of cost-based or PPS-based reimbursement through retroactive settlements. To receive reimbursement under the alternative system on a fiscal year basis, providers are required to submit a written request according to the scheduled outlined in II.B.

This written request is only necessary once. By written request, providers may at any time change their choice of reimbursement methods in accordance with the schedule provided in II.B.

A. Definitions

1. **Rate** – Payment for each qualified encounter or visit.
2. **Base Years or FY 1 & FY 2 – Current Providers** – Facility fiscal years 1999 and 2000.
3. **Base Years or FY 1 & FY 2 – New Providers** – Two facility fiscal years subsequent to the first year of business as a federally qualified health center
4. **Cost-Based Rate or Payment** – Based on reasonable cost of covered services.

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5. **Baseline Rate** - Average of cost-based rates from the base years.
6. **MEI** - Percentage increase in the Medicare Economic Index for primary care services.
7. **PPS Rate or Payment** - Meets PPS requirements outlined in the BIPA 2000.
8. **Non-PPS Rate or Payment** - Does not meet BIPA requirements.
9. **Preliminary** - Derived from unaudited cost report(s) or from only one base year.
10. **Final or Finalized** - Derived from Medicare cost reports for both base years.

B. Criteria for Election of the Alternative Payment Option

1. **For Facility Fiscal Years Beginning Prior to October 1, 2001** - The request must be received in our office no later than July 27, 2001 or as decided by the state at a later time
2. **For Facility Fiscal Years Beginning On or After October 1, 2001** - The request should be received in our office no later than forty five (45) days prior to the beginning of the facility fiscal year.
3. **No Request Received** - If no request for the alternative payment option is received timely for a facility fiscal year, the provider will be reimbursed under the PPS for that entire fiscal year with no settlement.

C. Cost Reports

Each provider shall be required to submit a federally qualified health center cost report on facility fiscal year basis using the most recent version of Form HCFA-222-92 (Rev. July 1994) within five (5) months after the fiscal year end. Non-reimbursable costs shall be reported in the appropriate sections of the cost report and shall not be co-mingled with allowable costs. All space, equipment, personnel and other expenses associated with laboratory services shall be separated from allowable FQHC expenses, and reported as a separate cost center in the non-FQHC or non-reimbursable section.

The cost report should be supplemented by a detailed trial balance which includes cost report line numbers for cross-checking, independent auditor's report & management letter, an itemized list of revenue including source & purpose, and any additional information necessary to facilitate reconciliation of reported expenditures with the trial balance and financial statements. Support for all information must be available for review.

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Federally Qualified Health Centers

D. Determination of Cost-Based Rate

1. **Total Reasonable Cost:** Total allowable cost of FQHC core services and dental services, after overhead allocation and revenue offsets, as described in section V.
2. **Adjusted Total Visits:** Actual visits shall be adjusted by applying a minimum productivity standard of 4,200 hours for Physicians and 2,100 hours for PA, ARNP, and Dentist.
3. **Cost-based Encounter Rate:** Total reasonable cost divided by adjusted total visits.

III. PROSPECTIVE PAYMENT SYSTEM (PPS)

Under this methodology, FQHCs shall be paid prospective rates based on an average of the reasonable costs of providing covered FQHC services during the base years, with no retroactive settlement.

A. Determination of PPS Baseline Rate

1. **Methodology** - It will depend on the time frames covered by an availability of cost reports as follows:
   (i) Both Base Years Full Twelve-Month Periods:
   (FY 1 Cost-Based Rate + FY 2 Cost-Based Rate) /2.
   (ii) One or Both Base Years Less Than Twelve-Month Periods:
   [(FY 1 Cost-Based Rate x No. of Mo.)+(FY 2 Cost-Based Rate x No. of Mo.)] / Total No. of Months
   (iii) Only One Base Year Cost Report Available: Cost-based rate derived from the available cost report.
   (iv) No Base Year Cost Report Available: The lower of current rate (eff. On 12/31/2000) or average of baseline rates of other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by Department of Commerce. The rates will be adjusted for dental services (not provided by all FQHCs).
2. **Frequency** - Once if *audited* cost reports from *both* base years are available at the time of initial rate setting, otherwise twice:
   (i) Initial Baseline Rate: After the approval of the state plan amendment (for current providers) or at the time of enrollment (for new providers). Initial rate can be preliminary or finalized.
   (ii) Final Baseline Rate: When audited cost reports for both base years become available.

Methods & Standards for Establishing Payment Rates

Federally Qualified Health Centers

B. Payment Procedure for January 1, 2001 to September 30, 2001

1. Prior to approval of this state plan, Medicaid has continued to pay interim rates effective 12/31/2000.
2. Upon SPA approval, initial PPS baseline rates will be computed using Medicare cost reports for facility fiscal years 1999 and 2000 received in our office before July 1, 2001.
3. Interim payments will be reconciled to the initial baseline rates retroactive to January 1, 2001.
4. In cases where the initial baseline rate is "preliminary", interim payments will again be retroactively reconciled to the "final" baseline rate when it becomes available.

C. Payment Procedure for October 1, 2001 to September 30, 2002

1. PPS baseline rates effective on September 30, 2001 times the MEI index will be set as payment rates.
2. In cases where the baseline rate is "preliminary", when the "final" baseline rate becomes available it will be adjusted by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.

D. Payment Rate Effective Each October 1 After September 30, 2002

1. The PPS rates effective on the previous day (9/30 of the same year) shall be adjusted by the MEI index.
2. In cases where the baseline rate used for this rate setting is "preliminary", when the "final" baseline rate becomes available it will be adjusted by MEI index to yield a finalized PPS rate. The payment rate will be updated and interim payments will be retroactively reconciled to the finalized rate.

E. Baseline Rate for New Providers

1. **If Historic Cost Reports Are Available:** If the facility is an established FQHC, cost-based rates from Medicare cost reports from the two most recent fiscal years will be used to determine the initial PPS baseline rate. If it is available only from one fiscal year, that will be used for rate setting, provided it is at least a twelve-month period. Data covering the first year of business as a FQHC will be excluded.
2. **If No Historic Cost Reports Are Available:** The payment rate shall be the average of the rates paid to other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce.

Methods & Standards for Establishing Payment Rates

Federally Qualified Health Centers

3. **If Neither Historic Nor Budgeted Data Available:** If neither is available, the payment rate shall be the average of the rates paid to other FQHCs in the same Metropolitan Statistical Area (MSA) as defined by the Department of Commerce, with an adjustment for dental services since they are not provided by all FQHCs.

F. **Adjustment for Laboratory**

Effective July 1, 2002, clinical diagnostic lab services furnished by a center are no longer within the scope of FQHC services under the Kansas Medicaid Program. A FQHC that provides this service will be reimbursed on fee-for-service basis. Medicare implemented this change effective January 1, 2001. SRS will retroactively adjust PPS rates effective 7/1/02 to exclude all expenses associated with laboratory services after receiving relevant data that facilitates identification of these expenditures.

G. **Change in Scope of Services**

To receive a PPS rate adjusted for a proposed increase or decrease in the scope of covered FQHC & dental services in a future fiscal year as compared to the current year, a provider shall be required to submit a proposal which should include enough information to facilitate an evaluation of the proposed change and its effect on the rate. At a minimum, this shall include a description of the change, budgeted expenditure, and change in total number of visits. Any rate change would be implemented on the first of the month following the SRS decision.

IV. ALTERNATIVE METHODOLOGY - "MODIFIED COST-BASED SYSTEM" (CBS)

Under this reimbursement system, interim payments shall be reconciled to the higher of cost-based or P.P.S.-based amount through fiscal year end retroactive cost settlements.

A. **Payment Rates Effective January 1, 2001 to September 30, 2001**

Prior to CMS approval of this state plan amendment, Medicaid has continued to pay rates that were effective on December 31, 2000. These will be changed to PPS baseline rates when they are computed (see III.B.2).

B. **Payment Rates Effective October 1, 2001 to September 30, 2002**

Baseline rates effective on September 30, 2001 times the MEI index.

Methods & Standards for Establishing Payment Rates

Federally Qualified Health Centers

C. Payment Rates Effective Each October 1 After September 30, 2002
The PPS rates effective on the previous day (September 30 of the same year) adjusted for the MEI index.

D. Retroactive Cost Settlement

1. **Cost-Based Medicaid Cost:** It is total reasonable cost of covered services furnished to eligible Program beneficiaries during the facility fiscal year. It will be determined by applying the cost-based rate determined from the cost report to total covered Medicaid visits obtained from the fiscal agent records.
2. **PPS-Based Medicaid Cost:** It is the amount that the provider would have received for covered services furnished to eligible Program beneficiaries during the facility fiscal year under the PPS option. It will be determined by applying the PPS rate(s) to total covered Medicaid visits.
3. **Total Payment Received by Provider:** It consists of Medicaid payment and third party liability payments obtained from fiscal agent records; and any other related transaction.
4. **Overpayment or (Underpayment):** The greater of cost-based or PPS-based Medicaid cost minus total payment received by the provider will be the settlement paid to or (due from) the provider.

V. DETERMINATION OF REASONABLE COST

Reasonable cost consists of necessary and proper cost incurred in providing covered federally qualified health center services and dental services to all patients. Cost reimbursement principles, productivity screens, other limits, and coverage criteria set forth in K.A.R. 30-5-118, K.A.R. 30-5-118a, K.A.R. 30-5-118b, 42 CFR Part 405.2411 and 405.2446 through 405.2452. Medicaid state plan, Medicaid provider manual, 42 CFR Part 413, and Medicare Publications 10 & 27 shall be applied to the data submitted to Medicaid as tests of reasonableness.

A. Review & Analysis of Reported Data
Expenditures & income reported to Medicaid will be reconciled with the trial balance, financial statements prepared by the independent auditor, and the finalized Medicare cost report. Expenses reported as allowable, including overhead cost, will be analyzed to evaluate if they are accurate, reasonable, necessary, patient related, associated with covered services, and reported in appropriate cost centers. Revenue will be analyzed for

refunds received. Any findings will be deducted from reported expenses to yield total allowable cost. The encounter data will be analyzed for reasonableness, accuracy, inclusion of nursing assessments, and visits not meeting the definition of billable visits.

B. Revenue Offsets

Income will also be analyzed to confirm that Medicaid payments do not duplicate revenue received from other sources to cover specific programs or expenses, whether in part or whole. If such duplication is found, it will be offset before rate calculation. NOTE: Public Health Service Grants under section 329, 330, and 340 shall not be offset against expenses in determining allowable cost. To prevent such offset, the provider shall clearly identify these grants by name, not just numbers, in the supplemental data submitted with the cost report.

C. Total Reasonable FQHC & Dental Cost for the Facility

Allowable overhead (indirect) expense will be allocated to total allowable FQHC & Dental (direct) costs and total non-reimbursable (direct) expenses based on the proportion of each "direct" cost center to their summation. Post-allocation total FQHC & Dental expenses minus any revenue offsets shall be the total reasonable cost of covered FQHC and Dental services furnished to all patients, regardless of payer.

VI. SERVICES FURNISHED UNDER CONTRACT WITH MANAGED CARE ENTITY (MCE)

If a FQHC elects the alternative reimbursement option for a given fiscal year, it will be eligible for a settlement on covered services provided during that time period to eligible Medicaid beneficiaries under a contract with a Medicaid managed care entity (MCE). The settlement will consist of the difference between the amount paid to the FQHC by the MCE and the amount that would have been paid by Medicaid under the alternative methodology, Modified Cost-Based System (CBS), for the elected fiscal year.

A. Quarterly Supplemental Payments

The FQHC must send copies of the remittance advices received from the MCE to Medicaid after the end of each calendar quarter. Without these, the agency will not be able to make the supplemental payments. The remittances will be reviewed and the procedure-based payment data will be converted to "FQHC encounters", making corrections if necessary (e.g., a payment not meeting the encounter definitions). The

state will compute "quarterly alternative amount" by applying the provider's Medicaid interim rate under the alternative system for the corresponding time period to total encounters. If it is less than the MCE payment, the agency will send the difference to the FQHC no more than 90 days from the receipt of the remittance advices.

B. Fiscal Year End Settlement

When a *fiscal* year end final retroactive cost settlement is determined for Medicaid payments as described in section IV (Modified CBS), the state will also make a final settlement on services provided under the MCE contract during the same fiscal year. A "yearly alternative amount" will be computed using total encounters for that time period obtained from the supplemental payment data and the alternative system methodology. This amount will be compared with total payments received by the provider, i.e., MCE payments plus quarterly supplemental payments. If the computed alternative amount for the year is higher than total payments, Medicaid shall pay the difference to the provider. If, on the other hand, the yearly alternative amount is lower than total payments, the FQHC shall refund the overpayment to the agency.

Other Laboratory and X-ray Services
Methods and Standards for Establishing Payment Rates

Laboratory and x-ray services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

Reimbursement for physician-referred laboratory services performed by an independent laboratory shall be made directly to the laboratory.

KANSAS MEDICAID STATE PLAN

Attachment 4.19B
4a

Methods and Standards for Establishing Payment Rates

#4a Skilled Nursing Facility Services for Individuals 21 Years of Age or Older

See Attachment 4.19-D

State Plan MS-83-37
Trans. No. ~~9-28-83~~

Submitted 9-28-83
Approved 11-22-83

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Methods and Standards for Establishing Payment Rates

EPSDT screens are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a Statewide maximum. Provider representatives and the EPSDT Advisory Committee are consulted in reviewing the maximum rate.

Agency staff will individually review claims for medically necessary services not normally covered under the plan when these services are provided to an EPSDT participant. Staff will consult with agency medical experts and compare the service to comparable services and determine a price based on expert advice and rates for similar services.

Reimbursement for positive behavior support services are based upon a Medicaid fee schedule established by the State of Kansas. Commercial third party payers and market rates will be considered when establishing the fee schedules. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, if applicable. If a service has no Kansas specific Medicare rate, Kansas will establish pricing based on similar services. Room and board costs are not included in the Medicaid fee schedule.

State developed fee schedule rates are the same for both public and private providers of EPSDT services and the fee schedule and any annual/periodic adjustments to the fee schedule are published.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Methods and Standards for Establishing Payment Rates (Continued)

Reimbursement for Local Education Agency or School Based services identified in Individualized Family Service Plans or Individualized Education Plans under the Individuals with Disabilities Education Act (IDEA) is based on a fee schedule established by the State of Kansas. The rates are based on the existing community fee for service rate paid by Kansas Medicaid for comparable services provided through the Medicaid state plan. Services to be reimbursed include: Health Screening, Medical Transportation, Nursing Services, Occupational Therapy, Physical Therapy, Speech, Language and Hearing Therapy, Vision Services.

State developed fee schedules for services provided by local education agencies or public school districts will be the same as the rates for comparable services provided by private providers. The fee schedule and any annual or periodic adjustments to the fee schedule are published in the Kansas Medical Assistance Program Provider Manual for Local Education Agencies (https://www.kmap-state-ks.us/public/providermanuals.asp)

KANSAS MEDICAID STATE PLAN

Attachment 4.19B 4c

Methods and Standards for Establishing Payment Rates

#4c Family Planning Services

Payment to health departments for family planning services are based on fee maximums determined by the Department.

See Attachment 4.19B#5 for physician's services.

State Plan
Trans. No. MS 83-39

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KANSAS MEDICAID STATE PLAN

Attachment 4.19-B
#5

Methods and Standards for Establishing Payment Rates

#5 Physician's Services

Physician's services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges, except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

Payment for physician extender services are limited to a maximum of 75% of the maximum reimbursement to the billing physician.

Reimbursement for physician-referred laboratory services performed by an independent laboratory or outpatient hospital department, shall be made directly to the independent laboratory or outpatient hospital department.

TN # MS-85-08 Approval Date 4/5/85 Effective Date 1/1/85 Supersedes TN# unnumbered

Methods and Standards for Establishing Payment Rates

Outpatient Services

Outpatient services for non-critical access hospitals are reimbursed on the basis of reasonable fees as related to customary charges.

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 established by the Health Care Access Improvement Panel, created pursuant to the legislation, are as follows:

1) Effective March 1, 2006, outpatient hospital payment rates will be 93.6% of rates in effect February 28, 2006;

2) Ambulatory and Emergency Room (ER) Access Payment are calculated with a base payment per Medicaid visit and an additional tiered payment for each Medicaid visit that varies with total ER visits within a hospital. The ER payment is tiered to address the high fixed costs of operating an emergency room.

   Eligibility Criteria:
   - All hospitals except state owned facilities and critical access hospitals.

   Payment:
   - Each eligible hospital will receive $60 for each calendar year 2004 Medicaid ER paid visit, excluding HMO encounter data and Medicare cross over data, paid as of June 30, 2005.
   - Tiered outpatient payments are based on calendar year 2004 total emergency department visits reported on the American Hospital Association survey filed with the state for licensing purposes in accordance with KSA 65-429.
   - For hospitals with fewer than 6,000 total ER visits per year, the hospital will receive an additional $240 per calendar year 2004 Medicaid ER paid visit, excluding HMO encounter data and Medicare cross over data, paid as of June 30, 2005
   - For hospitals with 6,000 total ER visits but less than 24,000 total ER visits per year, the hospital will receive an additional $120 per calendar year 2004 Medicaid ER paid visit, excluding HMO encounter data and Medicare cross over data, paid as of June 30, 2005.
   - For hospitals with 24,000 total ER visits but less than 36,000 total ER visits per year the hospital will receive an additional $60 per visit for each Medicaid ER paid visit, excluding HMO encounter data and Medicare cross over data, paid as of June 30, 2005.

Methods and Standards for Establishing Payment Rates

Outpatient Services

Critical Access Hospital (CAH) Outpatient Services (continued)

Effective for dates of service on or after October 5, 2007, critical access hospital outpatient services are reimbursed 100% of the reasonable cost of providing the services, as 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. Payments are adjusted to reflect elimination of fee schedule methods for specific services such as laboratory and radiology services. Final reimbursement for these and other outpatient services is made in accordance with reasonable cost principles.

1) Allowable Medicaid costs are defined as the costs Medicare defines as allowable on the Medicare finalized cost report. The Medicare cost report will be used to determine the Medicaid allowable costs and the Medicare fiscal intermediary's review of the Medicare cost report will be relied on for determining allowable costs. CAHs report Medicaid fee-for-service claim outpatient charges in the Title XIX section of the Medicare cost report. The Medicare cost report cost-to-charge ratios are applied to Medicaid billed charges to determine final Medicaid reimbursable costs.

2) Outpatient CAH interim payments will be made using the current outpatient fee amounts (reasonable fees as related to customary charges). Upon receipt of the finalized Medicare cost report, the Medicaid settlement will be calculated as the difference in payments based on reasonable fees as compared to hospital-specific reasonable reimbursable outpatient cost. For the CAH outpatient settlement, outpatient ancillary service cost-to-charge ratios are multiplied by covered billed Medicaid claim charges to determine reasonable, reimbursable Medicaid costs.

3) CAHs will be permitted to request an interim Medicaid cost settlements by filing an interim Medicare cost report. The interim Medicare cost report will be used for issuing an interim lump sum adjustment. Final cost settlement will be issued upon receipt of the finalized Medicare cost report. CAHs are required to file a copy of the finalized Medicare cost report, including completed Medicaid fee-for-service worksheets, with Kansas Medicaid upon receipt of the finalized Medicare cost report from the Medicare Administrative Contractor. Underpayments will be issued to the CAH. Overpayments will be either recouped from the CAH through offset, or billed and collected from the CAH. The CAH must repay the overpayment within 60 days of determination.

Physicians' Services
Obstetrical Practitioner Services
Methods and Standards of Established Payment Rates

Explanation of Method and Standards of
Established Fee for Service Payment Rates

This report is based on information collected by the fiscal agent from SFY1995 paid claims for the period of the fiscal year (July 1, 1994 - June 30, 1995). For this report, fiscal year data is used to provide an average payment rate per procedure code for SFY '95, the second previous year. Regardless of current maximum reimbursement rates, providers are instructed to bill their usual and customary charge.

Procedure Code: This reflects the CPT code for a specific medical procedure.

Procedure Description: This reflects the CPT nomenclature for the specified procedure code. Due to availability of space, the description may be shortened or abbreviations utilized.

Current Rate: This reflects the maximum rate currently reimbursed by the Kansas Medicaid program for the specified procedure code. Rates do not vary by geographic location of provider.

Physicians' Services
Obstetrical Practitioner Services
Methods and Standards of Established Payment Rates

Explanation of Method and Standards of
Established HMO Payment Rates

HMO rates were established using the fee for service rates for obstetrical services in claender year 1995 which is then inflated to the present time. The first HMO for Medicaid started on 12/1/95.

Due to the methodology used to establish HMO rates, there should be no direct affect due to the rate setting methodology upon Obstetrical access.

OBSTETRICAL PROVIDER ACCESS

#	GEOGRAPHIC AREA	H & E LICENSED	PARTICIPATING IN THE MEDICAID PROGRAM	% PARTICIPATION
1	CHANUTE	34	28	82.4%
2	EMPORIA	44	22	50.0%
3	GARDEN CITY	56	54	96.4%
4	HAYS	48	48	100.0%
5	HIAWATHA	25	24	96.0%
6	HUTCHINSON	75	35	46.7%
7&9	KANSAS CITY /METRO	344	262	76.2%
8	MANHATTAN	55	44	80.0%
10	OSAWATOMIE	50	21	42.0%
11	PARSONS	48	18	37.5%
12	PITTSBURG	20	16	80.0%
13	PRATT	56	46	82.1%
14	SALINA	51	34	66.7%
15	TOPEKA	101	60	59.4%
16	WICHITA	308	170	55.2%
17	WINFIELD	58	21	36.2%
	TOTAL	1,373	903	65.8%

KANSAS MEDICAID STATE PLAN

Physicians' Services
Obstetrical Practitioner Services

PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
590000000	AMINOCENTESIS , ANY METHOD		$79.51
590120000	CORDOCENTESIS (INTRAUTERINE) , ANY METHOD		$150.00
590150000	CHRIONIC VILLUS SAMPLING, ANY METHOD		Non-Covered
590200000	FETAL CONTRACTION STRESS TEST		$60.00
590250000	FETAL NON-STRESS TEST		$32.00
590300000	FETAL SCALP BLOOD SAMPLING		$75.00
590500000	INITIATION AND/OR SUPERVISION OR INTERNAL FETAL MONITORING DURING LABOR BY CONSULTANT WITH REPORT (SEPARATE PROCEDURE); SUPERVISION & INTERPRETATION		Non Covered
590510000	INITIATION AND/OR SUPERVISION OR INTERNAL FETAL MONITORING DURING LABOR BY CONSULTANT WITH REPORT (SEPARATE PROCEDURE); INTERPRETATION ONLY		Non Covered
591000000	HYSTEROTOMY , ABDOMINAL		$372.26
591200000	SURGICAL TREATMENT OF ECTOPIC PREGNANCY; TUBAL OR OVARIAN, REQUIRING SCALPINGECTOMY AND/OR OOPHORECTOMY		$551.11
591210000	WITHOUT SCALPINGECTOMY AND/OR OOPHRECTOMY		$450.00
591300000	ABDOMINAL PREGNANCY		$484.66
591350000	INTERSTITIAL, UTERINE PREGNANCY REQUIRING TOTAL HYSTERECTOMY		$690.00
591360000	INTERSTITIAL, UTERINE PREGNANCY WITH PARTIAL RESECTION OF UTERUS		$550.20
591400000	CERVICAL WITH EVACUATION		$300.00
591500000	LAPAROSCOPIC TREATMENT OF ECTOPIC PREGNANCY W/O SALPINGECTOMY AND/OR OOPHORECTOMY		$400.83
591510000	WITH SALPINGECTOMY AND/OR OOPHORECTOMY		$544.64
591600000	CURETTAGE, POSTPARTUM		$204.19
592000000	INSERTION OF CERVICAL DILATOR		$48.46
593000000	EPISIOTOMY OR VAGINAL REPAIR ONLY, BY OTHER THAN ATTENDING PHYSICIAN		$117.14
593200000	CERCLAGE OF CERVIX, DURING PREGNANCY; VAGINAL		$156.96
593250000	ADOMINAL		$241.28

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement. Rates do not vary by geographic area.

KANSAS MEDICAID STATE PLAN

Physicians' Services
Obstetrical Practitioner Services

PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
593500000	HYSTERORRHAPHY OF RUPTURED UTERUS		$313.02
594000000	TOTAL OBSTETRIC CARE (ALL-INCLUSIVE, "GLOBAL" CARE) INCLUDES ANTEPARTUM CARE, VAGINAL DELIVERY (WITH OR WITHOUT EPISIOTOMY, AND/OR FORCEPS OR BREECH DELIVERY) AND POSTPARTUM CARE	$1,358.98	$1,326.89
594090000	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY, FORCEPS OR BREECH DELIVERY) (SEPARATE PROCEDURE)	$734.08	$666.02
594100000	VAGINAL DELIVERY ONLY (WITH OR WITHOUT EPISIOTOMY, FORCEPS OR BREECH DELIVERY) INCLUDING POSTPARTUM CARE (SEPARATE PROCEDURE)	$808.11	$690.19
594120000	EXTERNAL CEPHALIC VERSION, WITH OR WITHOUT TOCOLYSIS	Non-Covered	Non-Covered
594140000	DELIVERY OF PLACENTA FOLLOWING DEL'RY OUTSIDE OF HOSP	$50.00	$50.00
594250000	ANTEPARTUM CARE ONLY; 4-6 VISITS (SEPARATE PROCEDURE)	$131.35	$192.00
594260000	ANTEPARTUM CARE ONLY; 7 OR MORE VISITS (SEPARATE PROCEDURE)	$254.85	$425.00
594300000	POSTPARTUM CARE ONLY (SEPARATE PROCEDURE)	$73.58	$75.00
595100000	ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, CESAREAN DELIVERY, AND POSTPARTUM CARE	$1,644.85	$1,496.23
595140000	CESAREAN DELIVERY ONLY	$673.97	$916.91
595150000	CESAREAN DELIVERY ONLY INCLUDING POSTPARTUM CARE	$1,130.90	$940.91
595250000	HYSTERECTOMY AFTER CESAREAN DELIVERY	$250.00	$250.00
598120000	TREATMENT OF SPONTANEOUS ABORTION, ANY TRIMESTER, COMPLETED SURGICALLY		$250.57
598200000	TREATMENT OF MISSED ABORTION, COMPLETE SURGICALLY FIRST TRIMESTER		$261.51
598210000	TREATMENT OF MISSED ABORTION, COMPLETE SURGICALLY SECOND TRIMESTER		$255.87
598300000	TREATMENT OF SEPTIC ABORTION		$366.96
598400000	INDUCED ABORTION, BY DILATION AND CURETTAGE		$228.77
598410000	INDUCED ABORTION BY DILATION AND EVACUATION		$259.59
598500000	INDUCED ABORTION, BY ONE OR MORE INTRA-AMNIOTIC INJECTIONS		$346.08
598510000	WITH DILATION AND CURETTAGE AND/OR EVACUATION		$350.00
598520000	WITH HYSEREOTOMY (FAILED INTRA-AMNIOTIC INJECTION)		$350.00

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement. Rates do not vary by geographic area.

KANSAS MEDICAID STATE PLAN

Physicians' Services
Obstetrical Practitioner Services

PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
598550000	INDUCED ABORTION, BY ONE OR MORE VAGINAL SUPPOSITORIES (eg, PROSTAGLANDIN) WITH OR WITHOUT CERVICAL DILATION (eg, LAMINARIA)		$333.23
598560000	WITH DILATION AND CURETTAGE AND /OR EVACUATION		$350.00
598570000	WITH HYSTEROTOMY (FAILED MEDICAL EVALUATION)		$350.00
598700000	UTERINE EVACUATION AND CURETTAGE FOR HYDATIDIFORM MOLE		$257.79
598990000	UNLISTED PROCEDURE, MATERNITY CARE AND DELIVERY		$250.00

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement. Rates do not vary by geographic area.

Physicians' Services
Pediatric Practitioner Services
Methods and Standards of Established Payment Rates

Explanation of Method and Standards of
Established Fee for Service Payment Rates

This report is based on information collected by the fiscal agent from SFY1995 paid claims for the period of the fiscal year (July 1, 1994 - June 30, 1995). For this report, fiscal year data is used to provide an average payment rate per procedure code for SFY '95, the second previous year. Regardless of current maximum reimbursement rates, providers are instructed to bill their usual and customary charge.

Procedure Code: This reflects the CPT code for a specific medical procedure.

Procedure Description: This reflects the CPT nomenclature for the specified procedure code. Due to availability of space, the description may be shortened or abbreviations utilized.

Current Rate: This reflects the maximum rate currently reimbursed by the Kansas Medicaid program for the specified procedure code. Rates do not vary by geographic location of provider.

Physicians' Services
Pediatric Practitioner Services
Methods and Standards of Established Payment Rates

Explanation of Method and Standards of
Established HMO Payment Rates

HMO rates were established using the fee for service rates for pediatric services in calender year 1995, which is then inflated to the present time. The first HMO for Medicaid started on 12/1/95.

Due to the methodology used to establish HMO rates, there should be no direct affect due to the rate setting methodology upon Pediatric access.

PEDIATRIC PROVIDER ACCESS

#	GEOGRAPHIC AREA	H & E LICENSED	PARTICIPATING IN THE MEDICAID PROGRAM	% PARTICIPATION
1	CHANUTE	34	28	82.4%
2	EMPORIA	40	19	47.5%
3	GARDEN CITY	56	51	91.1%
4	HAYS	53	51	96.2%
5	HIAWATHA	24	24	100.0%
6	HUTCHINSON	73	31	42.5%
7&9	KANSAS CITY METRO	424	260	61.3%
8	MANHATTAN .	48	42	87.5%
10	OSAWATOMIE	50	21	42.0%
11	PARSONS	49	18	36.7%
12	PITTSBURG	21	17	81.0%
13	PRATT	54	42	77.8%
14	SALINA	47	31	66.0%
15	TOPEKA	147	72	49.0%
16	WICHITA	322	174	54.0%
17	WINFIELD	57	20	35.1%
	TOTAL	1,499	901	60.1%

Physicians' Services
Pediatric Practitioner Services

PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
EVALUATION AND MANAGEMENT			
99201	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, NEW PATIENT	$25.56	$24.32
99202	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, NEW PATIENT	$31.34	$35.00
99203	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, NEW PATIENT	$33.74	$40.00
99204	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, NEW PATIENT	$39.44	$50.00
99205	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, NEW PATIENT	$59.41	$76.00
99211	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, ESTABLISHED PATIENT	$28.66	$11.24
99212	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, ESTABLISHED PATIENT	$23.34	$19.78
99213	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, ESTABLISHED PATIENT	$25.56	$27.00
99214	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, ESTABLISHED PATIENT	$36.69	$45.00
99215	OFFICE OR OTHER OUTPATIENT VISIT FOR E & M, ESTABLISHED PATIENT	$54.84	$68.00
99241	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR E & M, NEW OR ESTABLISHED		$18.00
99242	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR E & M, NEW OR ESTABLISHED		$24.00
99243	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR E & M, NEW OR ESTABLISHED		$30.00
99244	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR E & M, NEW OR ESTABLISHED		$45.00
99245	OFFICE OR OTHER OUTPATIENT CONSULTATION FOR E & M, NEW OR ESTABLISHED		$45.00
99271	CONFIRMATORY CONSULTATION FOR E & M, NEW OR ESTABLISHED PATIENT		$30.00
99272	CONFIRMATORY CONSULTATION FOR E & M, NEW OR ESTABLISHED PATIENT		$30.00
99273	CONFIRMATORY CONSULTATION FOR E & M, NEW OR ESTABLISHED PATIENT		$30.00
99274	CONFIRMATORY CONSULTATION FOR E & M, NEW OR ESTABLISHED PATIENT		$30.00
99275	CONFIRMATORY CONSULTATION FOR E & M, NEW OR ESTABLISHED PATIENT		$30.00

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement.
Rates do not vary by geographic area.

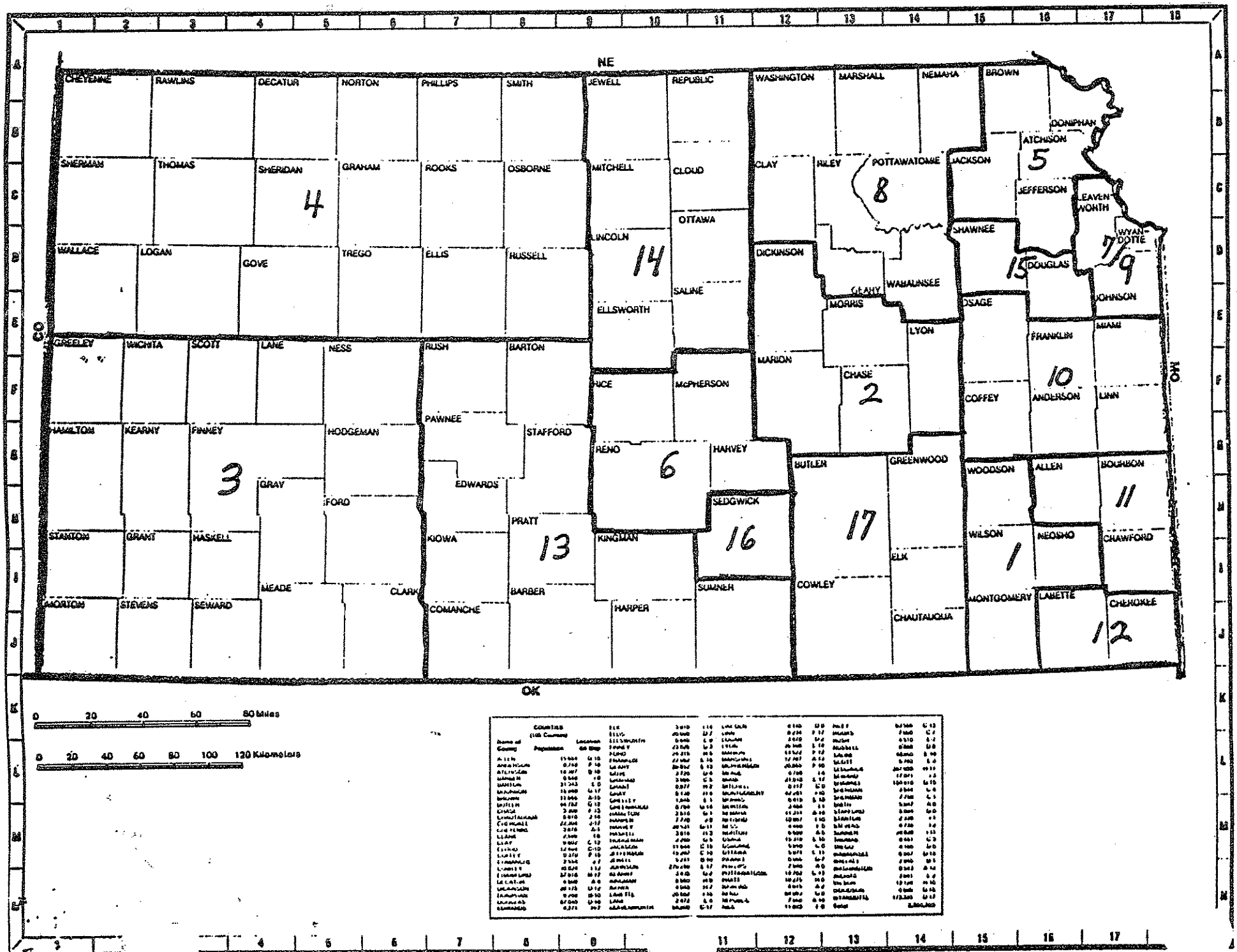
KANSAS MEDICAID STATE PLAN

Physicians' Services
Pediatric Practitioner Services

PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
99341	HOME SERVICES, NEW PATIENT		$8.00
99342	HOME SERVICES, NEW PATIENT		$8.00
99343	HOME SERVICES, NEW PATIENT		$12.00
99351	HOME SERVICES, ESTABLISHED PATIENT		$10.00
99352	HOME SERVICES, ESTABLISHED PATIENT		$10.00
99353	HOME SERVICES, ESTABLISHED PATIENT		$10.00
99354	PROLONGED PHYSICIAN SERVICE WITH DIRECT (FACE-TO-FACE) PATIENT CONTACT BEYOND THE USUAL SERVICE; FIRST HOUR		$55.21
99355	PROLONGED PHYSICIAN SERVICE WITH DIRECT (FACE-TO-FACE) PATIENT CONTACT BEYOND THE USUAL SERVICE; EACH ADDITIONAL 30 MINUTES		$24.88
99358	PROLONGED PHYSICIAN SERVICE WITHOUT DIRECT (FACE-TO-FACE) PATIENT CONTACT, E&M SERVICE; FIRST HOUR		$5.18
99359	PROLONGED PHYSICIAN SERVICE WITHOUT DIRECT (FACE-TO-FACE) PATIENT CONTACT, E&M SERVICE; EACH ADDITIONAL 30 MINUTES		Non Covered
PREVENTIVE MEDICINE SERVICES			
99381	INITIAL EVALUATION AND MANAGEMENT; INFANT (UNDER 1)	$41.93	$40.00
99382	INITIAL EVALUATION AND MANAGEMENT; EARLY CHILDHOOD (1-4 YRS)	$39.13	$35.00
99383	INITIAL EVALUATION AND MANAGEMENT; LATE CHILDHOOD (5-11 YRS)	$38.43	$35.00
99384	INITIAL EVALUATION AND MANAGEMENT; ADOLESCENT (12-17 YRS)	$34.87	$35.00
99391	PERIODIC REEVALUATION AND MANAGEMENT; INFANT (UNDER 1)	$28.95	$26.00
99392	PERIODIC REEVALUATION AND MANAGEMENT; EARLY CHILDHOOD (1-4 YRS)	$31.96	$25.00
99393	PERIODIC REEVALUATION AND MANAGEMENT; LATE CHILDHOOD (5-11 YRS)	$30.82	$25.00
99394	PERIODIC REEVALUATION AND MANAGEMENT; ADOLESCENT (12-17 YRS)	$29.05	$25.00
99401	PREVENTIVE MEDICINE INDIVIDUAL COUNSELING, NEW OR ESTABLISHED		Non Covered
99402	PREVENTIVE MEDICINE INDIVIDUAL COUNSELING, NEW OR ESTABLISHED		$20.00
99403	PREVENTIVE MEDICINE INDIVIDUAL COUNSELING, NEW OR ESTABLISHED		Non Covered

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement.
Rates do not vary by geographic area.

State of Kansas



Counties
(105 Counties)

Name of County	Population	Location	Name of County	Population	Location	Name of County	Population	Location	Name of County	Population	Location

TN No. MS-92-11 Approval Date 05/21/92 Effective Date 04/01/92

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

JOAN FINNEY, *Governor*

May 31, 1991

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

Kansas assures that rates which were effective May 15, 1991, for obstetrical practitioners services will insure that obstetric services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area. The attached listing of maximum rates is based upon the 75th percentile of calendar year 1989 usual and customary charges and maximum rates paid by Blue Shield of Kansas. The 75th percentile of calendar year 1990 usual and customary charges is not yet available.

The results of a comparison of licensed and enrolled obstetrical and family and general practice physicians by county are attached. The licensure information by county is based upon the address of the licensee. The enrollment information by county is based upon an enrollment address within the county. In some instances a physician may be providing services in more than one county and will be shown in each county of practice. This results in this data showing more enrolled than licensed physicians in some counties. This further substantiates that access is available in these counties. In addition, the licensing board has more choices for specialties than Medicaid so the matching of specialties is not exact. The end result again is that there may be more Medicaid-enrolled physicians than licensed. We will continue to refine the report.

There are no nurse midwives enrolled as independent practitioners in Kansas. There are few nurse midwives practicing in Kansas and those that are practicing do so in conjunction with a physician practice.

State Plan TN# 91-15 Effective Date 5/15/91

Supersedes TN# _____ Approval Date JUL 19 1991

Refers to MS-91-15.

We believe that the above-referenced documentation shows that the reimbursement rates for physicians providing obstetrical care assures access.

The rate data is submitted on a computer diskette in Lotus 123 file.

Sincerely,

Robert C. Harder
Acting Secretary

RCH:JWA:brj
Attachments

Refers to MS-91-15. State Plan TN# 91-15 Effective Date 5/15/91
Supersedes TN#_____ Approval Date JUL 19 1991

KANSAS MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER PARTICIPATION
IN OB PRACTICE

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF H&E LICENSED PROVIDERS	PERCENT OF LICENSED PROVIDERS ENROLLED
1	10	8	125.00
2	5	6	83.33
3	9	10	90.00
4	8	4	200.00
5	19	14	135.71
6	11	8	137.50
7	7	7	100.00
8	17	13	130.77
9	0	1	0.00*
10	3	4	75.00
11	11	8	137.50
12	2	2	100.00
13	3	3	100.00
14	5	6	83.33
15	8	5	160.00
16	3	4	75.00
17	1	2	50.00
18	26	22	118.18
19	17	9	188.89
20	5	3	166.67
21	10	9	111.11
22	6	3	200.00
23	23	25	92.00
24	3	3	100.00
25	1	0	**********
26	11	8	137.50
27	6	2	300.00
28	14	13	107.69
29	20	10	200.00
30	7	7	100.00
31	7	4	175.00
32	3	2	150.00
33	2	2	100.00
34	3	4	75.00
35	0	2	0.00**
36	1	2	50.00
37	4	4	100.00
38	2	1	200.00
39	10	7	142.86
40	19	15	126.67
41	2	1	200.00
42	1	1	100.00
43	5	2	250.00
44	7	7	100.00
45	2	2	100.00
46	109	149	73.15

State Plan TN# 91-15 Effective Date 5/15/91
Approval Date JUL 19 1991
Supersedes TN#

*In County 9 (Chase County), the population is 3,433. The closest towns are El Dorado in Butler County (130% participation), Emporia in Lyon County (92% participation) and Council Grove in Morris County (150% participation).

**In County 35 (Grant County), the population is 5,165. The closest towns are Dodge City in Ford County (190% participation), Garden City in Finney County (115% participation), Sublette in Haskell County (200% participation) and Meade in Meade County (100% participation).

KANSAS MEDICAI ...EMENT I...ORMATION SYSTEM
...ROVIDER PARTICIPATION
IN OB PRACTICE

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF H&E LICENSED PROVIDERS	PERCE...T ...F ...EN...D PROVI...RS ENR...ED
47	2	1	200.
48	6	5	120.0
49	3	2	150.00
50	11	10	110.00
51	2	1	200.00
52	12	17	70.59
53	1	2	50.00
54	7	2	350.00
55	2	1	200.00
56	12	13	92.31
57	6	5	120.00
58	8	7	114.29
59	16	16	100.00
60	3	3	100.00
61	14	12	116.67
62	4	3	133.33
63	19	17	111.76
64	6	4	150.00
65	2	1	200.00
66	7	6	116.67
67	11	9	122.22
68	4	4	100.00
69	5	3	166.67
70	3	5	60.00
71	5	3	166.67
72	6	3	200.00
73	9	11	81.82
74	5	3	166.67
75	14	9	155.56
76	4	4	100.00
77	4	2	200.00
78	30	15	200.00
79	3	4	75.00
80	3	5	60.00
81	23	19	121.05
82	4	3	133.33
83	2	1	200.00
84	3	3	100.00
85	20	22	90.91
86	3	2	150.00
87	193	222	86.94
88	7	5	140.00
89	61	55	110.91
90	2	3	66.67
91	5	3	166.67
92	3	2	150.00

State Plan TN# 91-15 Effective Date 5/15/91

Supersedes TN#_____ Approval Date JUL 19 1991

03/19/91

KANSAS MEDICAID MANAGEMEN[illegible]ATION SYSTEM
PROVIDE[illegible]TICIPATION
IN OB[illegible]CTICE

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF H&E LICENSED PROVIDERS	PERCENT OF LICENSED PROVIDERS ENROLLED
93	3	3	100.00
94	3	2	150.00
95	1	1	100.00
96	13	9	144.44
97	4	4	100.00
98	5	4	125.00
99	1	1	100.00
100	1	1	100.00
101	3	3	100.00
102	1	1	100.00
103	5	6	83.33
104	3	3	100.00
105	93	83	112.05
*** Total ***	1159	1093	

State Plan TN# 91-15 Effective Date 5/15/91
Supersedes TN#_____ Approval Date JUL 19 1991

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

JOAN FINNEY, *Governor*

May 31, 1991

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

Kansas assures that rates which were effective May 15, 1991, for pediatric practitioners services will insure that pediatric services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area. The attached list of maximum rates is based upon the 75th percentile of calendar year usual and customary charges and maximum rates paid by Blue Shield of Kansas. The 75th percentile of calendar year 1990 usual and customary charges is not yet available. Kansas is not able to supply the rate data for the immunization codes because vaccines are purchased through a Kansas Department of Health and Environment contract with the United State Center for Disease Control.

The results of a comparison of licensed and enrolled pediatric providers by county are attached. Pediatricians, family and general practice are the specialties included. The enrollment information by county is based upon an enrollment address within the county. In some instances a physician may be providing services in more than one county and will be shown in each county of practice. This results in the data showing more enrolled than licensed physicians in some counties. This substantiates that access is available in these counties. In addition, the licensing board has more choices for specialties than Medicaid so the matching of specialities is not exact. The end result again is that there may be more Medicaid-enrolled physicians enrolled than licensed. We will continue to refine the report.

There are very few nurse practitioners in independent practice and providing pediatric services in Kansas. Two are enrolled in Medicaid, one in Sedgwick county and one in Grant county.

State Plan TN# 91-16 Effective Date 05/15/91

Supersedes TN#_____ Approval Date 07/19/91

Refers to MS-91-16.

We believe that the above-referenced documentation shows that the reimbursement rates for physicians providing pediatric care assures access.

The data is submitted on a computer diskette in a Lotus 123 file.

Sincerely,

Robert C. Harder
Acting Secretary

RCH:JWA:brj
Attachments

Refers to MS-91-16.

State Plan TN# 91-16 Effective Date 05/15/91
Supersedes TN# _____ Approval Date 07/19/91

KANSAS MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER PARTICIPATION
IN PEDIATRICS

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF HEALTH LICENSED PROVIDERS	PERCENT OF LICENSED PROVIDERS ENROLLED
1	9	8	112.50
	5	6	83.33
	7	9	78.89
	0	4	.00
	13	13	100.00
	9	7	128.57
	7	7	100.00
	17	13	130.77
9	0	1	0.00*
13	3	4	75.00
14	11	8	137.50
	3	3	100.00
	3	3	100.00
17	5	6	83.33
	8	6	133.33
	3	4	75.00
	1	2	50.00
	21	21	114.29
	17	11	154.55
	16	9	177.78
	8	3	266.67
	33	25	132.00
	3	3	100.00
	1	1	100.00
	9	8	112.50
	15	13	115.38
	19	10	190.00
	7	7	100.00
	7	3	233.33
	3	2	150.00
	2	2	100.00
	3	4	75.00
37	0	2	0.00**
38	1	2	50.00
39	4	4	100.00
	2	1	200.00
	10	7	142.86
	23	17	135.29
41	2	1	200.00
	1	1	100.00
	5	2	250.00
	7	7	100.00
	2	2	100.00
	161	116	69.18

State Plan TN# 91-16 Effective Date 5/15/91

Supersedes TN# _____ Approval Date 7/19/91

*In County 9 (Chase County), the population is 3,433. The closest towns are El Dorado in Butler County (130% participation), Emporia in Lyon County (92% particpation) and Council Grove in Morris County (150% participation).

**In County 35 (Grant County), the population is 5,165. The closest towns are Dodge City in Ford County (190% participation), Garden City in Finney County (115% participation), Sublette in Haskell County (200% participation) and Meade in Meade County (100% participation).

KANSAS MEDICAID MANAGEM... ...ATION SYSTEM
PROVID... ...TICIPATION
...EDIATRICS

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF H&E LICENSED PROVIDERS	PERCENT OF LICENSED PROVIDERS ENROLLED
17	2	1	200.00
18	6	5	120.00
19	3	2	150.00
20	12	11	109.09
21	2	1	200.00
22	13	18	72.22
23	1	2	50.00
24	7	2	350.00
25	2	1	200.00
26	12	13	92.31
27	6	5	120.00
28	8	7	114.29
29	14	15	93.33
30	3	3	100.00
31	14	12	116.67
32	4	3	133.33
33	19	17	111.76
34	6	4	150.00
35	1	0	100.00
36	7	6	116.67
37	11	9	122.22
38	1	1	100.00
69	5	3	166.67
70	3	5	60.00
71	5	3	166.67
72	6	3	200.00
73	9	11	81.82
74	6	3	200.00
75	13	9	144.44
76	1	1	100.00
77	1	2	200.00
78	29	19	152.63
79	3	4	75.00
80	3	5	60.00
81	24	19	126.32
82	4	3	133.33
83	1	1	100.00
84	3	3	100.00
85	19	21	90.48
86	3	2	150.00
87	211	223	94.62
88	7	6	116.67
89	64	51	125.49
90	2	3	66.67
91	5	3	166.67
92	3	2	150.00

State Plan TN# 91-16 Effective Date 5/15/91

Supersedes TN#_____ Approval Date 7/19/91

KANSAS MEDICAID MANAGEME SYSTEM
PROVIDER PAL
IN PEDIATR.

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF H&E LICENSED PROVIDERS	PERCENT OF LICENSED PROVIDERS ENROLLED
93	3	3	100.00
94	3	2	150.00
97	1	1	100.00
96	13	9	114.44
97	1	4	100.00
98	5	4	125.00
99	1	1	100.00
100	1	1	100.00
101	3	3	100.00
102	1	1	100.00
103	5	6	83.33
104	3	3	100.00
105	117	90	130.00
*** Total ***	1190	1098	

State Plan TN# 91-16 Effective Date 5/15/91
Supersedes TN# _____ Approval Date 7/19/91

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

JOAN FINNEY, *Governor*

March 26, 1991

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

Kansas assures that rates which will be effective July 1, 1991, for obstetrical practitioners services will insure that obstetric services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area. The attached listing of maximum rates is based upon the 75th percentile of calendar year 1989 usual and customary charges and maximum rates paid by Blue Shield of Kansas. The 75th percentile of calendar year 1990 usual and customary charges is not yet available.

The results of a comparison of licensed and enrolled obstetrical and family and general practice physicians by county are attached. The licensure information by county is based upon the address of the licensee. The enrollment information by county is based upon an enrollment address within the county. In some instances a physician may be providing services in more than one county and will be shown in each county of practice. This results in this data showing more enrolled than licensed physicians in some counties. This further substantiates that access is available in these counties. In addition, the licensing board has more choices for specialties than Medicaid so the matching of specialties is not exact. The end result again is that there may be more Medicaid-enrolled physicians than licensed. We will continue to refine the report.

There are no nurse midwifes enrolled as independent practitioners in Kansas. There are few nurse midwives practicing in Kansas and those that are practicing do so in conjunction with a physician practice.

Refers to MS-91-13. Approval Date 4/24/91 Effective Date 1/1/91

We believe that the above-referenced documentation shows that the reimbursement rates for physicians providing obstetrical care assures access.

The rate data is submitted on a computer diskette in Lotus 123 file.

Sincerely,

Robert C. Harder
Acting Secretary

RCH:JWA:brj
Attachments

Refers to MS-91-13. Approval Date 4/24/91 Effective Date 1/1/91

HCFA MEDICARE
REGION VII
91 APR 22 AM 8:26

STATE OF KANSAS
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570
JOAN FINNEY, *Governor*

April 19, 1991

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

As a result of conversation between our mutual staffs, Kansas is submitting additional information and replacement pages for Kansas Medicaid State Plan amendments MS-90-37 and MS-90-38. Furthermore, Kansas is submitting additional information for amendments MS-91-12 and MS-91-13.

In regard to counties 9 (Chase County) and 35 (Grant County), Kansas' rural nature affects the accompanying statistics. These two counties do not have enrolled providers but all residents residing there travel to receive covered services to towns in neighboring counties which do have enrolled providers. Please refer to the footnoted text regarding access for these two counties.

We are requesting that the obstetrical survey material included in the previous transmittals be deleted.

Questions may be directed to Sally Adams at (913) 296-3981.

Sincerely,

Joyce C. Sugrue
Acting Director
Division of Medical Services

JCS:SA:brj
Enclosures

State Plan TN# 91-13 Effective Date 1/1/91
Supersedes TN# _____ Approval Date 4/24/91

KANSAS MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER PARTICIPATION
IN OB PRACTICE

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF H&E LICENSED PROVIDERS	PERCENT OF LICENSED PROVIDERS ENROLLED
1	10	8	125.00
2	5	6	83.33
3	9	10	90.00
4	8	4	200.00
5	19	14	135.71
6	11	8	137.50
7	7	7	100.00
8	17	13	130.77
9	0	1	0.00*
10	3	4	75.00
11	11	8	137.50
12	2	2	100.00
13	3	3	100.00
14	5	6	83.33
15	8	5	160.00
16	3	4	75.00
17	1	2	50.00
18	26	22	118.18
19	17	9	188.89
20	5	3	166.67
21	10	9	111.11
22	6	3	200.00
23	23	25	92.00
24	3	3	100.00
25	1	0	**********
26	11	8	137.50
27	6	2	300.00
28	14	13	107.69
29	20	10	200.00
30	7	7	100.00
31	7	4	175.00
32	3	2	150.00
33	2	2	100.00
34	3	4	75.00
35	0	2	0.00**
36	1	2	50.00
37	4	4	100.00
38	2	1	200.00
39	10	7	142.86
40	19	15	126.67
41	2	1	200.00
42	1	1	100.00
43	5	2	250.00
44	7	7	100.00
45	2	2	100.00
46	109	149	73.15

State Plan TN# 91-13 Effective Date 1/1/91
Supersedes TN# _____ Approval Date 4/24/91

*In County 9 (Chase County), the population is 3,433. The closest towns are El Dorado in Butler County (130% participation), Emporia in Lyon County (92% participation) and Council Grove in Morris County (150% participation).

**In County 35 (Grant County), the population is 5,165. The closest towns are Dodge City in Ford County (190% participation), Garden City in Finney County (115% participation), Sublette in Haskell County (200% participation) and Meade in Meade County (100% participation).

KANSAS MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER PARTICIPATION
IN OB PRACTICE

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF H&E LICENSED PROVIDERS	PERCENT OF LICENSED PROVIDERS ENROLLED
47	2	1	200.00
48	6	5	120.00
49	3	2	150.00
50	11	10	110.00
51	2	1	200.00
52	12	17	70.59
53	1	2	50.00
54	7	2	350.00
55	2	1	200.00
56	12	13	92.31
57	6	5	120.00
58	8	7	114.29
59	16	16	100.00
60	3	3	100.00
61	14	12	116.67
62	4	3	133.33
63	19	17	111.76
64	6	4	150.00
65	2	1	200.00
66	7	6	116.67
67	11	9	122.22
68	4	4	100.00
69	5	3	166.67
70	3	5	60.00
71	5	3	166.67
72	6	3	200.00
73	9	11	81.82
74	5	3	166.67
75	14	9	155.56
76	4	4	100.00
77	4	2	200.00
78	30	15	200.00
79	3	4	75.00
80	3	5	60.00
81	23	19	121.05
82	4	3	133.33
83	2	1	200.00
84	3	3	100.00
85	20	22	90.91
86	3	2	150.00
87	193	222	86.94
88	7	5	140.00
89	61	55	110.91
90	2	3	66.67
91	5	3	166.67
92	3	2	150.00

State Plan TN# 91-13 Effective Date 1/1/91
Supersedes TN# _____ Approval Date 4/24/91

03/19/91

KANSAS MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER PARTICIPATION
IN OB PRACTICE

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF H&E LICENSED PROVIDERS	PERCENT OF LICENSED PROVIDERS ENROLLED
93	3	3	100.00
94	3	2	150.00
95	1	1	100.00
96	13	9	144.44
97	4	4	100.00
98	5	4	125.00
99	1	1	100.00
100	1	1	100.00
101	3	3	100.00
102	1	1	100.00
103	5	6	83.33
104	3	3	100.00
105	93	83	112.05
*** Total ***	1159	1093	

e Plan TN# 91-13 Effective Date 1/1/91

Supersedes TN# _____ Approval Date 4/24/91

HCFA-MEDICAID
REGION VII

91 APR 22 AM 8:26

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

JOAN FINNEY, Governor

April 19, 1991

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

As a result of conversation between our mutual staffs, Kansas is submitting additional information and replacement pages for Kansas Medicaid State Plan amendments MS-90-37 and MS-90-38. Furthermore, Kansas is submitting additional information for amendments MS-91-12 and MS-91-13.

In regard to counties 9 (Chase County) and 35 (Grant County), Kansas' rural nature affects the accompanying statistics. These two counties do not have enrolled providers but all residents residing there travel to receive covered services to towns in neighboring counties which do have enrolled providers. Please refer to the footnoted text regarding access for these two counties.

We are requesting that the obstetrical survey material included in the previous transmittals be deleted.

Questions may be directed to Sally Adams at (913) 296-3981.

Sincerely,

Joyce C. Sugrue
Acting Director
Division of Medical Services

JCS:SA:brj
Enclosures

State Plan TN# 90-38 Effective Date 7/1/90
Supersedes TN# _____ Approval Date 4/26/91

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, 915 S.W. Harrison, Topeka, Kansas 66612

(913) 296-3271

September 25, 1990

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

Administrative Services
C. DUNCAN
Commissioner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance Medical Services
JOHN ALQUIST
Commissioner

Mental Health Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABRIEL FAIMON
Commissioner

Youth Services
ROBERT BARNUM
Commissioner

Mr. Richard Brummel
Associate Regional Administrator
Health Care Financing Administration
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

The State of Kansas submits this assurance letter to MS-90-38, Obstetrical Practitioner Services... Payment Rates. Kansas assures that equality of access is affirmed for Medicaid recipients.

Kansas bases this assurance upon a comparison of the number of obstetrical/gynecological physicians enrolled in the Kansas Medicaid Program versus the number of obstetrical/gynecological physicians who are licensed and practicing in Kansas of 156 obstetricians/gynecologists who are licensed and practicing in Kansas, 143 (91.66%) are enrolled in the Kansas Medicaid Program.

As family/general practice physicians also provide obstetrical/gynecological services, Kansas also looked at their numbers. There are 1,021 family/general practice physicians enrolled in the Kansas Medicaid Program. While there are differences in the definitions of speciality between the KMMIS and the data base used to obtain numbers of licensed and practicing physicians, 920 family/general practice physicians are licensed and practice in Kansas. The high correlation between the two numbers assures that Kansas Medicaid recipients have access to obstetrical/gynecological services.

Please do not hesitate to call if we may be of further assistance at 913-296-3981.

Sincerely,

Dennis R. Taylor
Secretary

DRT:JWA:plk

State Plan TN# 90-38 Effective Date 7/1/90
Supersedes TN#_____ Approval Date 4/26/91

HCFA MEDICAID
REGION VII
91 APR 22 AM 8:26

STATE OF KANSAS
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570
JOAN FINNEY, Governor

April 19, 1991

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

As a result of conversation between our mutual staffs, Kansas is submitting additional information and replacement pages for Kansas Medicaid State Plan amendments MS-90-37 and MS-90-38. Furthermore, Kansas is submitting additional information for amendments MS-91-12 and MS-91-13.

In regard to counties 9 (Chase County) and 35 (Grant County), Kansas' rural nature affects the accompanying statistics. These two counties do not have enrolled providers but all residents residing there travel to receive covered services to towns in neighboring counties which do have enrolled providers. Please refer to the footnoted text regarding access for these two counties.

We are requesting that the obstetrical survey material included in the previous transmittals be deleted.

Questions may be directed to Sally Adams at (913) 296-3981.

Sincerely,

Joyce C. Sugrue
Acting Director
Division of Medical Services

JCS:SA:brj
Enclosures

State Plan TN# 91-12 Effective Date 1/1/91
Supersedes TN#_____ Approval Date 4/24/91

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

JOAN FINNEY, *Governor*

March 26, 1991

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

Kansas assures that rates which will be effective July 1, 1991, for pediatric practitioners services will insure that pediatric services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area. The attached list of maximum rates is based upon the 75th percentile of calendar year usual and and customary charges and maximum rates paid by Blue Shield of Kansas. The 75th percentile of calendar year 1990 usual and customary charges is not yet available. Kansas is not able to supply the rate data for the immunization codes because vaccines are purchased through a Kansas Department of Health and Environment contract with the United States Center for Disease Control.

The results of a comparison of licensed and enrolled pediatric providers by county are attached. Pediatricians, family and general practice are the specialties included. The enrollment information by county is based upon an enrollment address within the county. In some instances a physician may be providing services in more than one county and will be shown in each county of practice. This results in the data showing more enrolled than licensed physicians in some counties. This substantiates that access is available in these counties. In addition, the licensing board has more choices for specialties than Medicaid so the matching of specialties is not exact. The end result again is that there may be more Medicaid-enrolled physicians enrolled than licensed. We will continue to refine the report.

There are very few nurse practitioners in independent practice and providing pediatric services in Kansas. Two are enrolled in Medicaid, one in Sedgwick county and one in Grant county.

Refers to MS-91-12. Approval Date 4/24/91 Effective Date 1/1/91

We believe that the above-referenced documentation shows that the reimbursement rates for physicians providing pediatric care assures access.

The data is submitted on a computer diskette in a Lotus 123 file.

Sincerely,

Robert C. Harder
Acting Secretary

RCH:JWA:brj
Attachments

Refers to MS-91-12. Approval Date 4/24/91 Effective Date 1/1/91

KANSAS MEDICAID MANAGE. NT INFORMATION SYSTEM
PROVIDER PARTICIPATION
IN PEDIATRICS

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF H&E LICENSED PROVIDERS	PERCENT OF LICENSED PROVIDERS ENROLLED
1	9	8	112.50
[illegible]	5	6	83.33
[illegible]	8	9	88.89
[illegible]	8	4	200.00
[illegible]	18	13	138.46
[illegible]	9	7	128.57
[illegible]	7	7	100.00
[illegible]	17	13	130.77
9	0	1	0.00*
10	3	4	75.00
11	11	8	137.50
12	2	2	100.00
13	3	3	100.00
14	5	6	83.33
15	8	6	133.33
16	3	1	75.00
17	1	2	50.00
[illegible]	24	21	114.29
19	17	11	151.55
[illegible]	[illegible]	3	166.67
[illegible]	10	9	111.11
[illegible]	6	3	200.00
[illegible]	23	25	92.00
34	3	3	100.00
[illegible]	1	0	100.00
[illegible]	11	8	137.50
[illegible]	6	2	300.00
[illegible]	15	13	115.38
[illegible]	19	10	190.00
[illegible]	7	7	100.00
[illegible]	7	3	233.33
[illegible]	3	2	150.00
33	2	2	100.00
[illegible]	3	4	75.00
35	0	2	0.00**
36	1	2	50.00
37	4	4	100.00
[illegible]	2	1	200.00
[illegible]	10	7	142.86
40	23	17	135.29
41	2	1	200.00
42	1	1	100.00
43	5	2	250.00
44	7	7	100.00
45	2	2	100.00
46	101	146	69.18

State Plan TN# 91-12 Effective Date 11/1/91
Supersedes TN# _____ Approval Date 4/24/91

*In County 9 (Chase County), the population is 3,433. The closest towns are El Dorado in Butler County (130% participation), Emporia in Lyon County (92% participation) and Council Grove in Morris County (150% participation).

In County 35 (Grant County), the population is 5,165. The closest towns are Dodge City in Ford County (190% participation), Garden City in Finney County (115% participation), Sublette in Haskell County (200% participation) and Meade in Meade County (100% participation).

KANSAS MEDICAID MANAGEM[illegible] INFORMATION SYSTEM
PROVIDER PARTICIPATION
IN PEDIATRICS

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF H&E LICENSED PROVIDERS	PERCENT OF LICENSED PROVIDERS ENROLLED
47	2	1	200.00
48	6	5	120.00
49	3	2	150.00
50	12	11	109.09
51	2	1	200.00
52	13	18	72.22
53	1	2	50.00
54	7	2	350.00
55	2	1	200.00
56	12	13	92.31
57	6	5	120.00
58	8	7	114.29
59	11	15	93.33
60	3	3	100.00
61	14	12	116.67
62	1	3	133.33
63	19	17	111.76
64	6	4	150.00
65	1	0	100.00
66	7	6	116.67
67	11	9	122.22
68	4	4	100.00
69	5	3	166.67
70	3	5	60.00
71	5	3	166.67
72	6	3	200.00
73	9	11	81.82
74	6	3	200.00
75	13	9	144.44
76	4	4	100.00
77	4	2	200.00
78	29	19	152.63
79	3	4	75.00
80	3	5	60.00
81	24	19	126.32
82	4	3	133.33
83	1	1	100.00
84	3	3	100.00
85	19	21	90.48
86	3	2	150.00
87	211	223	94.62
88	7	6	116.67
89	64	51	125.49
90	2	3	66.67
91	5	3	166.67
92	3	2	150.00

State Plan TN# 91-12 Effective Date 1/1/91
Supersedes TN#_____ Approval Date 4/24/91

KANSAS MEDICAID MANAGEMENT ... ATION SYSTEM
PROVIDER PAR ... TIPATION
IN PEDIATRICS

COUNTY CODE NUMBER	MEDICAID ACTIVE ENROLLED PROVIDERS	DEPT. OF H&E LICENSED PROVIDERS	PERCENT OF LICENSED PROVIDERS ENROLLED
93	3	3	100.00
94	3	2	150.00
95	1	1	100.00
96	13	9	144.44
97	4	4	100.00
98	5	4	125.00
99	1	1	100.00
100	1	1	100.00
101	3	3	100.00
102	1	1	100.00
103	5	6	83.33
104	3	3	100.00
105	117	90	130.00
*** Total ***	1110	1038	

State Plan TN# 91-12 Effective Date 1/1/91

Supersedes TN#_____ Approval Date 4/24/91

HCFA-MEDICAID
REGION VII

91 APR 22 AM 8:26

STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

JOAN FINNEY, *Governor*

April 19, 1991

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

As a result of conversation between our mutual staffs, Kansas is submitting additional information and replacement pages for Kansas Medicaid State Plan amendments MS-90-37 and MS-90-38. Furthermore, Kansas is submitting additional information for amendments MS-91-12 and MS-91-13.

In regard to counties 9 (Chase County) and 35 (Grant County), Kansas' rural nature affects the accompanying statistics. These two counties do not have enrolled providers but all residents residing there travel to receive covered services to towns in neighboring counties which do have enrolled providers. Please refer to the footnoted text regarding access for these two counties.

We are requesting that the obstetrical survey material included in the previous transmittals be deleted.

Questions may be directed to Sally Adams at (913) 296-3981.

Sincerely,

Joyce C. Sugrue
Acting Director
Division of Medical Services

JCS:SA:brj
Enclosures

State Plan TN# 90-37 Effective Date 7/1/90
Supersedes TN# _____ Approval Date 4/24/91

bill

HCFA-MEDICAID
REGION VII
90 NOV -6 AM 10:00

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

October 29, 1990

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Director
Human Resources

TIM OWENS
General Counsel

inistrative
vices
S. DUNCAN
Commissioner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug
Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance/
Medical Services
JOHN ALQUEST
Commissioner

Mental Health/
Retardation Services
AL NEMEC
Commissioner

Rehabilitation
Services
GABE FAIMON
Commissioner

Youth Services
ERT BARNUM
mmissioner

Mr. Richard Brummel
Associate Regional Administrator
Health Care Financing Administration
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

The State of Kansas submits this assurance letter to MS-90-37, Pediatric Practitioner Services. . . Payment Rates. Kansas assures that equality of access is affirmed for Medicaid recipients.

Kansas bases this assurance upon a comparison of the number of pediatric physicians enrolled in the Kansas Medicaid Program versus the number of pediatric physicians who are licensed and practicing in Kansas. Of 156 pediatricians who are licensed and practicing in Kansas, 154 (98.7%) are enrolled in the Kansas Medicaid Program.

As family/general practice physicians also provide pediatric services, Kansas also looked at their numbers. There are 1,021 family/general practice physicians enrolled in the Kansas Medicaid Program. While there are differences in the definitions of speciality between the KMMIS and the data base used to obtain numbers of licensed and practicing physicians, 920 family/general practice physicians are licensed and practice in Kansas. The high correlation between the two numbers assures that Kansas Medicaid recipients have access to pediatric practitioner services.

In regard to pediatric immunization codes, Kansas will not be able to supply code and payment specific data because vaccines are purchased through a Kansas Department of Health and Environment contract with the United States Center for Disease Control in Atlanta.

State Plan TN# 90-37 Effective Date 7/1/90

Supersedes TN#_____ Approval Date 4/24/91

Please do not hesitate to call if we may be of further assistance at 913-296-3981.

Sincerely,

Dennis R. Taylor
Acting Secretary

Refers to MS-90-37

DRT:JWA:brj

State Plan TN# 90-37 Effective Date 7/1/90
Supersedes TN#_____ Approval Date 4/24/91

MDB

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

HHS
HCFA-MEDICAID
REGION VII
93 APR 29 AM 8:22

April 14, 1993

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

The State of Kansas, in accordance with the State Medicaid Manual 6305.2 and 42 CFR 447.333, submits this assurance regarding Medicaid reimbursement for prescribed drugs.

The State of Kansas assures that the Medicaid payment rate for multiple source drugs does not exceed, in the aggregate, upper limit payment levels established by the Health Care Financing Administration (HCFA) per 42 CFR 447.332(a).

The State of Kansas also assures that the Medicaid payment rate for other drugs (defined as brand name drugs certified as medically necessary by a physician or drugs other than multiple source drugs) does not exceed, in the aggregate, the lower of either the estimated acquisition costs (average wholesale price less 10%) plus reasonable dispensing fees or the provider's usual and customary charges to the general public per 42 CFR 447.332 (b) and (c).

The State of Kansas assures that necessary findings support these assurances.

Sincerely,

Donna L. Whiteman

Donna L. Whiteman
Secretary

DLW:RLE:TAH:pm

cc: Steve Otto

TN#MS-93-09 Approval Date MAY 0 3 1993 Effective Date APR 0 1 1993 Supersedes No Number

file

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

November 14, 1989

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

Administrative
ces
DUNCAN
missioner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug
Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance/
Medical Services
JOHN ALQUEST
Commissioner

Mental Health/
Retardation Services
AL NEMEC
Commissioner

Rehabilitation
Services
GABE FAIMON
Commissioner

Youth Services
ROBERT BARNUM
mmissioner

Mr. William R. Blake, Jr.
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Blake:

The State of Kansas, in accordance with the State Medicaid Manual 6305.2 and 42 CFR 447.333, submits this assurance regarding Medicaid reimbursement for prescribed drugs. The State submits this assurance in addition to the Methods and Standards for Establishing Payment Rates for Prescribed Drugs as contained within Attachment 4.19-B, #12.a. of the Kansas Medicaid State Plan.

The State of Kansas assures that the Medicaid payment rate for multiple source drugs does not exceed, in the aggregate, upper limit payment levels established by the Health Care Financing Administration (HCFA) per 42 CFR 447.332(a).

The State of Kansas also assures that the Medicaid payment rate for other drugs (defined as brand name drugs certified as medically necessary by a physician or drugs other than multiple source drugs) does not exceed, in the aggregate, the lower of either the estimated acquisition costs (average wholesale price less 10%) plus reasonable dispensing fees or the provider's usual and customary charges to the general public per 42 CFR 447.332 (b) and (c).

The State of Kansas assures that necessary findings support these assurances.

Sincerely,

Winston Barton
Secretary

WB:JWA:SA:plk

cc: Steve Otto

TN#MS-89-27 Approval Date 12/13/89 Effective Date 10/1/89 Supersedes TN#MS-89-05

STATE OF KANSAS

MIKE HAYDEN, *Governor*

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Docking State Office Building, Topeka, Kansas 66612-1570

☎ (913) 296-3271

March 14, 1989

WINSTON BARTON
Secretary

THELMA HUNTER GORDON
Special Assistant

TIM OWENS
General Counsel

ANN ROLLINS
Public Information Director

ministrative
es
ner

Adult Services
JAN ALLEN
Commissioner

Alcohol and Drug Abuse Services
ANDREW O'DONOVAN
Commissioner

Income Maintenance/ Medical Services
JOHN ALQUIST
Commissioner

Mental Health/ Retardation Services
AL NEMEC
Commissioner

Rehabilitation Services
GABE FAIMON
Commissioner

Youth Services
ROBERT BARNUM
mmissioner

Mr. William R. Blake, Jr.
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Blake:

The State of Kansas, in accordance with the State Medicaid Manual 6305.2 and 42 CFR 447.333, submits this assurance regarding Medicaid reimbursement for prescribed drugs. The State submits this assurance in addition to the Methods and Standards for Establishing Payment Rates for Prescribed Drugs as contained within Attachment 4.19-B, #12.a. of the Kansas Medicaid State Plan.

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The State of Kansas also assures that the Medicaid payment rate for other drugs (defined as brand name drugs certified as medically necessary by a physician or drugs other than multiple source drugs) does not exceed, in the aggregate, the lower of either the estimated acquisition costs plus reasonable dispensing fees or the provider's usual and customary charges to the general public per 42 CFR 447.332 (b) and (c).

The State of Kansas assures that necessary findings support these assurances.

Sincerely,

Winston Barton

Winston Barton
Secretary

WB:JWA:SA:mrw

TN# MS-89-05 Approval Date 3/28/89 Effective Date 1/1/89 Supersedes TN# MS-87-44A

87-444

Assurances re: ATT 4.19B

STATE OF KANSAS

MIKE HAYDEN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

WINSTON BARTON, SECRETARY

DOCKING STATE OFFICE BUILDING
TOPEKA, KANSAS 66612-1570

December 28, 1987

Mr. Edward M. Brennan
Associate Regional Administrator
for Program Operations
Health and Human Services
Federal Office Building, Room 225
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brennan:

The State of Kansas, in accordance with 1902(a)(30)(A) of the Social Security Act and 42 CFR 447.332, submits this assurance regarding Medicaid reimbursement for prescribed drugs. The State submits this assurance in addition to the Methods and Standards for Establishing Payment Rates for Prescribed Drugs as contained within Attachment 4.19-B, #12.a. of the Kansas Medicaid State Plan.

The State of Kansas assures that the Medicaid payment rate for multiple source drugs does not exceed, in the aggregate, upper limit payment levels established by the Health Care Financing Administration (HCFA) per 42 CFR 447.332(a).

The State of Kansas also assures that the Medicaid payment rate for other drugs (defined as brand name drugs certified as medically necessary by a physician or drugs other than multiple source drugs) does not exceed, in the aggregate, the lower of either the estimated acquisition costs plus reasonable dispensing fees or the provider's usual and customary charges to the general public per 42 CFR 447.332 (b) and (c).

The State of Kansas assures that necessary findings support these assurances.

Sincerely,

Winston Barton
Secretary

WB:SA:bss

TN# MS-87-44A Approval Date 3/7/88 Effective Date 10/1/87 Supersedes TN# Nothing

12/3/86 Letter

STATE OF KANSAS

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

ROBERT C HARDER SECRETARY

STATE OFFICE BUILDING
TOPEKA KANSAS 66612 15

September 26, 1986

Mr. Dean R. Mordy
Associate Regional Administrator
for Program Operations
Federal Office Building, Room 225
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Mordy:

This letter conveys a Kansas Medicaid State Plan amendment concerning optional targeted case management services in accordance with Section 1915 (b) after (4) and 1915 (g) of the Social Security Act, and under Sections 1902 (a) (1) and (a) (23) of the Act. The State is waiving Section 1902 (a) (10), comparability of services per Section 1915 (g) (1).

Kansas provides targeted, medical case management services in seven counties (Douglas, Johnson, Leavenworth, Saline, Sedgwick, Shawnee and Wyandotte) for all Medicaid recipients except Medicare/Medicaid (dual) beneficiaries, adult care home residents and foster care recipients.

To qualify as a case manager, a physician must be licensed to practice medicine in Kansas, and be enrolled as a provider in the Kansas Medicaid Program in one of the following provider specialties: family practice, general practice, internal medicine, obstetrics/gynecology, pediatrics or osteopathy.

Reimbursement for the case management services is a capitated amount per month per recipient. Other medical services are reimbursed to the provider using the current reimbursement methodology appropriate to the category of service.

The physician case manager provides primary medical care and accepts the responsibility for the recipient's health care by authorizing, locating, coordinating and monitoring all medical care. Kansas has a 1915 (b) waiver regarding freedom of choice which restricts a recipient's choice of other medical providers and their services.

EPSDT services are provided by the case manager, or referral is made for EPSDT services if the case manager does not perform them. The case manager refers for nonemergency services provided by another doctor, a hospital, pharmacy, laboratory, psychologist, an ambulance, for radiology, medical supplies, durable medical equipment, orthotics and prosthetics, and home health. Referral is not needed for emergency, dental, optometric, podiatric, chiropractic, community mental health center or family planning services.

Kansas assures that medical case management services do not duplicate case management available from another authority. Case management services do not duplicate those included in the home and community based services waiver.

This amendment is an addition to Attachment 3.1-A and Attachment 4.19-B. Its number is 19.

Sincerely,

Robert C. Harder
Secretary

RCH:bss

cc: Steve Otto
L. Kathryn Klassen

STATE OF KANSAS

MIKE HAYDEN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

DOCKING STATE OFFICE BUILDING
TOPEKA, KANSAS 66612-1570

WINSTON BARTON, SECRETARY

July 12, 1988

Mr. Bill Schmeling, Chief
State and Contractors Branch I
Division of Program Operations
Department of Health & Human Services
Health Care Financing Administration
Region VII
Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

RE: MS-88-13

Dear Mr. Schmeling:

We are amending the Kansas Medical State Plan for adult care homes by revising the following sections:

1) 4.19C - Reserve Day Payment Policy. We are changing item 2 on page 1 to delete the words "prior to the period of hospitalization or therapeutic home visit.", from the text. We are also adding the word "document" after the word "turnaround" in item 3.

On Page 2 in item 5(a) the words "prior to" are being deleted and the word "for" is being substituted. Also the words "or within five working days of absence.", is being deleted. In item 5(c) the word "private psychiatric hospital" is being added to the text. Item 5(f) is being deleted since it is in Attachment 3.1-A #14.a. A new (f) is being added and it will read as follows:

(f) The adult care home cannot be approved for reserve days if it has more than 5 vacancies. If the facility requesting reserve days has 200 beds or more the vacancy number may not exceed 15.

On Page 3 there is some technical items being revised such as "patient" to "resident" in item 6 and "ICF-MH's" to "ICF's-MH" in item 7.

State Plan TN# MS-88-13 Effective Date 7/1/88

Supersedes TN# MS-88-11 Approval Date 10/4/88

In accordance with 42 CFR 447.253, the Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payments for long term care services in adult care homes. The requirements set forth in paragraphs (b) through (g) of this section are being met, the related information required by subsection 447.225 of this subpart is furnished herewith and the agency complies with all other requirements of this subpart.

42 CFR 447.253 (b) State Findings. The State of Kansas, through this agency, does make findings to insure that the rates used to reimburse providers satisfy the requirements of paragraph 447.253(b)(1)(i).

42 CFR 447.253(b)(1)(i) - Payment Rates. The State of Kansas, through this agency, continues to pay adult care homes for long term care services in accordance with a State Plan formula. We have found that the rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide the services in conformity with applicable state and federal laws, regulations and quality and safety standards.

42 CFR 447.253(b)(1)(i) - Subparagraphs (A), (B) and (C) apply to inpatient hospital services.

42 CFR 447.253(b)(2) - Upper limits. The State of Kansas, through this agency, does make findings that the estimated average proposed Medicaid payment rate is reasonably expected to pay no more in the aggregate for long term care facility services than the amount that the agency reasonably estimates would be paid for services under the Medicare principles of reimbursement.

42 CFR 447.253(c) - Provider appeals. The agency, in accordance with the Kansas Administrative Regulations, provides a fair hearing procedure that allows for an administrative review and an appeal by the provider before the Administrative Hearing Section of the agency.

42 CFR 447.253(d) - Uniform reporting. Adult care home providers are required to file annual cost reports with the Medicaid agency within three months following the end of their fiscal year in accordance with Kansas Administrative Regulation 30-10-17.

42 CFR 447.253(e) - Audit requirements. The State, through this agency, performs a desk review on all cost reports within six months after receipt and provides for periodic field audits of the financial and statistical records of the participating providers.

42 CFR 447.253(f) - Public notice. Appropriate public notice has been given for the changes included in this plan amendment.

State Plan TN# MS-88-13 **Effective Date** 7/1/88

Supersedes RN# MS-88-11 **Approval Date** 10/4/88

42 CFR 447.253(g) - Rates paid. The rates paid through the agency have been determined in accordance with methods and standards specified in an approved State Plan.

42 CFR 447.255 - Related Information:

	SNF	ICF	ICF/MR
Estimated Average Rate 1/1/88	$45.76	$35.98	$60.57
Estimated Average Rate 4/1/88	45.76	35.98	60.57
Estimated Decrease - State Plan Amendment	0	0	0
Average Percent Decrease	0	0	0

The change on the reserve day policy has no impact on the rates.

b) Quantified estimates of the short term and long term effect of these changes in rate will have on:

	SHORT TERM	LONG TERM
1) Availability of services on a statewide and geographic area basis:	None	None
2) Type of care furnished:	None	None
3) Extent of provider participation	None	None

1) There are approximately 405 licensed adult care homes in the State of Kansas with at least one in every county. Of these, approximately 393, or 97%, are also certified to participate in the Medicaid Program. Beds are available in every area of the State and close coordination with the local and area SRS offices allows the agency to keep close track of vacancies.

2) The type of care furnished may show some decline in the standard in some facilities that was set under the previous limits. There may be some tendency by facilities to staff at a lower level ratio than they previously did under the prior limits. However, the overall care of all adult care home residents should not be affected by this change in either the short or long term periods.

3) The extent of provider participation should not be affected by this change. Ninety-seven percent of the available providers are already participating in the program. This change will not encourage the remaining three percent to begin participation. Two providers have indicated that they wish to withdraw from the Program.

4) Subparagraph (4) applies to inpatient hospital services.

42 CFR 447.272(b) - Application of Upper Limit. The State through this agency, doe smake findings that the State operated facilities may not exceed a payment amount that can reasonable be estimated would have been paid under Medicare payment principles

Section 1902(a)(13)(C) of the Consolidated Omnibus Recomciliation Act (COBRA) of 1985. The State of Kansas through this agency, does make assurances that its payment methodology is not reasonably expected to result in an increase in payments based on a change in ownership in excess of the increase that would result from application of Section 1902(a)(13)(C) of COBRA.

This information is being submitted in accordance with Section 6002 of the State Medicaid Manual. If you have additional questions, please write or call (913) 296-3728.

Sincerely,

Winston Barton

Winston Barton
Secretary

WB:JA:JJG:slr

cc Jack Gumb
Bill McDaniel
L. Kathryn Klassen

State Plan TN# MS-88-13 Effective Date 7/1/88

Supersedes TN# MS-88-11 Approval Date 10/4/88

Physicians' Services
Pediatric Practitioner Services

PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
99404	PREVENTIVE MEDICINE INDIVIDUAL COUNSELING, NEW OR ESTABLISHED		$40.00
99411	PREVENTIVE MEDICINE GROUP COUNSELING, NEW OR ESTABLISHED		$20.00
99412	PREVENTIVE MEDICINE GROUP COUNSELING, NEW OR ESTABLISHED		$40.00
99420	OTHER PREVENTIVE MEDICINE SERVICES, ADMN. AND INTERPRETATION		Non-Covered
99429	OTHER PREVENTIVE MEDICINE SERVICES, UNLISTED		Non-Covered
99432	NORMAL NEWBORN CARE, OTHER THAN HOSPITAL,		$45.00
IMMUNIZATIONS			
90700	DTaP		$8.00
90701	DTP	$6.37	$8.00
90702	DT		$8.00
90703	TETANUS		$2.03
90704	MUMPS		Non-Covered
90705	MEASLES		Non-Covered
90706	RUBELLA		Non-Covered
90707	MEASLES, MUMPS, AND RUBELLA	$6.56	$8.00
90708	MEASLES AND RUBELLA		Non-Covered
90709	RUBELLA AND MUMPS		Non-Covered
99710	MEASLES, MUMPS, RUBELLA, AND VARICELLA		Non-Covered
90711	DTP AND INJECTABLE POLIOMYELITIS		Non-Covered
90712	POLIO, ORAL	$5.95	$8.00
90713	POLIO VACCINE		$8.00
90714	TYPHOID		$11.75
90716	VARICELLA (CHICKEN POX)		$8.00

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement. Rates do not vary by geographic area.

Physicians' Services
Pediatric Practitioner Services

PROCEDURE CODE	PROCEDURE DESCRIPTION	AVERAGE PAYMENT AMOUNT AS OF 7/1/95	MAXIMUM RATE
90717	YELLOW FEVER		Non-Covered
90719	DIPTHERIA		Non-Covered
90720	DTP AND HIB		$8.00
90721	DTaP and HIB		
90724	INFLUENZA VIRUS		$4.38
90725	CHOLERA		$6.48
90726	RABIES		$130.00
90727	PLAGUE		Non-Covered
90728	BCG		$30.00
90730	HEPATITIS A		Non-Covered
90732	PNEUMOCCAL VACCINE, POLYVALENT		$27.11
90733	MENINGOCCAL POLYSACCHARIDE		Non-Covered
90737	HEMOPHILUS INFLUENZA B	$4.49	$8.00
90741	IMMUNIZATION, PASSIVE; IMMUNE SERUM GLOBULIN, HUMAN (ISG)		Non-Covered
90742	SPECIFIC HYPERIMMUNE SERUM GLOBULIN		$3.00
90744	HEPATITIS B, NEWBORN TO 11 YEARS		
90745	HEPATITIS B, 11 TO 19 YEARS		
90749	UNLISTED IMMUNIZATION PROCEDURE		Non-Covered

Note: When average payment amounts are higher than current rates, it is due to the encounter rate payment methodology for Rural Health Clinics and Federally Qualified Health Centers. These providers receive all-inclusive, cost-based reimbursement. Rates do not vary by geographic area.

Targeted Case Management

"Reimbursement for Targeted Case Management Services (TCM) for individuals meeting criteria for mental health (MH), mental retardation/developmental disabilities (MR/DD), traumatic brain injury (TBI), physical disabilities (PD), frail elderly (FE) and early inter family services coordination (FSC) is based on a fee schedule established by the State of Kansas.

The per unit (one unit = 15 minutes) rates were developed using information on salary and benefits gained from an aggregate survey of existing providers of targeted case management services. Mileage and vehicle expenses were determined from the aggregate survey expense data. Indirect costs were calculated at a rate of ten percent. General and administrative time (training, vacation, holidays, sick time and other non-billable time) was removed from the calculation of billable time.

Rates for each provider were developed using the following calculation:

$$\frac{\text{Total Allowed Cost (salary, fringe benefits, mileage/vehicle expenses, indirect costs)}}{\text{2,080 – General and Administrative time}} = \text{TCM Rate per hour}$$

For these "per provider" rates, a rate range was established for all TCM services and the final rates were selected from this rate range.

Kansas, with CMS guidance and approval, will leave ACIL services where they are currently located in the State plan. Within one year from the date CMS approves this State plan or upon approval of the 1915 (c) Home and Community Based Waiver Program that would include children who are dependent upon technology, whichever is earlier, the State will terminate targeted case management services to this group.

ACIL services were not included in the rate survey Kansas conducted in order to establish rates for targeted case management based on the CMS rate methodology. ACIL rates were established utilizing the comparative hourly rate for Advanced Registered Nurse Practitioners and related administrative costs. The rate has not changed since 1991.

Claims will be made for targeted case management (TCM) services delivered to an eligible person prior to leaving a medical institution only when the person is enrolled in a 1915(c) waiver program."

The agency's rates were set as of July 1, 2007 and are effective for services on or after that date. All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of targeted case management services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's website at https://www.kmap-state-ks.us/.

KANSAS MEDICAID STATE PLAN

Attachment 4.19B 6b

Methods and Standards for Establishing Payment Rates

#6b Optometrist's Services

Optometrist's services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges, except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

State Plan
Trans. No. MS-83-42

Submitted 9-28-83
Approved 11-22-83

KANSAS MEDICAID STATE PLAN

Attachment 4.19B 6c

Methods and Standards for Establishing Payment Rates

#6c Chiropractor's Services

Chiropractor's services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges, except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

State Plan
Trans. No. MS-83-43

Submitted 9-28-83
Approved 11-22-83

Other Practitioner's Services
Methods and Standards for Establishing Payment Rates

Reimbursement for services are based upon a Medicaid fee schedule established by the State of Kansas. Commercial third party payers and market rates will be considered when establishing the fee schedules. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, if applicable. If a service has no Kansas specific Medicare rate, Kansas will establish pricing based on similar services. Room and board costs are not included in the Medicaid fee schedule.

State developed fee schedule rates are the same for both public and private providers of Other Practitioner's services and the fee schedule and any annual/periodic adjustments to the fee schedule are published.

KANSAS MEDICAID STATE PLAN

Attachment 4.19-B
#7

Home Health Services
Methods and Standards for Establishing Payment Rates

Home health services are reimbursed per unit of service provided. Kansas Medicaid establishes individual rates for the following units of service:

- Skilled nursing services
- Physical therapy services
- Occupational therapy services
- Speech therapy services
- Home health aide services
- Restorative Aide

Durable medical equipment and medical supplies are reimbursed on the basis of rates established by Kansas Medicaid. Payment for used equipment is limited to a maximum of 75% of the payment for new equipment.

Clinic Services
Methods and Standards for Establishing Payment Rates

Day Treatment Programs

Adult day health services are reimbursed on the basis of a negotiated rate.

Ambulatory Surgical Centers

Ambulatory surgical centers are reimbursed on the basis of a rate determined by Medicaid customary charges. Payments may not exceed reasonable fees as related to customary charges, whichever is less.

Local Health Departments

Local health departments are reimbursed on the basis of reasonable fees as related to customary charges within range maximums.

KANSAS MEDICAID STATE PLAN

Attachment 4.19B 10

Methods and Standards for Establishing Payment Rates

#10 Dental Services

Dental services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

State Plan
Trans. No. MS-83-48

Submitted 9-28-83
Approved 11-22-83

KANSAS MEDICAID STATE PLAN

Attachment 4.19B 11 a, b, c

Methods and Standards for Establishing Payment Rates

#11 a, b, and c. Physical Therapy, Occupational Therapy, Speech, Hearing, and Language Disorders.

Inpatient Hospital - services are reimbursed in accordance with the payment methodology described in Attachment 4.19-A

Outpatient Hospital - services are reimbursed in accordance with the payment methodology described in Attachment 4.19-B #1

Home Health Agency - services are reimbursed in accordance with the payment methodology described in Attachment 4.19-B #7

Physician - services are reimbursed in accordance with the payment methodology described in Attachment 4.19-B #5

Hearing Aid services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a Statewide maximum. Provider representatives are consulted in reviewing the maximum rate.

1627M
/fzs

State Plan
Trans. No. HS-83-49

Submitted 9-28-83
Approved 11-22-83

Prescribed Drugs
Methods and Standards for Establishing Payment Rates

Reimbursement to pharmacy providers is based upon agency-determined allowable product cost for covered drugs plus an agency-determined dispensing fee. The dispensing fee assigned to each pharmacy provider is $3.40 per prescription or a rate established by the agency.

A vaccine administration fee of $10.00 or rate as established by the Kansas Secretary of the Department of Social and Rehabilitation Services may be paid to pharmacy providers certified to administer vaccines. Proof of certification must be on file with Medicaid.

Substitute per letter dated 5/16/02 m

KANSAS MEDICAID STATE PLAN

Attachment 4.19
#12.a., page 1a

Reimbursement for Unused Drugs from Long Term Care Facility

If a drug product is issued to a patient of a long-term care facility and subsequently is not used, the long term care facility shall return the drug product to the vendor pharmacy for repackaging and crediting to the secretary if the drug product meets all of the following conditions:

1. The drug product is a prescription drug product that is not a controlled substance.
2. The drug product is sealed in individually packaged units or in a multiple-dose, sealed container approved by the federal food and drug administration from which no doses have been withdrawn.
3. The drug product is returned to the vendor pharmacy at least 90 days before the expiration date.
4. The drug product is determined to be of acceptable integrity by a licensed pharmacist

Each long-term care facility shall establish procedures for the return of unused drug products to the vendor pharmacy from which the unused drug products were received.

Each provider of pharmacy services may be reimbursed the reasonable cost of returning and crediting unused drug products, as determined by the secretary, described in the following table:

Level	Credited Prescription Amount	Adjusted Dispensing F
1	$5.00 - $8.25	$1.70
2	$8.26 - $11.50	$2.50
3	$11.51 - $14.75	$3.25
4	$14.76 - $17.99	$4.00
5	$18.00 and over	$4.50

After prior notification of each provider, reimbursement under the unused drug return program may denied for any of the following:

1. Certain drugs determined by the secretary to be less than effective;
2. Drugs that do not meet the requirements of section 1927 of the Social Security Act;
3. Drugs restricted by the secretary under the provisions of section 1927 of the social security act, 42 U.S.C. 1396r-8 regarding permissible restrictions.

TN # MS 02-02 Approval Date MAY 21 2002 Effective Date 01/01/02 Supersedes TN # New

Prescribed Drugs
Methods and Standards for Establishing Payment Rates

The allowable drug product cost for determining reimbursement is based upon agency determinations which consider the aggregate upper limits of payment as defined in 42 C.F.R. Sec. 447.331 and 447.332, the State Maximum Allowable Cost (SMAC), or the estimated acquisition cost (EAC) as determined by the state for all drugs covered by the program. The estimated acquisition cost is determined by consideration of a specific drug product's probable acquisition cost or average wholesale price (AWP). If the AWP is utilized, 13% is deducted for brand name drugs and 27% is deducted for generic drugs to set the estimated acquisition cost as the reimbursable cost. The percentage deducted from AWP may be changed at the discretion of the Kansas Health Policy Authority.

In no case shall reimbursement for a prescription exceed the provider usual and customary charges for that prescription. Where payment to a provider is limited as a result of the usual and customary change, such reduction shall first be made to the cost of drugs dispensed.

KANSAS MEDICAID STATE PLAN

Attachment 4.19B 12b

Methods and Standards for Establishing Payment Rates

#12b Dentures

Dentures are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

State Plan
Trans. No. KS-83-51

Submitted 9-28-83
Approved 11-22-83

KANSAS MEDICAID STATE PLAN

Attachment 4.19B

12c

Methods and Standards for Establishing Payment Rates

#12c Prosthetic Devices

Prosthetic and orthotic devices are reimbursed on the basis of reasonable fees as related to Medicaid customary charges, except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

State Plan
Trans. No. MS-83-52

Submitted 9-28-83
Approved 11-22-83

KANSAS MEDICAID STATE PLAN

Attachment 4.19B 12d

Methods and Standards for Establishing Payment Rates

#12d Eyeglasses

Eyeglasses are reimbursed on the basis of reasonable fees as related to Medicaid customary charges except no fee is reimbursed in excess of a Statewide maximum. Provider representatives are consulted in reviewing the maximum rate.

State Plan
Amend. #: MS-83-63
9-28-83
11-22-83

Rehabilitation Services
Methods and Standards for Establishing Payment Rates

Reimbursement for services are based upon a Medicaid fee schedule established by the State of Kansas. Commercial third party payers and market rates will be considered when establishing the fee schedules. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, if applicable. If a service has no Kansas specific Medicare rate, Kansas will establish pricing based on similar services. Room and board costs are not included in the Medicaid fee schedule.

KANSAS MEDICAID STATE PLAN

Attachment 4.19B

146

Methods and Standards for Establishing Payment Rates

#14b Services for Individuals Age 65 or Older in Institutions for Mental Diseases

(1) Inpatient Hospital - See Attachment 4.19-A

(2) Intermediate Care Faciltiy - See Attachment 4.19-D

State Plan
Trans. No. MS-83-55

Submitted: 9-28-83
Approved: 11-22-83

KANSAS MEDICAID STATE PLAN

Attachment 4.19B 15

Methods and Standards for Establishing Payment Rates

#15 Intermediate Care Facility Services

See Attachment 4.19-D

State Plan
Trans. No. MS-83-54

Submitted: 9-28-83
Approved: 11-22-83

KANSAS MEDICAID STATE PLAN

Attachment 4.19B 16

Methods and Standards for Establishing Payment Rates

#16 Inpatient Psychiatric Services for Individuals Under 22

See Attachment 4.19-A

State Plan
Trans. No. MS-83-57

Submitted 9-28-83
Approved 11-22-83

KANSAS MEDICAID STATE PLAN

Attachment 4.19-B
#17

Methods and Standards for Establishing Payment Rates for Nurse-Midwife Services

Nurse-midwife services are reimbursed on the basis of reasonable fees as related to customary charges except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computations.

KANSAS MEDICAID STATE PLAN

Attachment 4.19-B
#18

Hospice Services
Methods and Standards for Establishing Payment Rates

Reasonable fees as related to the Medicare standards of hospice reimbursement shall be paid for hospice services.

File

KANSAS MEDICAID STATE PLAN

Attachment 4.19-B
#23.e.

Emergency Hospital Services
Methods and Standards for Establishing Payment Rates

Emergency hospital services are reimbursed on the basis of the reimbursement methodology for comparable services rendered by non-hospital providers.

Laboratory and radiology services relating to emergency hospital services are reimbursed according to the customary charges not to exceed range maximums plus two percent.

KANSAS MEDICAID STATE PLAN

Attachment 4.19-B
~~#20-f~~ #33f

Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Methods and Standards for Establishing Payment Rates

Reimbursement for medical attendant care for independent living is based upon rates determined by the agency.

Reimbursement for registered nurses supervising medical attendant care is comparable to skilled nursing services rates in home health agencies.

KANSAS MEDICAID STATE PLAN

Attachment 4.19-B
#24

Pediatric or Family Nurse Practitioners' Services
Pursuant to OBRA 1989
Methods and Standards for Establishing Payment Rates

Pediatric or family nurse practitioners' services pursuant to OBRA 1989 are reimbursed at the lesser of the billed charges or at 75% of the maximum rate. Kan Be Healthy (EPSDT) and anesthesiology are reimbursed at the lesser of the billed charges or at the maximum rate.

Methods and Standards for Establishing Payment Rates

Transportation

Ambulance

Ambulance transportation services are reimbursed on the basis of reasonable fees as related to Medicaid customary charges, except no fee is reimbursed in excess of a range maximum. The range of charges provides the base for computation of range maximums.

Non-Ambulance

Private motor carriers are reimbursed at the established rate of .22 per mile.

Public motor carriers are reimbursed at the following established rates –
Non-emergency medical transportation, wheelchair van - $20.00 per one way trip
Non-emergency medical transportation - $12.50 per one-way trip
Non-emergency medical transportation - $10.00 per one-way trip

Subsistence is reimbursed at the established rates of; lodging in-state maximum allowed amount of $54.00, lodging out-of-state maximum allowed amount of $81.00. In-state meal allowance maximum allowed amount of $21.00 per day and out-of -state meal allowance maximum allowed amount of $21.75 per day.

Substitute per letter dated 05/21/01

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES
Methods and Standards for Payment Rates

Kansas Medicaid will pay all facilities operated by IHS or a tribal 638 facility owned and operated by tribes or tribal organizations with the federally established rate in the most recently published Federal Register Notice.

Services included in the all-inclusive rate are jointly determined by HCFA and IHS. Services that are billable to Kansas Medicaid would include all professional services in the State Plan.

KANSAS MEDICAID STATE PLAN

Revision: HCFA-PM-91-4 (BPD)
August 1991

Supplement 1 to Attachment 4.19-B
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copyament (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item 1 of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ____ of this attachment, for thos groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ____ of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Other Medicaid Recipients	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Dual Eligible (QMB Plus)	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kansas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

---

1. For QMB-only individuals, payments are limited to State plan rates and paymen methodologies.

30-10-21. Reserve days. (a) Payment shall be available for nursing facility residents, excluding those on planned temporary stays, for days for which it is necessary to reserve a bed in a nursing facility (NF) or nursing facility for mental health (NF-MH) when the resident is absent for any of the following reasons:

(1) Admission to a hospital for acute conditions;

(2) therapeutically indicated home visits with relatives and friends; or

(3) participation in any state-approved therapeutic or rehabilitative program.

(b) In order for payment to be available, the following requirements shall be met when a bed is reserved in a nursing facility or nursing facility for mental health because of a resident's hospitalization for acute conditions:

(1) The period of hospitalization shall not exceed either of the following limits:

(A) 10 days for each single hospital stay for an acute condition; or

(B) 21 days for residents from a nursing facility for mental health for each admission to a state mental institution or admission to a psychiatric ward in any of the following:

(i) A general hospital;

(ii) a private psychiatric hospital; or

(iii) a veterans administration medical center.

(2) The resident shall intend to return to the same

facility after hospitalization.

(3) The hospital shall provide a discharge plan for the resident.

(4) Reimbursement shall not be made to reserve a bed in a swing bed hospital if a nursing facility will be reimbursed for the same day to reserve a bed for the resident's return from the hospital.

(c) The resident's plan of care shall provide for the non-hospital-related absence.

(1) Payment for non-hospital-related reserve days for eligible residents in nursing facilities for mental health shall not exceed 21 days per calendar year, including travel. If additional days are required to obtain or retain employment, participate in a job readiness training program, or alleviate a severe hardship, the requesting party shall send a request for additional days and supporting documentation to the fiscal agent for approval or disapproval.

(2) Payment for non-hospital-related reserve days for all eligible residents in nursing facilities shall not exceed 18 days per calendar year, including travel. If additional days are required to alleviate a severe hardship, the requesting party shall send a request for additional days and supporting documentation to the fiscal agent for approval or disapproval.

(d) This regulation shall not prohibit any resident from leaving a facility if the resident so desires.

(e) Payments made for unauthorized reserve days shall be reclaimed by the agency.

(f)(1) Before any routine absence by residents, the provider shall notify the local agency office.

(2) In case of emergency admission to a hospital, the provider shall notify the local agency office not later than five working days following admission.

(g) Payment for reserve days shall be approved except when the absence is longer than 10 hospital days for NF or NF-MH residents or 21 hospital days for NF-MH residents who enter either of the following:

(1) A state mental hospital; or

(2) a psychiatric ward in any of the following:

(A) A general hospital;

(B) a private psychiatric hospital; or

(C) a veterans administration medical center.

(Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-3-29-90, April 1, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1996; amended Oct. 1, 2000; amended July 1, 2002; amended Aug 15, 2003.)

RESERVE DAY PAYMENT POLICY

Payment for reserve days is authorized for days in which the recipient is absent from the facility and it is necessary to reserve a bed in an intermediate care facility for the mentally retarded (ICF/MR) during a temporary absence in a hospital for acute conditions or for therapeutic home visits. Therapeutic home visits are defined to include visits with relatives and friends or leaves to participate in state-approved therapeutic or rehabilitative programs. The following provisions apply in any instance in which a bed is reserved:

1. Payment is available only for the days during which there is a likelihood that the reserved bed would otherwise be required for occupancy by some other resident.

2. The provider is required to notify the local agency office of any routine absence from the facility by a recipient in the Kansas Medicaid Program. In case of admission to a hospital, notification must be submitted to the local agency office no later than 5 working days following admission.

3. No payment for medical reserve days shall be made until authorization has been given by the local agency office in writing to the provider. A copy of the authorization shall be attached to the claim submitted for payment.

4. The following conditions must be met when a bed is reserved in an ICF/MR because of hospitalization for an acute medical condition:

   a. The local agency office has approved the recipient reserve days for hospitalization of an acute condition for each period of hospitalization. The period hospitalization for an acute condition does not exceed 10 days per any single hospital stay.

   b. When an ICF/MR recipient is transferred to one of the state mental retardation facilities, he or she is eligible for 21 hospital reserve days.

   c. The recipient intends to return to the same facility after the hospitalization and the facility accepts the recipient for service.

   d. The hospital provides a discharge plan for the recipient which includes returning to the facility requesting the reserve days.

   e. An ICF/MR which has less than 90% occupancy may not be approved for the hospitalization reserve days.

RESERVE DAY PAYMENT POLICY

5. When a bed is reserved in an ICF/MR because of a therapeutic home visit, the recipient plan of care must provide for such visits. Reimbursement for therapeutic home visits are not to exceed 21 days per year (including travel) for recipients in an ICF/MR. Additional therapeutic home visit days may be allowed provided prior authorization is obtained. The ICF/MR vacant beds are not a factor for therapeutic reserve days for home visits.

6. Payment for authorized ICF/MR reserve days shall be at 100% of the per diem rate for each provider.

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

March 29, 1997

Nanette Foster Reilly
Health Care Financing Administration
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Dear Ms. Reilly:

Kansas assures services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area based on rates that are effective July 1, 1997, for obstetrical practitioners. The attached listing of rates is based upon the average payment rate for each procedure code in FY '95. This represents the second previous year.

The results of a comparison of licensed obstetrical providers participating in the Medicaid program, by SRS catchment areas, is attached. Obstetricians, internal and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment. These results substantiate that access is available in these areas.

The state's fee for service rates were taken into account in the development of the HMO rates. The state assures that our §1903(m) HMO contract rate setting activities are consistent with the data submitted with this state plan amendment.

We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing obstetrical care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

Sincerely,

Janet Schalansky,
Deputy Secretary
Kansas Department of
Social and Rehabilitation Services

JS:dat

TN#MS-97-06 Approval Date MAY 14 1997 Effective Date APR 1 1997 Supersedes TN#MS-96-04

APR 3 AM 10:11
HHS
HCFA-MEDICAID
REGION VII

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

March 29, 1997

Nanette Foster Reilly
Health Care Financing Administration
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Dear Ms. Reilly:

Kansas assures services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area based on rates that are effective July 1, 1997, for pediatric practitioners. The attached listing of rates is based upon the average payment rate for each procedure code in FY '95. This represents the second previous year.

The results of a comparison of licensed pediatric providers participating in the Medicaid program, by SRS catchment areas, is attached. Pediatricians, internal and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment. These results substantiate that access is available in these areas.

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We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing pediatric care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

Sincerely,

Janet Schalanasky
Deputy Secretary
Kansas Department of
Social and Rehabilitation Services

JS:dat

TN#MS-97-07 Approval Date MAY 12 1997 Effective Date APR 1 1997 Supersedes TN#MS-96-05

97 APR -3 AM 11:11
HHS
HCFA-MEDICAID
REGION VII

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

March 29, 1996

Mr. Robert Epps
Health Care Financing Administration
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Dear Mr. Epps:

Kansas assures services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area based on rates that are effective July 1, 1996, for pediatric practitioners. The attached listing of rates is based upon the average payment rate for each procedure code in FY '94. This represents the second previous year.

The results of a comparison of licensed pediatric providers participating in the Medicaid program, by SRS catchment areas, is attached. Pediatricians, internal and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment. These results substantiate that access is available in these areas.

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We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing pediatric care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

Sincerely,

Janet Schalanasky
Deputy Secretary
Kansas Department of
Social and Rehabilitation Services

96 APR -1 PM 12:38
HCFA - REGION VII
KANS. MEDICAID

JS:dat

TN#MS-96-05 Approval Date APR 25 1996 Effective Date APR 01 1996 Supersedes TN#MS-95-07

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

March 29, 1996

Mr. Robert Epps
Health Care Financing Administration
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Dear Mr. Epps:

Kansas assures services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area based on rates that are effective July 1, 1996, for obstetrical practitioners. The attached listing of rates is based upon the average payment rate for each procedure code in FY '94. This represents the second previous year.

The results of a comparison of licensed obstetrical providers participating in the Medicaid program, by SRS catchment areas, is attached. Obstetricians, internal and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment. These results substantiate that access is available in these areas.

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We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing obstetrical care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

96 APR 1 PM 12:38
HCFA-MEDICAID
REGION VII

Sincerely,

Janet Schalansky

Janet Schalansky,
Deputy Secretary
Kansas Department of
Social and Rehabilitation Services

JS:dat

TN#MS-96-04 Approval Date APR 25 1996 Effective Date APR 01 1996 Supersedes TN#MS-95-06

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

March 31, 1994

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Health Care Financing Administration
601 East 12th Street
Kansas City, Missouri 64106

94 APR -4 AM 10:44
HHS
HCFA-MEDICAID
REGION VII

Dear Mr. Brummel:

Kansas assures services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area based on rates effective July 1, 1994, for Pediatrician Practitioners. The attached listing of rates is based upon the average payment rate for each procedure code in FY '93.

The results of a comparison of licensed and enrolled pediatric providers participating in the Medicaid program, by SRS catchment areas, is attached. Pediatricians, family and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program, by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment. These results substantiate that access is available in these areas.

We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing pediatric care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

Sincerely,

Joyce C. Sugrue, R.N.
Director
Division of Medical Services

JCS:TAH:pm
cc: Steve Otto

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

TN#MS-94-05 Approval Date MAY 04 1994 Effective Date APR 01 1994 Supersedes TN#MS-93-08

mrb

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

March 31, 1994

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Health Care Financing Administration
601 East 12th Street
Room 235
Kansas City, Missouri 64106

HHS
HCFA-MEDICAID
REGION VII
94 APR -4 AM 10:43

Dear Mr. Brummel:

Kansas assures services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area based on rates that are effective July 1, 1994, for obstetrical practitioners. The attached listing of rates is based upon the average payment rate for each procedure code in FY '93.

The results of a comparison of licensed obstetrical providers participating in the Medicaid program, by SRS catchment areas, is attached. Obstetricians, family and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment. These results substantiate that access is available in these areas.

We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing obstetrical care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

Sincerely,

Joyce C. Sugrue, R.N.
Director
Division of Medical Services

JCS:TAH:pm
cc: Steve Otto

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

TN#MS-94-04 Approval Date MAY 04 1994 Effective Date APR 01 1994 Supersedes TN#MS-93-07

MO 3

HHS
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REGION VII
93 APR -9 PM 1:25

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

March 29, 1993

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

Kansas assures services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area based on rates effective July 1, 1993, for Pediatrician Practitioners. The attached listing of rates is based upon the average payment rate for each procedure code in FY '92.

The results of a comparison of licensed and enrolled pediatric providers participating in the Medicaid program, by SRS catchment areas, is attached. Pediatricians, family and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program, by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment on March 24, 1992. These results substantiate that access is available in these areas.

There are very few nurse practitioners in independent practice and providing pediatric service in Kansas. Two are enrolled in Medicaid, one in Sedgwick County and one in Grant County.

We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing pediatric care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

Sincerely,

Joyce C. Sugrue
Director, Medical Services

JCS:TAH:pm
Attachment
cc: Steve Otto

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

TN#MS-93-08 Approval Date MAY 2 1 1993 Effective Date APR 0 1 1993 Supersedes TN#MS-92-11

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

HHS
HCFA-MEDICAID
REGION VII
93 APR 15 AM 8:09

April 12, 1993

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

When Kansas mailed its Assurance Letters advising the Health Care Financing Administration of the adequacy of the rates in Kansas for Pediatric Services and for Obstetric Services, we did not include the HCFA form 179 with the two Medicaid State Plan submissions that contained the assurances. Enclosed are the HCFA 179 transmittal forms for MS 93-07 and for MS 93-08.

In addition, one page in each of the Plan pieces contained a page with a table that did not contain the transmittal line at the bottom. Enclosed are corrected copies of these two tables, one for MS 93-07 and one for MS 93-08. Please replace the affected pages in the submissions you received with these replacement pages.

Any questions may be directed to Tina Hayes at (913) 296-2459.

Sincerely,

Joyce C. Sugrue, R.N.
Director
Division of Medical Services

JCS:TAH:pm

Enclosures

cc: Steve Otto

MS 93-07 Approved 05/21/93 Effective 04/01/93 Supersedes MS 92-10

MX3

HHS
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REGION VII

93 APR -9 PM 1:26

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

March 29, 1993

Mr. Richard P. Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

Kansas assures services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area based on rates that are effective July 1, 1993, for obstetrical practitioners. The attached listing of rates is based upon the average payment rate for each procedure code in FY '92.

The results of a comparison of licensed obstetrical providers participating in the Medicaid program, by SRS catchment areas, is attached. Obstetricians, family and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment on March 24, 1992. These results substantiate that access is available in these areas.

There are no nurse midwives participating in the Medicaid program as independent practitioners in Kansas. There are few nurse midwives practicing in Kansas and those that are practicing do so in conjunction with a physician practice.

We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing obstetrical care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

Sincerely,

Joyce C. Sugrue
Director, Medical Services

JCS:TAH:pm
Attachment
cc: Steve Otto

TN#MS-93-07 Approval Date MAY 21 1993 Effective Date APR 01 1993 Supersedes TN#MS-92-10

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

May 7, 1992

HCFA-REGIONAL AID
MAY 12 1 45 PM '92

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

Kansas assures that rates that are effective July 1, 1992, for obstetrical practitioners services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area. The attached listing of rates is based upon the average payment rate for each procedure code in FY '91.

The results of a comparison of licensed obstetrical providers participating in the Medicaid program, by SRS catchment areas, is attached. Obstetricians, family and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment on March 24, 1992. These results substantiate that access is available in these areas.

There are no nurse midwives participating in the Medicaid program as independent practitioners in Kansas. There are few nurse midwives practicing in Kansas and those that are practicing do so in conjunction with a physician practice.

We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing obstetrical care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

Sincerely,

Joyce C. Sugrue
Director, Medical Services

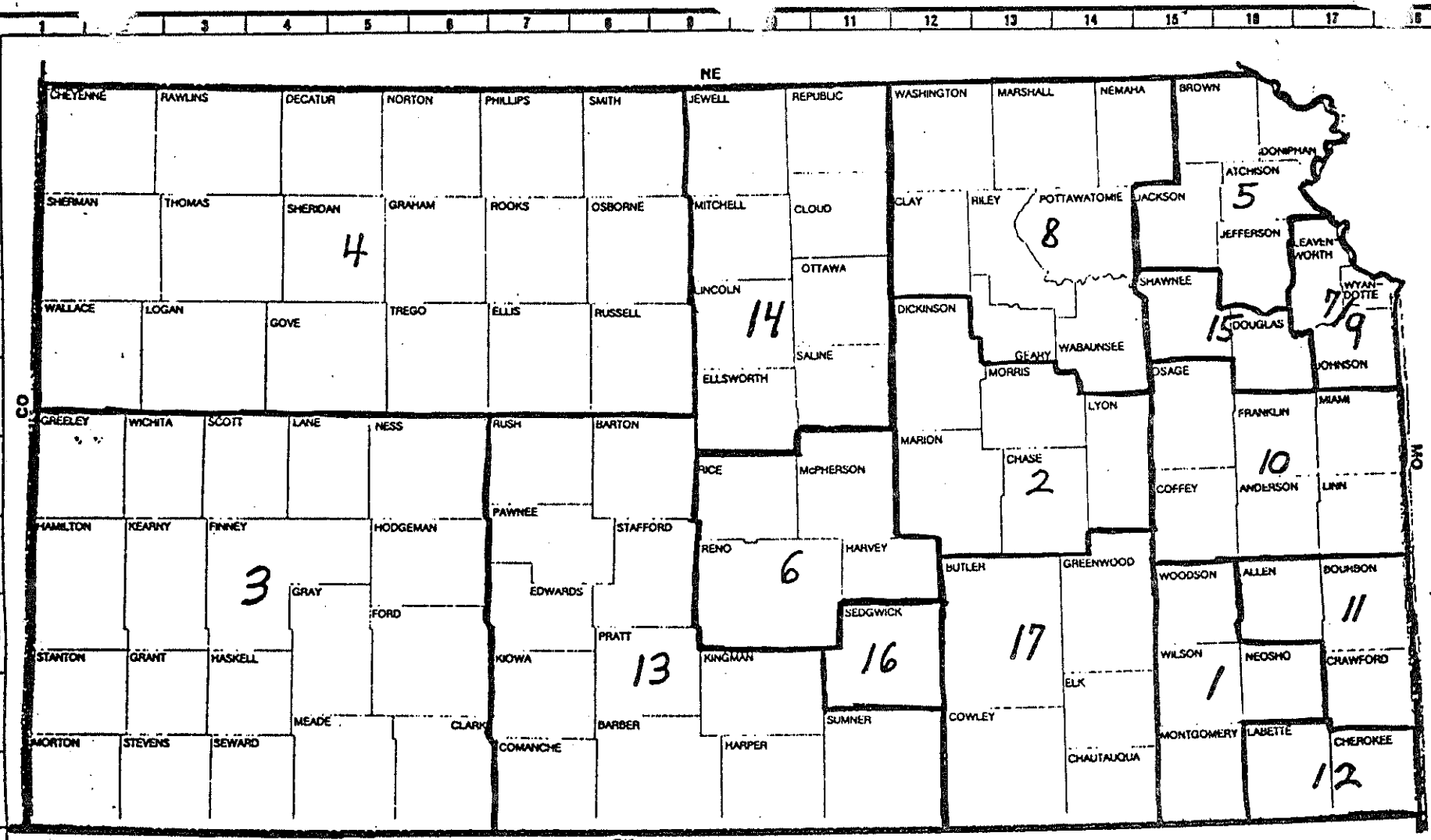
JCS:MLM
Attachment
cc: Steve Otto

TN#MS-92-10 Approval Date MAY 2 1 1992 Effective Date APR 0 1 1992 Supercedes TN#MS-91-15

OBSTETRICS PROVIDER ACCESS 1992

GEOGRAPHIC AREA	H & E LICENSED	PARTICIPATING IN THE MEDICAID PROGRAM	% PARTICIPATING
CHANUTE (1)	41	26	63.4%
EMPORIA (2)	33	25	75.8%
GARDEN CITY (3)	66	62	93.9%
HAYS (4)	59	51	86.4%
HIAWATHA (5)	31	30	96.8%
HUTCHINSON (6)	52	41	78.8%
K C METRO (7&9)	275	152	55.3%
MANHATTAN (8)	60	51	85.0%
OSAWATOMIE (10)	33	30	90.9%
PARSONS (11)	19	12	63.2%
PITTSBURG (12)	34	25	73.5%
PRATT (13)	62	59	95.2%
SALINA (14)	44	34	77.3%
TOPEKA (15)	83	75	90.4%
WICHITA (16)	243	133	54.7%
WINFIELD (17)	49	30	61.2%
	1,184	836	70.6%

State of Kansas



Name of County	Population	Location on Map
ALLEN	15,666	G-15
ANDERSON	8,249	F-15
ATCHISON	16,924	C-15
BARBER	5,874	J-7
BARTON	29,152	F-9
BOURBON	15,379	G-15
BROWN	10,724	C-15
BUTLER	50,580	H-12
CHASE	3,030	F-11
CHAUTAUQUA	4,359	I-14
CHEROKEE	22,258	G-15
CHEYENNE	3,243	A-1
CLARK	2,390	J-3
CLAY	8,822	C-12
CLOUD	12,860	C-10
COFFEY	8,743	F-13
COMANCHE	2,313	J-6
COWLEY	36,915	I-12
CRAWFORD	38,818	H-15
DECATUR	4,170	B-1
DICKINSON	20,466	D-11
DONIPHAN	8,419	C-15
DOUGLAS	81,798	D-13
EDWARDS	3,787	H-8
ELK	3,327	I-14
ELLIS	26,004	E-7
ELLSWORTH	6,525	E-9
FINNEY	33,070	G-3
FORD	27,463	H-5
FRANKLIN	24,784	F-14
GEARY	30,053	D-12
GOVE	4,015	D-4
GRAHAM	4,390	D-6
GRANT	7,829	I-2
GRAY	6,482	H-3
GREELEY	1,703	G-1
GREENWOOD	8,882	I-14
HAMILTON	2,670	H-1
HARPER	6,536	J-8
HARVEY	30,371	G-11
HASKELL	4,074	I-3
HODGEMAN	2,085	G-5
JACKSON	11,525	C-14
JEFFERSON	15,207	C-14
JEWELL	4,151	C-8
JOHNSON	270,269	E-13
KEARNY	3,996	H-2
KINGMAN	8,905	H-9
KIOWA	3,660	J-7
LABETTE	23,693	H-15
LANE	2,470	G-4
LEAVENWORTH	64,371	C-13
LINCOLN	3,578	D-9
LINN	9,570	E-14
LOGAN	3,349	D-3
LYON	35,942	F-12
MARION	13,361	G-12
MARSHALL	12,888	C-12
MCPHERSON	27,268	G-10
MEADE	4,631	I-4
MIAMI	23,466	F-15
MITCHELL	7,204	D-9
MONTGOMERY	38,816	I-15
MORRIS	6,104	E-12
MORTON	3,792	I-1
NEMAHA	11,691	B-12
NEOSHO	19,782	H-14
NESS	4,098	F-5
NORTON	5,947	C-5
OSAGE	15,913	E-13
OSBORNE	5,145	D-8
OTTAWA	6,127	D-10
PAWNEE	7,761	H-7
PHILLIPS	6,301	C-7
POTTAWATOMIE	16,780	C-13
PRATT	9,879	H-8
RAWLINS	3,407	B-3
RENO	62,998	H-10
REPUBLIC	5,835	C-9
RICE	11,620	F-10
RILEY	62,843	C-13
ROOKS	6,845	D-7
RUSH	3,944	F-8
RUSSELL	7,835	E-8
SALINE	42,727	E-11
SCOTT	5,289	G-3
SEDGWICK	403,662	G-13
SEWARD	22,732	I-3
SHAWNEE	160,976	D-13
SHERIDAN	3,368	D-5
SHERMAN	6,760	B-4
SMITH	5,924	C-8
STAFFORD	5,572	G-8
STANTON	2,406	I-2
STEVENS	5,048	I-2
SUMNER	25,946	I-11
THOMAS	8,180	B-5
TREGO	3,851	D-5
WABAUNSEE	6,603	D-12
WALLACE	2,023	B-5
WASHINGTON	9,971	C-11
WICHITA	2,531	G-2
WILSON	10,332	H-15
WOODSON	4,116	G-15
WYANDOTTE	162,026	D-13
Total	2,364,236	

TN No: MS-92-10 Approval Date 05/21/92 Effective Date 04/01/92

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

May 7, 1992

Mr. Richard Brummel
Associate Regional Administrator
for Division of Medicaid
Room 227, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

Kansas assures that rates that are effective July 1, 1992, for Pediatrician Practitioners services will be available to Medicaid recipients at least to the extent that such services are available to the general population in the same geographic area. The attached listing of rates is based upon the average payment rate for each procedure code in FY '91.

The results of a comparison of licensed and enrolled pediatric providers participating in the Medicaid program,by SRS catchment areas, is attached. Pediatricians, family and general practice are the specialties included. The information about the number of practitioners participating in the Medicaid program, by SRS catchment areas is based upon an enrollment address within the area and documented in a report received from the Kansas Department of Health and Environment on March 24, 1992. These results substantiate that access is available in these areas.

There are very few nurse practitioners in independent practice and providing pediatric service in Kansas. Two are enrolled in Medicaid, one in Sedgwick County and one in Grant County.

We believe that the above-mentioned documentation shows that the reimbursement rates for physicians providing pediatric care and the proportion of physicians participating in the Medicaid program to the total licensed physicians assures access.

Sincerely,

Joyce C. Sugrue
Director, Medical Services

JCS:MLM
Attachment
cc: Steve Otto

TN#MS-92-11 Approval Date MAY 2 1 1992 Effective Date APR 0 1 1992 Supercedes TN#MS-91-16

PEDIATRIC PROVIDER ACCESS 1992

GEOGRAPHIC AREA	H & E LICENSED	PARTICIPATING IN THE MEDICAID PROGRAM	% PARTICIPATING
CHANUTE (1)	33	24	72.7%
EMPORIA (2)	32	30	93.8%
GARDEN CITY (3)	70	70	100.0%
HAYS (4)	72	72	100.0%
HIAWATHA (5)	29	29	100.0%
HUTCHINSON (6)	50	49	98.0%
K C METRO (7&9)	288	165	57.3%
MANHATTAN (8)	55	52	94.5%
OSAWATOMIE (10)	33	33	100.0%
PARSONS (11)	15	9	60.0%
PITTSBURG (12)	26	23	88.5%
PRATT (13)	71	71	100.0%
SALINA (14)	43	38	88.4%
TOPEKA (15)	85	80	94.1%
WICHITA (16)	227	148	65.2%
WINFIELD (17)	40	29	72.5%
	1,169	922	78.9%

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

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Methods and Standards for Establishing Payment Rates
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Methods and Standards for Establishing Payment Rates- Skilled Nursing and Intermediate Care Facility Rates (NFs and NFs/MH)

Cost Reporting

The cost reporting requirements are included in the Kansas Administrative Regulation 30-10 series. The applicable regulations are in Attachment 4.19D, Subpart I, Exhibit A. Cost reporting is also addressed in Attachment 4.19D, Subpart I, Exhibit C-1, Narrative Explanation of Nursing Facility Reimbursement Formula.

30-10-1a. Nursing facility program definitions. (a) The following words and terms, when used in this article, shall have the following meanings, unless the context clearly indicates otherwise.

(1) "Accrual basis of accounting" means that revenue of the provider is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(2) "Active treatment for individuals with mental retardation or a related condition" means a continuous program for each client, which shall include aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed toward the following:

(A) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and

(B) the prevention or deceleration of regression or loss of current optimal functional status.

(3) "Agency" means the department of social and rehabilitation services.

(4) "Ancillary services and other medically necessary services" means those special services or supplies, in addition to routine services, for which charges are made.

(5) "Case mix" means a measure of the intensity of care and

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services used by a group of residents in a facility.

(6) "Case mix index" means a numeric score with a specific range that identifies the relative resources used by a particular group of residents and represents the average resource consumption across a population or sample. Two average case mix index scores are considered in setting rates for nursing facility program participants. These indexes are the following:

(A) "Medicaid average case mix index," which means the average case mix index calculated using case mix scores for only the medicaid residents in a population; and

(B) "facility average case mix index," which means the average case mix index calculated using case mix scores for all the residents in a nursing facility.

(7) "Change of ownership" means a transfer of rights and interests in real and personal property used for nursing facility services through an arm's-length transaction between unrelated persons or legal entities.

(8) "Change of provider" means a change of ownership or lessee specified in the provider agreement.

(9) "Common ownership" means that an entity holds a minimum of five percent ownership or equity in the provider facility or in a company engaged in business with the provider facility.

(10) "Control" means that an individual or organization has

the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(11) "Cost and other accounting information" means adequate financial data about the nursing facility operation, including source documentation, that is accurate, current, and sufficiently detailed to accomplish the purposes for which it is intended. Source documentation, including petty cash payout memoranda and original invoices, shall be valid only if the documentation originated at the time and near the place of the transaction. In order to provide the required cost data, the provider shall maintain financial and statistical records in a manner that is consistent from one period to another. This requirement shall not preclude a beneficial change in accounting procedures when there is a compelling reason to effect a change of procedures.

(12) "Cost finding" means recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(13) "Costs not related to resident care" means costs that are not appropriate, necessary, or proper in developing and maintaining the nursing facility operation and activities. These costs shall not be allowed in computing reimbursable costs.

(14) "Costs related to resident care" means all necessary and proper costs, arising from arm's-length transactions in

accordance with general accounting rules, that are appropriate and helpful in developing and maintaining the operation of resident care facilities and activities. Specific items of expense shall be limited pursuant to K.A.R. 30-10-23a, K.A.R. 30-10-23b, K.A.R. 30-10-23c, K.A.R. 30-10-24, K.A.R. 30-10-25, K.A.R. 30-10-26, K.A.R. 30-10-27, and K.A.R. 30-10-28.

(15) "Cost report" means the nursing facility financial and statistical report (MS-2004).

(16) "Educational activities" means an approved, formally organized, or planned program of study usually engaged in by providers in order to enhance the quality of resident care in an institution. These activities shall be licensed when required by state law.

(17) "Educational activities--net cost" means the cost of approved educational activities less any grants, specific donations, or reimbursements of tuition.

(18) "Hospital-based nursing facility" means a nursing facility, as defined in this regulation, that is attached to or associated with a hospital.

(19) "Inadequate care" means any act or failure to act that may be physically or emotionally harmful to a recipient.

(20) "Level of care " means the type and intensity of services prescribed in the resident's plan of care as based on

the assessment and reassessment process.

(21) "Mental illness" means a clinically significant behavioral or psychological syndrome or pattern that is typically associated with either a distressing symptom or impairment of function. Relevant diagnoses shall be limited to schizophrenia, recurrent and severe major affective disorders, atypical psychosis, bipolar disorder, paranoid disorders, schizoaffective disorder, psychotic disorder, obsessive-compulsive disorder, or borderline personality disorder.

(22) "Mental retardation" means subaverage general intellectual functioning that originates in the developmental period and is associated with an impairment in adaptive behavior.

(23) "Nonworking owners" means any individual or organization having five percent or more interest in the provider who does not perform a resident-related function for the nursing facility.

(24) "Nonworking related party or director" means any related party, as defined in this regulation, who does not perform a resident-related function for the nursing facility.

(25) "Nursing facility (NF)" means a facility that conforms to these criteria:

(A) Meets state licensure standards;

(B) provides health-related care and services, as prescribed by a physician; and

(C) provides 24-hour-a-day, seven-day-a-week licensed nursing supervision to residents for ongoing observation, treatment, or care for long-term illness, disease, or injury.

(26) "Nursing facility for mental health" means a nursing facility that meets these criteria:

(A) Meets state licensure standards;

(B) provides structured mental health rehabilitation services, in addition to health-related care, for individuals with a severe and persistent mental illness; and

(C) provides 24-hour-a-day, seven-day-a-week licensed nursing supervision. The nursing facility shall have been operating in accordance with a provider agreement with the agency on June 30, 1994.

(27) "Ongoing entity" means that a change in the provider has not been recognized for Kansas medical assistance program payment purposes.

(28) "Organization costs" means those costs directly incidental to the creation of the corporation or other form of legal business entity. These costs shall be considered to be intangible assets representing expenditures for rights and privileges that have value to the business.

(29) "Owner and related party compensation" means salaries, drawings, consulting fees, or other payments paid to or on behalf

of any owner with a five percent or greater interest in the provider or any related party, as defined in this regulation, whether the payment is from a sole proprietorship, partnership, corporation, or nonprofit organization.

(30) "Owner" means the person or legal entity that has the rights and interests of the real and personal property used to provide the nursing facility services.

(31) "Plan of care for nursing facilities" means a document completed by the nursing facility staff that states the need for care, the estimated length of the program, the methodology to be used, and the expected results for each resident.

(32) "Prescription drug" means a simple or compound substance or mixture of substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance that is prescribed by a licensed physician or practitioner and dispensed by a licensed pharmacist.

(33) "Projected cost report" means a cost report submitted to the agency by a provider prospectively for a 12-month period of time. The projected cost report shall be based on an estimate of the costs, revenues, resident days, and other financial data for that 12-month period of time.

(34) "Provider" means the operator of the nursing facility specified in the provider agreement.

(35) "Recipient" means a person determined to be eligible for the Kansas medical assistance program in a nursing facility.

(36) "Related parties" means two or more parties with a relationship in which one party has the ability to influence another party to the transaction in the following manner:

(A) When one or more of the transacting parties might fail to pursue the party's or parties' own separate interests fully;

(B) when the transaction is designed to inflate the Kansas medical assistance program costs; or

(C) when any party considered a related party to a previous owner or operator becomes the employee, or otherwise functions in any capacity on behalf of a subsequent owner or operator. Related parties shall include parties related by family, business, or financial association, or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arm's-length negotiations.

(37) "Related to the nursing facility" means that the facility is significantly associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

(38) "Representative" means either of the following:

(A) A legal guardian, conservator, or representative payee as designated by the social security administration; or

(B) any person who is designated in writing by the resident to manage the resident's personal funds and who is willing to accept the designation.

(39) "Resident assessment form" means the document that meets these requirements:

(A) Is jointly specified by the Kansas department of health and environment and the agency;

(B) is approved by the health care finance administration; and

(C) includes the minimum data set.

(40) "Resident assessment instrument" means the resident assessment form, resident assessment protocols, and the plan of care, including reassessments.

(41) "Resident day" means that period of service rendered to a resident between census-taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any Kansas medical assistance program or non-Kansas medical assistance program resident who was not in the nursing facility. Census-taking hours shall consist of 24 hours beginning at midnight.

(42) "Resident status review" means a reassessment to identify any nursing facility resident who may no longer meet the level of care criteria.

(43) "Routine services and supplies" means services and

supplies that are commonly stocked for use by or provided to any resident. The services and supplies shall be included in the provider's cost report.

(44) "Sale-leaseback" means a transaction in which an owner sells a facility to a related or nonrelated purchaser and then leases the facility from the new owner to operate as the provider.

(45) "Severe and persistent mental illness" means mental illness as defined in this regulation, but shall include both of the following additional requirements:

(A) The individual meets one of the following criteria:

(i) Has undergone psychiatric treatment more intensive than what could have been provided through outpatient care more than once in a lifetime; or

(ii) has experienced a single episode of continuous, structured, supportive residential care other than hospitalization for a duration of at least two months.

(B) The individual meets at least two of the following criteria, on a continuing or intermittent basis, for at least two years:

(i) Is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history;

(ii) requires public financial assistance for out-of-hospital maintenance and may be unable to procure this

assistance without help;

(iii) shows a severe inability to establish or maintain a personal social support system;

(iv) requires help in basic living skills; or

(v) exhibits inappropriate social behavior that results in a need for intervention by the mental health or judicial system.

(46) "Specialized mental health rehabilitation services" means one of the specialized rehabilitative services that provide ongoing treatment for mental health problems and that are aimed at attaining or maintaining the highest level of mental and psychosocial well-being. The specialized rehabilitative services shall include the following:

(A) Crisis intervention services;

(B) drug therapy or monitoring of drug therapy;

(C) training in medication management;

(D) structured socialization activities to diminish tendencies toward isolation and withdrawal;

(E) development and maintenance of necessary daily living skills, including grooming, personal hygiene, nutrition, health and mental health education, and money management; and

(F) maintenance and development of appropriate personal support networks.

(47) "Specialized services" means inpatient psychiatric care

for the treatment of an acute episode of mental illness.

(48) "State licensing agency" means the department of health and environment for hospital-based nursing facilities and the department on aging for all other nursing facilities.

(49) "Swing bed" means a hospital bed that can be used interchangeably as either a hospital bed or nursing facility bed.

(50) "Twenty-four-hour nursing care" means the provision of 24-hour licensed nursing services with the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(51) "Working trial balance" means a list of the account balances in general ledger order that was used in completing the cost report.

(b) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended April 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended Jan. 1, 1999; amended May 1, 2002; amended May 1, 2005.)

30-10-5

30-10-5. Authorized by K.S.A. 1979 Supp. 39-708c; effective, E-74-59, Oct. 24, 1974; effective May 1, 1975; amended May 1, 1976; amended, R-78-35, Dec. 30, 1977; amended May 1, 1978; amended, R-79-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.]

(Contents of this rule and regulation have been transferred to Article 5.)

2002. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended April 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended Jan. 1, 1999; amended May 1, 2002.)

30-10-10. (Authorized by K.S.A. 1973 Supp. 39-708c; effective, E-74-43, Aug. 16, 1974; effective May 1, 1975; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; revoked May 1, 1981.)

(Contents of this rule and regulation have been transferred to Article 5.)

30-10-12. (Authorized by and implementing K.S.A. 1982 Supp. 39-708c, as amended by L. 1983, ch. 143, § 2; effective, E-74-43, Aug. 16, 1974; effective, E-74-44, Aug. 28, 1974; effective May 1, 1975; amended, E-76-34, July 1, 1975; amended May 1, 1976; amended Feb. 15, 1977; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended, E-81-25, Aug. 27, 1980; amended May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended, T-85-9, April 11, 1984; revoked May 1, 1985.)

30-10-13

30-10-13. (Authorized by and implementing K.S.A. 1982 Supp. 39-708c, as amended by L. 1983, ch. 143, § 2; effective, E-74-44, Aug. 28, 1974; effective May 1, 1975; amended May 1, 1976; amended Feb. 15, 1977; amended, E-78-35, Dec. 30, 1977; amended May 1, 1978; amended, E-79-20, Aug. 17, 1978; amended May 1, 1979; amended, E-80-13, Aug. 8, 1979; amended May 1, 1980; amended May 1, 1981; amended May 1, 1982; amended May 1, 1983; amended, T-84-9, March 29, 1983; amended May 1, 1984; amended, T-85-34, Dec. 19, 1984; revoked May 1, 1985.)

30-10-30

30-10-30. This rule and regulation shall expire on May 1, 1991. (Authorized by K.S.A. 39-708c; implementing 1989 HB 2028; effective Jan. 2, 1990; revoked May 1, 1991.)

This exhibit is reserved for future use.

30-10-15a. Reimbursement. Payment for services. (a) Providers with a current signed provider agreement shall be paid a per diem rate for services furnished to Kansas medical assistance-eligible residents. Payment shall be for the type of medical or health care required by the resident, as determined by the attending physician's or physician extender's certification upon admission, and the individual's level of care needs, as determined through assessment and reassessment. However, payment for services shall not exceed the type of care that the provider is certified to provide under the Kansas medical assistance program. The type of care required by the resident may be verified by the agency before and after payment.

(b) Payment for routine services and supplies, pursuant to K.A.R. 30-10-1a, shall be included in the per diem reimbursement, and these services and supplies shall not be otherwise billed or reimbursed.

(1) The following durable medical equipment, medical supplies, and other items and services shall be considered routine for each resident to attain and maintain the highest practicable physical and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, and shall not be billed or reimbursed separately from the per diem rate:

(A) Alternating pressure pads and pumps;

(B) armboards;

(C) bedpans, urinals, and basins;

(D) bed rails, beds, mattresses, and mattress covers;

(ii blood glucose monitors and supplies;

(F) canes;

(G) commodes;

(H) compressors;

(I) crutches;

(J) denture cups;

(K) dialysis, including supplies and maintenance, if the service is provided in the facility by facility staff;

(L) dressing items, including applicators, tongue blades, tape, gauze, bandages, adhesive bandages, pads, compresses, elasticized bandages, petroleum jelly gauze, cotton balls, slings, triangle bandages, pressure pads, and tracheostomy care kits;

(M) emesis basins and bath basins;

(N) enemas and enema equipment;

(O) extra nursing care and supplies;

(P) facial tissues and toilet paper;

(Q) first-aid ointments and similar ointments;

(R) footboards;

(S) foot cradles;

(T) gel pads or cushions;

(U) geriatric chairs;

(V) gloves, rubber or plastic;

(W) heating pads;

(X) heat lamps and examination lights;

(Y) humidifiers;

(Z) ice bags and hot water bottles;

(AA) intermittent positive pressure breathing (IPPB) machines;

(BB) irrigation solution, both water and normal saline;

(CC) I.V. stands and clamps;

(DD) laundry, including personal laundry;

(EE) laxatives;

(FF) lifts;

(GG) lotions, creams, and powders, including baby lotion, oil, and powders;

(HH) maintenance care for residents who have head injuries;

(II) mouthwash;

(JJ) nebulizers;

(KK) nonemergency transporation;

(LL) nutritional supplements;

(MM) occupational therapy;

(NN) orthoses and splints to prevent or correct contractures;

(OO) over-the-counter analgesics and antacids taken for the occasional relief of pain or discomfort, as needed;

(PP) over-the-counter vitamins;

(QQ) oxygen masks, stands, tubing, regulators, hoses, catheters, cannulae, and humidifiers;

(RR) parenteral and enteral infusion pumps;

(SS) patient gowns, pajamas, and bed linens;

(TT) physical therapy;

(UU) respiratory therapy;

(VV) restraints;

(WW) sheepskins and foam pads;

(XX) skin antiseptics, including alcohol;

(YY) speech therapy;

(ZZ) sphygmomanometers, stethoscopes, and other examination equipment;

(AAA) stool softeners;

(BBB) stretchers;

(CCC) suction pumps and tubing;

(DDD) syringes and needles, except insulin syringes and needles for diabetics that are covered by the pharmacy program;

(EEE) thermometers;

(FFF) traction apparatus and equipment;

(GGG) underpads and adult diapers, disposable or nondisposable;

(HHH) walkers;

(III) water pitchers, glasses, and straws;

(JJJ) weighing scales; and

(KKK) wheelchairs.

(2) Urinary supplies. Urinary catheters and accessories shall be covered services in the Kansas medical assistance program when billed through the durable medical equipment or medical supply provider. This expense shall not be reimbursed through the per diem rate derived from the cost report.

(3) Total nutritional replacement therapy. Total nutritional replacement therapy shall be a covered service in the Kansas medical assistance program and billed through the durable medical equipment or medical supply provider. Total nutritional replacement therapy expenses shall not be reimbursed through the per diem rate derived from the cost report.

(4) Each nursing facility shall provide at no cost to residents over-the-counter drugs, supplies, and personal comfort items that meet these criteria:

(A) Are available without a prescription at a commercial pharmacy or medical supply outlet; and

(B) are provided by the facility as a reasonable accommodation for individual needs and preferences. These over-the-counter products shall be included in the nursing facility cost report. A nursing facility shall not be required to stock

all products carried by vendors in the nursing facility's community that are viewed as over-the-counter products.

(5) Occupational, physical, respiratory, speech, and other therapies. The Kansas medical assistance program cost of therapies shall be determined as follows:

(A) Compute the medicaid therapy ratio as the total number of medicaid therapy units not otherwise reimbursed to the total number of therapy units provided to all nursing facility residents during the cost report period;

(B) multiply the medicaid therapy ratio by the total reported therapy costs to determine the allowable medicaid portion of therapy costs;

(C) multiply the allowable medicaid portion of the therapy costs by the ratio of total days to medicaid resident days to determine the allowable therapy expenses for the cost report period;

(D) offset the nonallowable portion of the therapy cost in the provider adjustment column and on the related therapy expense line in the cost report; and

(E) submit a work paper with the cost report that supports the calculation of the allowable Kansas medical assistance program therapy expenses determined in accordance with paragraphs (b)(5)(A) through (C) above.

(c) Each provider of ancillary services, as defined in

K.A.R. 30-10-1a, shall bill separately for each service when the services or supplies are required. Payment for oxygen shall be reimbursed to the oxygen supplier through the agency's fiscal agent, or the fiscal agent may reimburse the nursing facility directly if an oxygen supplier is unavailable.

(d) Payment for specialized rehabilitative services or active treatment programs shall be included in the per diem reimbursement.

(e) Payment shall be limited to providers who accept, as payment in full, the amount paid in accordance with the fee structure established by the Kansas medical assistance program.

(f) Payment shall not be made for allowable, nonroutine services and items unless the provider has obtained prior authorization.

(g) Private rooms for recipients shall be provided when medically necessary or, if not medically necessary, at the discretion of the facility. If a private room is not medically necessary or is not occupied at the discretion of the facility, then a family member, guardian, conservator, or other third party may pay the difference between the usual, customary charge and the medicaid payment rate. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1,

1997; amended Jan. 1, 1999; amended July 1, 2002; amended Aug. 15, 2003.)

30-10-15b. Financial data. (a) General. The per diem rate or rates for providers participating in the Kansas medical assistance program shall be based on an audit or desk review of the costs reported to provide resident care in each facility. The basis for conducting these audits or reviews shall be form MS 2004, as adopted by reference in K.A.R. 30-10-17. Each provider shall maintain sufficient financial records and statistical data for proper determination of reasonable and adequate rates. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the nursing facility and related fields shall be followed, except to the extent that they may conflict with or be superseded by state or federal medicaid requirements. Changes in these practices and systems shall not be required in order to determine reasonable and adequate rates.

(b) Pursuant to K.A.R. 30-10-17, cost reports shall be required from providers on an annual basis.

(c) Adequate cost data and cost findings. Each provider shall provide adequate cost data on the cost report. This cost data shall be in accordance with state and federal medicaid requirements and general accounting rules and shall be based on the accrual basis of accounting. Estimates of costs shall not be allowable except on projected cost reports submitted pursuant to K.A.R. 30-10-17.

(d) Recordkeeping requirements.

(1) Each provider shall furnish any information to the agency that is necessary to meet these criteria:

(A) To assure proper payment by the program pursuant to paragraph (d)(2) below;

(B) to substantiate claims for program payments; and

(C) to complete determinations of program overpayments.

(2) Each provider shall permit the agency to examine any records and documents that are necessary to ascertain information

pertinent to the determination of the proper amount of program payments due. These records shall include the following:

(A) Matters of the nursing facility ownership, organization, and operation, including documentation as to whether transactions occurred between related parties;

(B) fiscal, medical, and other recordkeeping systems;

(C) federal and state income tax returns and all supporting documents;

(D) documentation of asset acquisition, lease, sale, or other action;

(E) franchise or management arrangements;

(F) matters pertaining to costs of operations;

(G) amounts of income received, by source and purpose; and

(H) a statement of changes in financial position.

(3) Other records and documents shall be made available as necessary.

(4) Records and documents shall be made available in Kansas.

(5) Each provider, when requested, shall furnish the agency with copies of resident service charge schedules and changes to them as they are put into effect. The charge schedules shall be evaluated by the agency to determine the extent to which they may be used for determining program payment.

(6) Suspension of program payments may be made if the agency determines that any provider does not maintain or no longer maintains adequate records for the determination of reasonable and adequate per diem rates under the program, or the provider fails to furnish requested records and documents to the agency. Payments to that provider may be suspended.

(7) Thirty days before suspending payment to the provider, written notice shall be sent by the agency to the provider of the agency's intent to suspend payments, except as provided in paragraph(e)(2). The notice shall explain the basis for the agency's determination with respect to the provider's records and shall identify the provider's recordkeeping deficiencies.

(8) All records of each provider that are used in support of costs, charges, and payments for services and supplies shall be subject to inspection and audit by the agency, the United States department of health and human services, and the United States general accounting office. All financial and statistical records used to support cost reports shall be retained for five years after the date of filing the cost report with the agency.

(e) Desk review requirement.

(1) Each provider shall submit all information requested by the agency that is necessary to complete the desk review of the cost report.

(2) If a provider does not submit the information deemed necessary by the agency to complete the desk review of the cost report for a nursing facility, the provider shall be notified in writing by the agency that it has 10 working days from the date of this notice to submit the required information, or the Kansas medical assistance program payments shall be suspended for the nursing facility.

(f) This regulation shall be effective on and after July 1, 2002. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 1, 1999; amended July 1, 2002.)

30-10-16

30-10-16. This rule and regulation shall expire on July 1, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective May 1, 1987; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; revoked July 1, 1991.)

30-10-17. Cost reports. (a) Historical cost data.

(1) For cost reporting purposes, each provider shall submit the "nursing facility financial and statistical report," form MS-2004,revised August 2004 and hereby adopted by reference, completed in accordance with the accompanying instructions. The MS-2004 cost report shall be submitted on diskette, using software designated by the agency for cost report periods ending on or after December 31, 1999.

(2) Each provider who has operated a facility for 12 or more months on December 31 shall file the nursing facility financial and statistical report on a calendar year basis.

(b) Projected cost data.

(1) Projected cost reports for providers.

(A) If a provider is required to submit a projected cost report under K.A.R. 30-10-18 (c) or (e), the provider's rate shall be based on a proposed budget with costs projected on a line item basis.

(B) The projected cost report for each provider who is required to file a projected cost report shall begin according to either of the following schedules:

(i) On the first day of the month in which the nursing facility was certified by the state licensing agency if that date is on or before the 15th of the month; or

(ii) on the first day of the following month if the facility

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is certified by the state licensing agency between the 16th and 31st of the month.

(C) The projected cost report shall end on the last day of the 12-month period following the date specified in paragraph (b)(1)(B) above, except under either of the following:

(i) The projected cost report shall end on December 31 when that date is not more than one month before or after the end of the 12-month period.

(ii) The projected cost report shall end on the provider's normal fiscal year-end used for the internal revenue service when that date is not more than one month before or after the end of the 12-month period and the criteria in K.A.R. 30-10-18 for filing the projected cost report ending on December 31 do not apply.

(D) The projected cost report period shall cover a consecutive period of time not less than 11 months and not more than 13 months.

(E) The projected cost report shall be reviewed for reasonableness and appropriateness by the agency. The projected cost report items that are determined to be unreasonable shall be disallowed before the projected rate is established.

(2) Projected cost reports for each provider with more than one facility.

(A) Each provider who is required to file a projected cost report in accordance with this subsection and who operates more than one facility, either in state or out of state, shall

allocate central office costs to each facility that is paid rates from the projected cost data. The provider shall allocate the central office cost at the end of the provider's fiscal year or the calendar year that ends during the projection period.

(B) The method of allocating central office costs to those facilities filing projected cost reports shall be consistent with the method used to allocate the costs to those facilities in the chain that are filing historical cost reports.

(c) Amended cost reports.

(1) Each provider shall submit an amended cost report revising cost report information previously submitted if an error or omission is identified that is material in amount and results in a change in the provider's rate of $.10 or more per resident day.

(2) An amended cost report shall not be allowed after 13 months have passed since the last day of the year covered by the report.

(d) Due dates of cost reports.

(1) Each calendar year cost report shall be received not later than the close of business on the last working day of February following the year covered by the report.

(2) An historical cost report covering a projected cost report period shall be received by the agency not later than the close of business on the last working day of the second month following the close of the period covered by the report.

(3) Each cost report approved for a filing extension in accordance with subsection (e) shall be received not later than the close of business on the last working day of the month approved for the extension request.

(e) Extension of time for submitting a cost report.

(1) A one-month extension of the due date for the filing of a cost report may be granted by the agency when the cause for delay is beyond the control of the provider. Delays beyond the control of the provider that may be considered by the agency in granting an extension shall include the following:

(A) Disasters that significantly impair the routine operations of the facility or business;

(B) destruction of records as a result of a fire, flood, tornado, or another accident that is not reasonably foreseeable; and

(C) computer viruses that impair the accurate completion of cost report information.

(2) The provider shall make the request in writing. The request shall be received by the agency on or before the due date of the cost report. Requests received after the due date shall not be accepted.

(3) A written request for a second one-month extension may be granted by the Kansas medical assistance program director if the cause for further delay is beyond the control of the

provider. The request shall be received by the agency on or before the due date of the cost report, or the request shall not be approved.

(f) Penalty for late filing. Each provider filing a cost report after the due date shall be subject to the following penalties:

(1) If the complete cost report has not been received by the agency by the close of business on the due date, all further payments to the provider shall be suspended until the complete cost report has been received. A complete cost report shall include all the required documents listed in the cost report.

(2) Failure to submit the cost report within one year after the end of the cost report period shall be cause for termination from the Kansas medical assistance program.

(g) Balance sheet requirement. Each provider shall file a balance sheet prepared in accordance with cost report instructions as part of the cost report forms for each provider.

(h) Working trial balance requirement. Each provider shall submit a working trial balance with the cost report. The working trial balance shall contain account numbers, descriptions of the accounts, the amount of each account, and the cost report expense line on which the account was reported. Revenues and expenses shall be grouped separately and totaled on the working trial balance and shall reconcile to the applicable cost report schedules. A schedule that lists all general ledger accounts

grouped by cost report line number shall be attached.

(i) An allocation of expenditures between the hospital and the long-term care unit facility shall be submitted through a step-down process prescribed in the cost report instructions.

(j) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended Jan. 1, 1999; amended July 1, 2002; amended Dec. 31, 2002; amended, T-30-5-30-03, July 1, 2003; amended July 25, 2003; amended May 1, 2005.)

State of Kansas
Department of Social & Rehabilitation Services (SRS)/
Department on Aging (KDOA)

INSTRUCTIONS FOR COMPLETING THE NURSING FACILITY FINANCIAL AND STATISTICAL REPORT (FORM MS-2004)

PURPOSE

The purpose of this report is to obtain the resident-related costs incurred by nursing facilities (NF) and nursing facilities-mental health (NF-MH) in providing services according to applicable state and federal laws, regulations, and quality and safety standards. The regulations governing the completion of this report and NF reimbursement can be found in the Kansas Administrative Regulations (KAR), Chapter 30, Part 10.

SUBMITTAL INSTRUCTIONS

1. One blank Form MS-2004 on diskette, Nursing Facility Financial and Statistical Report, will be sent by the Program and Policy Commission to each nursing facility in the Kansas Medical Assistance Program before the end of the home's reporting period.

2. Send the completed form MS-2004 and form AU-3803 (Census Summary) for each month of the reporting period on diskette, along with two printed and signed copies of page 16 of the MS-2004 to the following address:

Kansas Department on Aging
New England Building
503 S. Kansas Avenue
Topeka, Kansas 66603-3404
Attention: Director, Nursing Facility Rate Setting

3. All inquires on completion of these forms should be directed to the Director, NF Rate Setting at (785) 296-0703.

GENERAL

The cost report is organized by the following sections and numbering schemes. Not all line numbers within each range are used.

General Information	Lines 1-99
Schedule A, Operating Cost Center	Lines 101-199
Schedule A, Indirect Health Care Cost Center	Lines 201-299
Schedule A, Direct Health Care Cost Center	Lines 301-399
Schedule A, Ownership Cost Center	Lines 401-499
Schedule A, Non-Reimbursable/Non-Resident Related Expense Items	Lines 501-599
Schedule B, Expense Reconciliation	Lines 601-650
Schedule C, Statement of Owners and Related Parties	Not Numbered
Schedule D, Statement Related to Interest...	Lines 651-699
Schedule E, Balance Sheet	Lines 701-750
Schedule F, Beginning & Ending Residual Balances Reconciliation	Lines 751-799
Schedule G, Revenue Statement	Lines 801-850
Schedules H(1), Related ACH Info, and H(2), Non-Resident Related...	Lines 851-899
Schedule I, Fixed Asset, Depreciation & Amortization Questionnaire	Lines 901-950
Schedule J, Employee Turnover Report	Lines 951-999

1. Complete the forms accurately and legibly. Any report that is incomplete or is not legible shall be promptly returned to the provider. Failure to submit a complete cost report shall result in suspension of payment until the complete cost report is received.

2. All amounts must be rounded to the nearest dollar and sum to the total.

3. **DO NOT** add lines to the forms. Use "OTHER" lines for resident-related expenses not designated on the Expense Statement, Schedule A. Attach a schedule if necessary.

4. **DO NOT** cross out or re-title lines on the forms. **DO NOT** include more than one amount per line. If more than one amount or journal entry is combined, submit an attachment with explanation. The attachment should be **sorted by cost report line number** and should include subtotals.

5. Enter the ten (10) digit SRS provider number and the ten (10) digit EDS provider number on page 1 and in the blank space provided at the top of each schedule. **DO NOT** use your federal number assigned by the Dept. of Health & Environment.

6. Use the accrual method of accounting in reporting financial data. Revenues are reported in the period when **earned**, and not when received, and expenses are reported when **incurred**, not when paid.

7. Estimates of revenues and expenses are not acceptable.

8. All cost reports, historical or projected, must be for a period of 12 consecutive months except as provided in KAR 30-10-17. Providers who filed a projected cost report must file a historical report for the projection period and a historical report for the first calendar year following the end of the projection period.

9. All calendar year cost reports shall be received by the agency no later than the close of business on the last working day of February. All other historical cost reports covering a projection status period shall be received by the agency no later then the close of business on the last working day of the second month after the reporting period ends. The provider may request a one month extension of the due date by submitting the request in writing to the address in the submittal instructions within the time period allowed for filing the original cost report. The extension will be granted if the agency determines that the provider has shown good cause. NOTE: IF A COST REPORT IS RECEIVED AFTER THE DUE DATE WITHOUT AN APPROVED TIME EXTENSION, THE PROVIDER IS SUBJECT TO THE PENALTIES SPECIFIED IN KAR 30-10-17.

10. Each NF/NF-MH must maintain adequate accounting end/or statistical records. Inadequate record keeping is cause for suspension of payments. KAR 30-10-15b. If non-NF/NF-MH program expenses have been commingled with the NF or NF-MH, see the instructions for provider adjustments on Schedule A, Expense Schedule.

11. Reimbursement rates (per diem) for NF: The per diem rate of reimbursement for those facilities participating in the Kansas Medical Assistance program is based on the reported costs and resident days as adjusted by a desk review of the cost report and payment limitations. Each cost report is also subject to a field audit to arrive at a final settlement for the period upon which the per diem rate was based.

12. **KANSAS ADMINISTRATIVE REGULATIONS:** Copies of the regulations governing NF Kansas Medical Assistance reimbursement may be obtained at a cost by sending a request to the Department on Aging to the address given in the submittal instructions. NOTE: SINCE THE REGULATIONS MAY BE CHANGED, THE PREPARER OF THE COST REPORT SHOULD CAREFULLY REVIEW THE MOST RECENT VERSION PRIOR TO COMPLETING THE FORM MS-2004 FOR SUBMISSION.

13. **NURSING FACILITIES ATTACHED TO HOSPITALS:** A nursing facility that is attached or associated with a hospital and shares expenditures shall submit the cost report (MS-2004), census sheets (AU-3902), and the following Medicare schedules: W/S A, A-6, A-8, B Part I and B-1. Also include the working trial balance that includes both the hospital and the long-term unit. A "step-down process" will be run using the statistical information from W/S B-1 and the net expenses for cost allocation from Column 0 on W/S B Part 1. This will provide the indirect long-term care unit costs. Based on the long term care cost to net expense ratio, each department cost will be allocated to the appropriate line of the cost report. The total cost reported on the cost report should equal the long-term care total, Column 25, on W/S B Part 1.

COST REPORT INSTRUCTIONS

COVER PAGE

PROVIDER IDENTIFICATION:

Lines 11-20: Complete these lines as indicated on the report form.

Lines 21-23: Check only one box.

Line 21 Check if the cost data is for the calendar year report period and does not include any portion of a projection period.

Line 22 Applies to projected cost reports for new providers and newly constructed facilities.

Line 23 Applies to providers filing their first historical cost report for a non-calendar year.

Lines 26-32: Check only one box. Check the type of business organization which most accurately describes your provider status or explain on line 33, Other. Limited Liability Companies should check the box that matches their declaration for tax purposes.

NF and NF-MH:

Lines 43-43d: Enter the number of licensed NF or NF-MH beds under the BED COUNT column. Then calculate and record the number of bed days at that bed count (multiply the bed count by the number of calendar days this count is maintained, see example below). If a change in the number of beds has occurred during the reporting period, show the increase or decrease, the date of the change, the new bed count, and the bed days at that count.

Example of Bed Days calculation:
Assume a home of 20 beds was increased on July 1 to 25 beds, the number of bed days for the period would be determined as follows:

January 1 to June 30 - 181 days x 20 beds =	3,620 bed days
July 1 to December 31- 184 days x 25 beds =	4,600 bed days
	8,220 bed days for period

Line 45: Record the bed count as of the ending date of the cost report period.

Line 46: **Total Bed Days** – Record the sum of the BED DAYS AT THIS COUNT column from lines 43-43d.

Line 48: **Total Resident Days** - The total number of resident days shall be determined in accordance with KAR 30-10-28. A resident day means that period of service rendered to a resident between the census-taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any Kansas Medical Assistance or non-Kansas Medical Assistance resident who was not in the facility (KAR 30-10-1a). If both the admission and discharge occur on the same day, it shall count as a resident day. If the provider does not make refunds on behalf of a resident for unused days in the case of death or discharge, and if the bed is available and actually used by another resident, these unused days shall not be counted as a resident day. Any bed days paid for the resident before an admission date shall not be counted as a resident day. The total resident day count for the cost report period shall be accurate. An estimate of the days of care provided shall not be acceptable. **The total resident days must agree with the 12 month total as submitted on the diskette of the Form AU-3902.**

Day care and day treatment shall be counted as one resident day for 18 hours of service. The recipients of day care/treatment shall be listed on the monthly census summary diskette of the Form (AU-3903) with the number of hours reflected on the appropriate day column.

Occupancy Percentage: Agency staff will determine this percentage.

Line 48a: **Total Kansas Medical Assistance Days** - Enter the total number of **Kansas Medical Assistance** days reported on the diskette of the Form AU-3902. Partial, as well as full paid days must be included (please refer to KAR 30-10-28).

Line 48b: **Total Medicare Days** - Enter the total Medicare days in the report period.

OTHER FACILITY BEDS:

Lines 49: **Assisted Living/Res. Care** - Enter the number of beds for assisted living and residential health care. If a change in the number of beds occurred during the reporting period, show the increase or (decrease) and the date of the change. Attach a schedule if additional space is needed to show all changes in the number of licensed beds.

Line 50: **Unlicensed Beds** - Enter the number of unlicensed beds i.e., apartments within the facility. If a change in the number of beds occurred during the reporting period, show the increase or (decrease) and the date of the change. Attach a schedule if additional space is needed to show all changes in the number of licensed beds.

Line 51: Enter the total number of other residential days with shared NF/NF-MH costs. The total other residential days must agree with the 12 month total as submitted on the diskette of the Form AU-3903.

Line 52: Check the appropriate box regarding Medicare certified beds.

Line 53: Please indicate if the facility is a hospital based long term care (LTC) facility or a free standing facility.

SCHEDULE A - EXPENSE STATEMENT

Attach a copy of the working trial balance used to prepare the cost report.

Total Annual Hours Paid - Column 1 - Enter the total hours paid to the employees on each of the salary lines for the reporting period. Employees shall be reported on the appropriate salary line for their position classification.

Per Books or Federal Tax Return - Column 2 - Report the expenses reflected in the accounting records under the appropriate cost center (i.e., Operating, Indirect Health Care, Direct Health Care, Ownership and Non-Reimbursable). The total of all the expense lines (Column 1 - Line 599) shall reconcile to the income tax return and/or the accounting records.

Provider Adjustments - Column 3 - Enter the necessary adjustments to the expenses reported in Column 2 that are not resident-related according to the regulations and/or offset expense recoveries reported in the Revenue Statement, Schedule G. Attach a schedule if necessary.

Resident Related Expense - Column 4 - Enter the difference between Column 2 and Column 3. Please complete Column 4 even if no adjustments were made in Column 3, except for lines 501 through 514.

State Adjustments/Adjusted Resident Related Expenses - Columns 5 & 6 - Leave blank - FOR AGENCY USE ONLY

Expense Lines

General: All costs shall be reported on the designated expense lines. If all expense classifications are not addressed, report the amount on the line and in the cost center that most nearly describes the expense. For example, telephone expense is included in the Operating cost center. Therefore, the expense for telephone lines to the nurses' station shall **not** be reported in the Direct or Indirect Health Care cost center. See specific line instructions for more detail. **DO NOT CROSS OUT OR USE A LINE DESIGNATED FOR A PARTICULAR TYPE OF EXPENSE FOR SOME OTHER TYPE OF EXPENSE.**

The specific instructions, which follow, do not cover each line item of the expense statement, but are designed to cover items that may require additional explanation or examples.

All Salaries - Lines - 101-104, 201-213, and 301-306, - Salaries are compensation paid for personal services that were reported to the Internal Revenue Service (IRS). These lines, plus the owner/related party compensation lines, shall reconcile to your IRS 941 Report forms as adjusted by benefits or other bonuses.

Each facility must have a full time licensed administrator. Non-owner/related party administrator compensation shall be reported on line 101. Owner/related party administrator compensation shall be reported on line 121. A hospital-based long term care unit, under the jurisdiction of a hospital administrator, must report a percentage of the administrator's salary on line 101, and the salary of the staff person serving as an assistant administrator on line 102. Salaries and benefits of the administrator and co-administrator paid as central office costs shall be reported on lines 101, 102, and 119.

Report the salaries of the Direct Health Care Cost Center personnel on the most appropriate classification for lines 301-306. In the Indirect Health Care Cost Center, lines 205-210, are for reporting salaried employee therapists. DO NOT REPORT CONSULTANTS ON THESE LINES.

Employee Benefits - Lines 119, 219, and 319- Allocate employee benefits to the benefit lines in each cost center based on the percentage of gross salaries or the actual amount of expense incurred in each center. Employee benefits, if offered to substantially all employees may include, but are not limited to:

1) Employer's share of payroll taxes

2) State and federal unemployment contributions
3) Workers' compensation insurance
4) Group health and life insurance
5) Employee "non-cash" gifts
6) Moving/relocation expenses
7) Employee retirement plans
8) Employee parties - except alcoholic beverages
9) Profit sharing
10) Physical examinations
11) Malpractice insurance that specifically protects employees. This shall be specifically identified on the insurance bill from the agent.
12) Employee Uniforms
13) Employee Meals

Employee benefits shall not include:

1) Employee cash bonuses and/or incentive awards - these payments shall be considered additional compensation and be reported on salary lines.

2) Benefits given to owner/related parties - these benefits shall be reported on the owner/related party employee benefits lines (125, 225, 325).

Employee benefits with restrictions include:

1) Employee benefits offered to select non-owner/related party employees shall be reported as a benefit in the cost center in which the salary is reported.

Contracted Labor - Lines130, 230 and 330. These lines shall be used to report all contract labor for services that would normally be provided by employees listed in the cost center.

Consultants - Lines131, 231-238, and 331. Consulting fees paid to related parties are subject to the restrictions of KAR 30-10-1a and KAR 30-10-23b (c) and (d). Report fees paid to professionally qualified non-salaried consultants. List the titles of consultants reported on line 238.

Owners and Related Party Compensation - Lines121, 122, 221, and 321. - Record the amount earned and reported to IRS for owner/related parties. In order to be allowed, the compensation must be paid within 75 days after close of the cost report period. The amount reported must be in agreement with entries made in Schedule C. Compensation may be included in allowable cost only to the extent that it represents reasonable remuneration for managerial and administrative functions, professionally qualified health care services and other services related to the operation of the nursing facility, and was rendered in connection with resident care. All compensation paid to an owner/related party shall appear on the appropriate lines above regardless of the label placed on the services rendered (See KAR 30-10-24).

"Other" - Lines 181 and 281 - "Other" or blank lines have been provided in the operating and indirect health care cost centers. Types of expense entered on these lines shall be identified and be applicable to the cost center unless further restricted. Attach a schedule to the cost report. **Failure to do so can cause unnecessary delay in the processing of your cost report.**

Management Consultant Fees - Line 131 - Report fees paid to non-related party management consultants. If the management services company is owned or controlled by the company or person(s) that own or control the facility, actual cost of the management company must be reported as central office costs and/or owner's compensation. See instructions for reporting central office costs - line 151.

Allocation of Central Office Costs - Line 151 - All providers with more than one facility and pooled administrative costs shall report allocated costs on line 151. All facilities, including the central office, must

use the same reporting period. Central office costs shall be reported in accordance with KAR 30-10-27. **Attach a detailed schedule listing the central office costs and method of allocation to each facility.** Submit a copy of the Medicare Home Office Cost Report if applicable. The same method of allocation used on the Medicare Cost Report must be used in the Medicaid Cost Report.

Allowable central office costs are subject to the following conditions:

- Only expense allocations related to Kansas facilities will be allowed.
- Purchases from related-party vendors - Costs of resident-related goods and services supplied to the central office by related parties will be allowed at the lower of the cost to the vendor or the charge to the central office;
- Costs directly attributable to a specific provider or non-provider activity must be allocated directly to the entity for which they were incurred;
- Salaries of owner/related parties - Any of these costs that are included in central office costs must be reported on line 121;
- Central office bulk purchases of adult care home supplies - These expenses may be allocated to the supplies lines in the appropriate cost centers, if the allocation method is adequately documented; and
- Consultants - Costs directly applicable to the indirect and direct health care cost centers may be reported on the applicable consultant lines in these cost centers.

Office Supplies and Printing - Line 152 - Report all office supplies, postage, duplicating and printing expenses on this line. The printing and duplicating of forms are considered to be an administrative expense and shall not be reported in any other cost center. **The exception to this rule is medical records forms that may be reported on line 351, Nursing Supplies.**

Telephone and Other Communication - Line 153 - Report routine telephone and communications expense on this line regardless of the department or cost center benefit.

Travel - Line 154 - Report administrative and staff travel expenses that are related to resident care. **Vehicle costs must be documented by detailed expense and mileage records kept at the time of the travel activity.** Estimates shall not be acceptable. Exceptions:

1) Long term or recurring vehicle lease expense for business purposes shall be reported on line 402.
2) Expenses associated with the personal use of a vehicle are not allowable unless reported within otherwise allowable limits of compensation.
3) Costs related to "in town" entertainment are non-allowable.
4) Travel expenses related to **Provider** board meetings are non-allowable.
5) Resident transportation expense shall be reported on line 258.

Advertising & Recruitment- Line 155 - Report allowable advertising and recruitment expense on this line. This line shall be used for fees paid to employment agencies, employment advertisements and ads in telephone directories. Fund raising, public relations, advertising for resident utilization and sponsorships are **not allowable** and shall be reported on line 505.

Licenses and Dues - Line 156 - Report allowable licenses and dues expense on this line. Refer to KAR 30-10-23a for non-reimbursable dues and membership costs. Personal automobile club memberships are not allowable unless reported as compensation.

Accounting and Data Processing - Line 157 - Report accounting expense on this line, except fees paid to owner/related party firms or individuals which must be reported on the owners compensation line 121.

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Data processing expense related to financial management (i.e., accounting, payroll, budgeting, etc.) shall be reported on this line.

Liability Insurance - Line 158 - Report liability insurance expense on this line.

Other Insurance - Line 159 - Report property insurance expense on this line. Workers' compensation and employee health and life insurance expense shall be reported on employee benefit lines. Insurance premiums on lives of owners and related parties are not an allowable expense, and shall be reported on line 505.

Interest - Line 160 - Report the interest expense related to operating loans and equipment purchases. Submit copies of each new note of $5,000 or more for the year originated. Interest on loans for real and personal property that is included in a re-base, in accordance with KAR 30-10-25e, shall be reported with real estate interest on line 401.

Legal - Line 161 - Report allowable legal expense on this line, subject to KAR 30-10-1a, 23a, and 23b. Allowable fees paid to owner/related party firms or individuals must be reported as owner/related party compensation on line 121.

Criminal Background Check - Line 162 - Report the amount expended for criminal background checks for all employees on this line.

Real Estate and Personal Property Taxes - Line 163 - Report all real and personal property taxes on this line.

Maintenance & Repairs - Line 164 - Report all maintenance and repair expenses applicable to the building, grounds, equipment and vehicles.

Operating Supplies - Line 165 - Report supplies expense incidental to the operation and maintenance of the building, grounds, and equipment.

Small Equipment - Line 166 - Equipment purchases of $1,000 to $5,000 that were not capitalized must be expensed on this line. Equipment purchases of $1 to $999 may be reported in the cost center of benefit as a supply expense.

Other - Line 181 - Report miscellaneous expenses incidental to the operation and/or maintenance of the facility and grounds. These include but are not limited to amortization of administrative organizational and/or start-up costs, trash hauling, snow removal and lawn care. This line shall be used for training and educational expenses for employees with salaries reported in the operating cost center.

Housekeeping Salaries - Line 202 - Report the hours paid and salaries of housekeeping and janitorial staff involved in floor care and in cleaning of the building.

Therapy Salaries - Lines 205-210 - Report the hours paid and salaries of therapists who are directly involved in providing health care. Note: Physical, occupational, speech, and respiratory therapy salaries are subject to the same allowance as therapy consultants.

Medical Records/Resident Activities/Social Worker/ Other Salaries - Lines 204, 211-213 - Report the hours paid and salaries on the appropriate line for these classifications. Specify the job classification of other indirect health care salaries.

Consultants - Lines 231-238 - Record the fees paid to consultants on the appropriate lines. Provider adjustments for physical therapy, occupational therapy, speech therapy, respiratory therapy, and other therapies shall be in accordance with KAR 30-10-15a(b)(5). Submit a work paper with the cost report that shows the units and calculation of the allowable Medicaid/Medikan therapy expenses.

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Utilities Except Telephone - Line 251 - Report expenses for gas, water, electricity, heating oil, trash hauling, etc. Cablevision may be considered a utility or resident activity expense.

Food - Line 252 - Report all food costs. Nutritional supplements are to be included on line 351. The provider shall be required to keep records on the total number of meals served to residents, employees, guests, and outside programs. If the food expense for the employees, guests, and outside programs is included in the MS-2004 expenses, the expense should be offset against the dietary cost center as follows:

A. Line 201 - Dietary Salaries
   Line 219 - Dietary Portion Employee Benefits
   Line 221 - Dietary Owner/Related Party Compensation
   Line 231 - Dietary Consultant
   Line 252 - Food
   Line 253 - Dietary Supplies
   Line 281 - Other
   Total Dietary Cost ÷ Total Number of Meals Served = Cost Per Meal

B. Cost per meal x number of meals served to employees, guests, and outside programs = amount of offset

C. The cost of free employee meals shall be allocated and reported on employee benefit lines. If employees pay less than the cost for a meal, the difference between the meal revenue and cost may be reported as an employee benefit.

Dietary Supplies - Line 253 - Report supplies expense directly related to the preparation and service of food to the residents unless further restricted by another expense line (i.e., printed menus are reported on line 152 - Office Supplies and Printing). Examples include but are not limited to paper goods, kitchen utensils, etc.

Linen and Bedding Material - Line 254 - Report linen and bedding material expenses on this line.

Laundry and Linen Supplies - Line 255 - Report all supplies expense directly related to laundry and linen services for the residents, unless restricted by another line.

Housekeeping Supplies - Line 256 - Report all supplies expense related to keeping the building clean and sanitary. Floor care supplies shall be expensed on this line.

Resident Activity Supplies - Line 257 - Report the supplies expense involved in providing resident activities. This does not include the cost of newsletters, which should be included in line 152.

Resident Transportation - Line 258 - Report resident transportation expense incurred for non-emergency medical, shopping, activities, etc., in which the residents are the primary passengers. **Trip logs must be kept to document the expense. Do not include vehicle lease, interest, depreciation, insurance or other expense restricted to another expense line.**

Acceptable methods of allocating cost to line 258, Resident Transportation are as follows:

1) Allocated at a set rate per mile. The rate would be determined by dividing total vehicle expense, not restricted to another expense line, by the total miles. The IRS allowed rate per mile is not acceptable because it includes factors for depreciation, insurance and repairs.

2) Allocated directly per the following formula:

$$\frac{\text{Resident Travel Miles}}{\text{Total Miles}} \times \text{Total Vehicle Expenses not Restricted to Another Expense Line} = \text{Resident Travel Expense}$$

3) If private vehicles are used to transport residents, the entire amount of the reimbursement paid to the employee for use of the vehicle is allowable as Resident Transportation. The rate of reimbursement must, however, be reasonable.

Barber and Beauty – Line 259 – Report the barber and beauty expenses on this line. If you charge residents for these services offset the expense up to the revenue received in column 3.

Nursing Aide Training - Line 260 - Report the costs of fees, tuition, books, etc. for education or training seminars provided to aides with salaries reported on lines 303, 304, and 306. Travel, lodging and meals associated with the education/seminars may be reported on this line.

Other Health Care Training - Line 261 - Report the costs of fees, tuition, books, etc., for education or training seminars to employees, except aides reported on line 303, 304 and 306, with salaries reported in the Indirect or Direct Health Care cost centers. Travel, lodging and meals associated with the education/seminars may be reported on this line.

Aides- Lines 303, 304, and 306 - Record the hours paid and salaries of aides involved in direct resident care, on the line that most appropriately defines their classification.

Nursing Supplies - Line 351 - Report expenses of all **routine** supplies directly related to the provision of nursing and/or health related services for residents, unless further restricted by another expense line. Medical records forms may be expensed on this line. Nutritional supplements shall be reported on this line.

Total Rate Formula Costs - Line 399 - Enter the sum of the totals in the Operating, Indirect Health Care, and Direct Health Care cost centers.

Interest on Real Estate - Line 401 - Report all interest expense incurred for the acquisition or construction of real estate. Describe fully on Schedule D. Include amortization expense for loan costs. The interest for equipment and furnishings purchased along with the building shall be reported on this line. Report interest expense on loans for real and personal property included in a re-base of the real and personal property fee, in accordance with KAR 30-10-25e.

Rent or Lease Expense - Line 402 - Report all recurring rent and lease expense regardless of the item and use except therapeutic beds which are non-allowable or computer software lease expense which can be reported in the cost center of benefit or line 157, Accounting and Data Processing.

Amortization of Leasehold Improvement - Line 403 - Report only amortization of leasehold improvements on this line. Leasehold improvements are defined as betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

Depreciation Expense - Line 404 - This amount must be computed by the straight-line method. Such amounts must be reconciled to a detailed depreciation schedule. The determination of capitalized property must be in conformity with Generally Accepted Accounting Principles. **Attach a detailed depreciation schedule to the cost report.**

Non-Reimbursable & Non-Resident Related Items

General: Lines 501-514- Provider adjustments must be made in column 3 that offset column 2 expenses in total. Column 4 will show zero expenses.

Fund Raising/Public Relations/Advertising for Resident Utilization - Line 506- Include non-allowable advertising expenses. See Line 155 – Advertising and Recruitment.

Oxygen Concentrators & Cylinders - Line 507 - Billing for reimbursement of oxygen, cylinder rental and allowable supplies is to be done by the oxygen supplier to the fiscal agent. Homes with a central supply are to bill the fiscal agent directly.

Drugs (Pharmaceuticals) - Line 508 - Report expenses for prescription drugs and other items not covered as a routine item in KAR 30-10-15a.

Resident Purchases - Line 511 - Report the expense for items purchased for residents but not listed as routine services or supplies in KAR 30-10-15a.

SCHEDULE B - EXPENSE RECONCILIATION

General: This schedule shall be used to reconcile the expenses reported on the Nursing Facility Financial and Statistical Report (Form MS-2004) to the provider's financial books and federal tax return.

Books - Column 1 - Reflect the expenses as they appear in the general ledger or other financial records.

Federal Tax Return - Column 2 - Reflect the expenses as they appear on the federal tax return.

Cost Report - Column 3 - Reflect the expenses as they were reported on the cost report the Expense Statement, Schedule A.

Total Expenses Per Books - Line 601 - Record the total expenses per the general ledger or other financial records in Column 1.

Total Expenses Per Federal Tax Return - Line 602 - Record total expenses from tax return in Column 2.

Total Expenses Per Cost Report - Line 603 - Enter total expenses from the Expense Statement, Schedule A (Column 2 line 599) in Column 3.

Expenses on Books or Federal Tax Return Not on Cost Report - Lines 604 & 605 - Itemize each expense reflected in the books or federal tax return and not included in the cost report. These expenses should be recorded in the appropriate column under books and/or federal tax return as an offset to the total expense in that column. Use an additional schedule if necessary to list expenses.

Expenses on Cost Report Not on Books or Federal Tax Return - Lines 606 & 607 - Itemize the expense reflected in the cost report but not in the total from the books or tax return. These items should be offset to the total expense in Column 3 - Cost Report. Use an additional schedule if necessary.

Totals - Line 608 - The differences between the totals per lines 601 (books), 602 (federal tax return) and 603 (cost report) less the negative adjustments in lines –604-607 in each of the three columns shall be entered on line 608. The adjusted totals per the books, federal tax return and cost report shall agree after the applicable offsets to the total expenses reported.

Working Trial Balance: The working trial balance should reflect how the costs on the books are reported on the Nursing Facility Financial and Statistical Report. This detailed reconciliation also applies to providers who use a different fiscal year end for IRS but are reporting on the required calendar year end, beginning in 1991, for Medicaid rate setting purposes.

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SCHEDULE C - STATEMENT OF OWNERS AND RELATED PARTIES

General: List all owners of the provider entity with 5% or more ownership interest and all related parties (KAR 30-10-24). Fill out Schedule C completely and accurately. Attach an additional schedule if more explanation or space is needed. Providers shall base all allocations on reasonable factual information and make the information available on request. Such information shall include details of dates, hours worked, nature of work performed, how it relates to resident care and the prevailing wage rates for such activities.

ENTER - Name, Social Security Number and Address

Column (1) - % of ownership (if applicable) or state the relationship to owner

Column (2) - % of time devoted to this facility per customary workweek

Column (3) - Total salaries, drawings, consulting fees, and other payments to owners and related parties as defined in KAR 30-10-1a and KAR 30-10-24.

Column (4) - List the titles, functions or descriptions of the jobs performed or transactions made with all owners and related parties. The job titles should correspond with those included in the Owner/Related Party Salary Chart (please refer to KAR 30-10-24).

Column (5) - Enter the distribution by cost report line item of the total compensation incurred for all job functions. Owner/related party compensation shall be reported on the owner compensation expense lines (121, 122, 221, and 321) in Schedule A.

Totals - The total compensation in Column 3 and Column 5 should agree. These two totals should also agree with the total of lines 121, 122, 221, and 321 from Schedule A.

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SCHEDULE D - STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE

Note: Submit copies of loan agreements and amortization schedules with this cost report for all loans of $5,000 or more. Failure to document interest expense is cause for disallowance. (KAR 30-10-15b). Schedules need to be submitted for related party loans showing the interest paid, check numbers and dates.

Column (1) - Enter the original date and duration of the loan in months.

Column (2) - Enter the interest rate. If it is a variable rate, provide the range of the interest rates for the cost report period.

Column (3) - Enter the amount of the loan.

Column (4) - Enter the unpaid principal balance at the end of the cost report period. The total of Column 4, Line 667, must agree with the Balance Sheet, Schedule E.

Column (5) - Enter the total amount of interest and principal payments made during the cost report year.

Column (6) - Enter the total amount of interest incurred during the cost report year. The total of Column 6, Line 667 must agree with the total interest reported on Schedule A, Lines 160 and 401.

Lines –651-666 - Enter each lender's name, address and the items financed. Indicate whether the interest expense was reported on line 160 or line 401 of Schedule A. If interest expense on a loan is pro-rated to both lines, show the breakdown.

Line 667 - Enter the totals of Column 4 - Unpaid Balance and Column 6 - Interest Expense, for Lines 651-666 as reported on lines 160 and 401 in Schedule A.

SCHEDULE E - BALANCE SHEET

General: The balance sheet should be prepared from the books of the specific facility for which the cost report is filed. In other words, chain units should report only those balance sheet accounts that relate to the particular facility for which the cost report applies. Subject to the above, the balance sheet must be prepared in conformity with Generally Accepted Accounting Principles. Report all ownership claims that are customarily used by your particular type of entity. A partial listing of these accounts by type of entity follows:

Individual Proprietor	Owner's Capital
Partnership	Partner's Capital Accounts
Not-For-Profit Entities	Fund Balance
Corporation	Common Stock, Additional Paid in Capital, Retained Earnings
Chain Unit -- All Chain Units (regardless of type of ownership)	Central or Home Office Account

NOTE: Beginning of period account balances shall be reported for providers allowed to submit projected cost reports.

Lines 705, 706, 707 & 723 - If the amount reported exceeds $10,000, attach a schedule showing the details.

SCHEDULE F - RECONCILIATION OF BEGINNING AND ENDING RESIDUAL BALANCES

General: This schedule explains the change in owner's equity or the fund balance from the beginning to the end of the cost reporting period.

Beginning Balance

Line 751 - Enter the beginning owner's equity or fund balance. This is the total of Column 2 lines 727-729 in the Balance Sheet, Schedule E.

Increase to Owner's Equity or Fund Balance

Line 752 - Enter total revenue from Schedule G, Column 1, Line 822.

Line 753 - Enter the total of cash or other assets transferred or contributed by the owners.

Line 754 - Enter the total of cash or other assets transferred or contributed by the central office.

Line 755 - Enter the proceeds from the sale of common stock.

Line 756 & 757 - Enter and specify all other transactions which increase the residual owner equity or fund balance accounts.

Line 758 - Enter the total of Lines 752-757.

Decreases to Owner's Equity or Fund Balance

Line 761 - Enter the total expenses per Schedule A, Column 2, Line 599.

Line 762 - Enter total of cash or other assets withdrawn by the owners but not reported in the Expense Statement, Schedule A.

Line 763 - Enter total cash or other assets withdrawn by the central office.

Line 764 - Enter the total of duly declared dividends paid to stockholders.

Line 765 - Enter the depreciation expense in excess of the straight line method unless reflected as a negative adjustment in Schedule A, Line 404, Column 3.

Line 766 & 767 - Enter and specify all other transactions which decrease the residual owner equity or fund balance accounts.

Line 768 - Enter the totals of Lines 761-767.

Ending Balance

Line 769 - Enter the net of adding lines 751 and 758 and subtracting line 768. The balance at the end of the period (line 769) should equal the total of Column 4, lines 727-729 in the Balance Sheet, Schedule E.

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SCHEDULE G - REVENUE STATEMENT

Column 1 - Enter the revenues from the general ledger accounts on the appropriate lines. Revenues from services not designated on this schedule must be identified and reported on line 821. The amount of the total revenue entered on line 822, Column 1 must also be entered on line 752, Beginning and Ending Residual Balances Reconciliation, Schedule F.

Column 2 - Enter the amount of the offset to the appropriate expense accounts. **Note the Following:** The amount of the offset should be the cost of reimbursable expenses. Non-reimbursable items (i.e. Vending) are offset at cost.

Column 3 - Enter the line number of the expense reported on the Expense Statement, Schedule A, against which the offset has been made. The amount of the offset must be entered in Column 3, Provider Adjustments, on the Expense Statement, Schedule A.

Line 807 - Routine Nursing supplies sold to private pay residents.
There is no offset required for routine items covered under KAR 30-10-15a that are sold to private pay residents.

Line 810 - Resident Purchases/Non Routine Items Sold - Enter the total of all reimbursements for personal purchases not designated as routine items in KAR 30-10-15a.

Line 817- Adult Day Care/Treatment Income - Enter total revenue from all sources for adult day care and day treatment programs.

Line 820 – Non-Nursing Facility Residential Income – Enter total revenue from assisted living, residential care, and apartments.

SCHEDULE H(1) - STATEMENT OF RELATED ADULT CARE HOME INFORMATION

General: All Kansas facilities operated by common ownership or related parties shall be listed. Common ownership and related parties are defined in KAR 30-10-1a. Additional schedules shall be attached as necessary. If the provider is a publicly held entity, provide the annual report and a Form 10-K.

SCHEDULE H(2) – STATEMENT OF NON-RESIDENT RELATED ACTIVITIES

General: Indicate any non-resident related activities that you participate in at the facility for which you are reporting by marking yes in column (1). If adjustments were made on schedule A for any of these activities indicate so by marking yes in column (2). List additional activities that are not identified on the lines provided. Attach a separate schedule if additional room is required.

SCHEDULE I - FIXED ASSET, DEPRECIATION AND AMORTIZATION QUESTIONNAIRE

General: Each question shall be answered completely and accurately.

Lines 902-909 - Complex Capital Structures:

Attach a complete explanation of the ownership/management structure of the nursing facility including owners with 5% or more interest in the property and/or business, related parties as defined in KAR 30-10-1a, and all relevant contracts, leases, and assignments. This information must be accurate and comprehensive enough to present a true and clear account of the ownership and control of the adult care home.

Line 911 - If the facility is leased, a copy of the original lease agreement and subsequent amendments and/or agreements shall be submitted and on file with the agency. A provider making payments under Industrial Revenue Bonds with a nominal purchase upon maturity shall report the cost of ownership versus lease expense.

Line 914 - A new provider that purchases a facility shall submit a copy of the loan agreement(s), and any other pertinent information concerning the transaction.

Line 915 - Submit a copy of the detailed depreciation schedule with the cost report. Each asset shall be listed with the cost, date of purchase, life, salvage value, accumulated depreciation expense and current depreciation expense. Depreciation must be computed using the STRAIGHT LINE method. If the provider has filed a detailed depreciation schedule with the agency, an annual submission of addition and deletion schedules and a summary of depreciation expense are permissible.

SCHEDULE J - EMPLOYEE TURN OVER REPORT

Column 2 - Show the total number of employees at the beginning of the cost report period for each classification.

Column 3 - Show the total number of employees hired during the cost report period for each classification.

Column 4 - Show the total number of employees who ended employment during the cost report period for each classification.

Column 5 - Show the total number of employees at the end of the cost report period for each salary classification.

Column 6 - From the total number of employees listed in column 5, show how many are full-time and how many are part-time.

Column 7 – From the total number of employees listed in column 5, show how many were included in column 2 as employees at the beginning of the cost report period.

The number of employees listed in column 2, plus the number of employees listed in Column 3, less the number of employees reflected in Column 4, should equal Column 5. Please explain any discrepancy. The W-2's are an excellent source of information for the calender year end cost report.

ATTENTION

The cost report is not considered complete unless all required documents are submitted with the cost reports. Review the list of questions/documents following Schedule J in the Cost Report.

DECLARATION STATEMENT

Declaration by Owner; Partner; or Officer of the Corporation, City or County which is the Provider. The cost report is not considered complete unless signed by an owner or authorized agent of the facility and/or business and the preparer. If person signing is not an owner or partner, documentation or a resolution stating their authority to sign needs to be attached. It is not required, if it has been submitted previously and has not changed. If the facility/business owner and the preparer are the same individual, please sign both spaces. Print the names of the owner/authorized agent and preparer in the space provided. **PLEASE READ DECLARATION STATEMENT.**

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EXCEL VERSION

Question #			
10	SRS Provider ID Number (need 10 digits)		
	EDS Provider Number (need 10 digits)		
11	Employer's Federal ID Number		
12	Provider Name (The person or business organization responsible for meeting requirements, providing services and receiving payments)		
13	Facility Name		
14a	Facility Address (street)		
14b	City		
15a	State		
15b	Zip Code		
16	Administrator's Name		
17a	Phone Number		
17b	Fax Number		
18	Email Address		
19	Report Period		TO
20	Fiscal Year End		
For questions 21 - 32 please answer Y for yes for all that are applicable and leave blank if not applicable:			
21	Calendar Year Historical		
22	Projected (New Provider/Facility)		
23	First Historical Non-Calendar Year (R/Y Same as Prof)		
26	Sole Proprietorship		
27	Partnership		
28	Corporation - Profit		
29	Corporation - Non Profit		
30	City Owned		
31	County Owned		
32	Other Government Owned		
33	Other (specify)		
43	Nursing Facility or NF-Mental Health Beds- Beg.of Period		
43a.	Bed Increase or Decrease		
43a.	Date of Change		
43b.	Bed Increase or Decrease		
43b.	Date of Change		
43c.	Bed Increase or Decrease		
43c.	Date of Change		
43d.	Bed Increase or Decrease		
43d.	Date of Change		
48	Total Nursing Facility/NFMH Resident Days (All Residents from AU-3902 Diskette)		
48a	Total Medicaid Days		
48b	Total Medicare Days		
49	Assisted Living/Res. Care Beds - Beginning of Period		
49	Assisted Living/Res. Care Beds - Increase (Decr)		
49	Assisted Living/Res. Care Beds - Date of Change		
50	Unlicensed Beds - Beginning of Period		
50	Unlicensed Beds - Increase (Decr)		
50	Unlicensed Beds - Date of Change		
51	Other Residential Days with Shared Nursing Facility Costs (All Residents from AU-3903 Diskette)		
52	Does this facility have Medicare certified beds?		
53	Is this facility Hospital Based LTCU or Freestanding? Enter H for hospital based or F for freestanding.		

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EXCEL VERSION

Rev. 09/04

State of Kansas
Department of Social and Rehabilitation Services/
Department on Aging

NURSING FACILITY FINANCIAL AND STATISTICAL REPORT

SEND TO: KANSAS DEPARTMENT ON AGING
New England Building
503 S. Kansas Avenue
TOPEKA, KANSAS 66603-3404

AGENCY USE ONLY

		RETRO ADJUSTMENT	
(1,2)		FULL	PARTIAL
(3,4)			
(5,6)			

INSTRUCTIONS AND REGULATIONS ARE AN INTEGRAL PART OF THIS REPORT. YOU MUST READ THEM BEFORE COMPLETING.

SRS PROVIDER ID NUMBER (NEED 10 DIGITS) 0	EDS PROVIDER NUMBER (NEED 10 DIGITS) 0	11. EMPLOYERS' FEDERAL ID NUMBER 0
12. PROVIDER NAME (The person or business organization responsible for meeting requirements, providing services and receiving payments.) 0		13. FACILITY NAME 0
14. & 15. FACILITY ADDRESS (STREET, CITY, STATE, ZIP) 0	0	0 0
16. ADMINISTRATOR'S NAME 0	17a. PHONE NUMBER 0 17b. FAX NUMBER 0	18. EMAIL ADDRESS 0 19. REPORT PERIOD 01/00/00 TO 01/00/00
		20. FISCAL YEAR END 01/00/00

CHECK ONLY ONE
21. ____ CALENDAR YEAR HISTORICAL
22. ____ PROJECTED (NEW PROVIDER/FACILITY)
23. ____ FIRST HISTORICAL NON-CALENDAR YEAR (MY SAME PERIOD AS PROJECTED)

CHECK ONLY ONE
24. ____ SOLE PROPRIETORSHIP
25. ____ CORP. - NON PROFIT
26. ____ CORP - PROFIT
27. ____ PARTNERSHIP
30. ____ CITY OWNED
31. ____ COUNTY OWNED
32. ____ OTHER - GOVERNMENT OWNED
33. ____ OTHER (SPECIFY)

NURSING FACILITY BEDS	BED INCREASE OR DEC.	DATE OF CHANGE	BED COUNT	BED DAYS AT THIS BED COUNT
43. NURSING FACILITY OR NF-MENTAL HEALTH BEDS AT THE BEG. OF THE PERIOD			0	0
43a.	0	0	0	0
43b.	0	0	0	0
43c.	0	0	0	0
43d.	0	0	0	0
45. TOTAL NF OR NF-MH LICENSED BEDS AT THE END OF THE PERIOD				0
46. TOTAL BED DAYS AVAILABLE (TOTAL OF BED DAYS AT THIS COUNT COLUMN FROM LINES 43 THROUGH 43d)				0
48. TOTAL NURSING FACILITY /NFMH RESIDENT DAYS (ALL RESIDENTS FROM AU-3902 DISKETTE)			(4)	0
48a. TOTAL MEDICAID DAYS			(6)	0
48b. TOTAL MEDICARE DAYS				0

OTHER FACILITY BEDS	BEGINNING OF PERIOD	BED INCREASE OR DEC.	DATE OF CHANGE	END OF PERIOD
49. ASSISTED LIVING/RES. CARE	0	0	01/00/00	0
50. UNLICENSED BEDS	0	0	01/00/00	0

51. OTHER RESIDENTIAL DAYS WITH SHARED NURSING FACILITY COSTS (ALL RESIDENTS FROM AU-3903 DISKETTE)

52. DOES THE FACILITY HAVE MEDICARE CERTIFIED BEDS? ☐ YES ☐ NO IF YES, COMPLETE 48b

53. IS THIS FACILITY (please check one): ☐ HOSPITAL BASED LTCU ☐ FREE-STANDING NF

This form Supersedes Form MS-2004, Rev. 09/02

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EXCEL VERSION

DO NOT CROSS OUT OR RETITLE LINES

SRS PROVIDER NUMBER 0
EDS PROVIDER NUMBER 0

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

SCHEDULE A

EXPENSE STATEMENT

OPERATING COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
SALARY - ADMINISTRATOR	101	0	$0	$0	$0		$0
SALARY - CO ADMINISTRATOR	102	0	$0	$0	$0		$0
OTHER ADMINISTRATIVE SALARIES	103	0	$0	$0	$0		$0
PLANT OPERATING SALARIES	104	0	$0	$0	$0		$0
EMPLOYEE BENEFITS	119		$0	$0	$0		$0
OWNER/RELATED PARTY ADMIN COMPENSATION - SCHEDULE C	121		$0	$0	$0		$0
OWNER/RELATED PARTY PLNT OP COMPENSATION - SCHEDULE C	122		$0	$0	$0		$0
OWNER/RELATED PARTY EMPLOYEE BENEFITS	125		$0	$0	$0		$0
CONTRACTED LABOR	130	0	$0	$0	$0		$0
MANAGEMENT CONSULTANT FEES	131		$0	$0	$0		$0

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EXCEL VERSION

DO NOT CROSS OUT OR RETITLE LINES

SRS PROVIDER NUMBER 0
EDS PROVIDER NUMBER 0

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

SCHEDULE A **EXPENSE STATEMENT**

OPERATING COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
ALLOCATION OF CENTRAL OFFICE COSTS (SEE INSTRUCTIONS)	151		$0	$0	$0		$0
OFFICE SUPPLIES & PRINTING	152		$0	$0	$0		$0
PHONE & OTHER COMMUNICATION	153		$0	$0	$0		$0
TRAVEL	154		$0	$0	$0		$0
ADVERTISING AND RECRUITMENT	155		$0	$0	$0		$0
LICENSES & DUES	156		$0	$0	$0		$0
ACCOUNTING & DATA PROCESSING	157		$0	$0	$0		$0
LIABILITY INSURANCE	158		$0	$0	$0		$0
OTHER INSURANCE (EXCEPT LIFE)	159		$0	$0	$0		$0
INTEREST (EXCEPT RE LOANS)	160		$0	$0	$0		$0
LEGAL	161		$0	$0	$0		$0
CRIMINAL BACKGROUND CHECK	162		$0	$0	$0		$0
REAL & PERSONAL PROPERTY TAX	163		$0	$0	$0		$0
MAINTENANCE & REPAIRS	164		$0	$0	$0		$0
OPERATING SUPPLIES	165		$0	$0	$0		$0
SMALL EQUIPMENT (SEE INSTRUCTIONS)	166		$0	$0	$0		$0
OTHER (PLEASE SPECIFY)	181		$0	$0	$0		$0
TOTAL OPERATING COST CENTER	190	0	$0	$0	$0	$0	$0

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EXCEL VERSION

DO NOT GROSS OUT OR RETITLE LINES

SRS PROVIDER NUMBER 0
EDS PROVIDER NUMBER 0

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

SCHEDULE A **EXPENSE STATEMENT**

INDIRECT HEALTH CARE COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
DIETARY SALARIES	201	0	$0	$0	$0		$0
HOUSEKEEPING SALARIES	202	0	$0	$0	$0		$0
LAUNDRY SALARIES	203	0	$0	$0	$0		$0
MEDICAL RECORDS SALARIES	204	0	$0	$0	$0		$0
OCCUPATIONAL THERAPIST SALARIES	205	0	$0	$0	$0		$0
PHYSICAL THERAPIST SALARIES	206	0	$0	$0	$0		$0
PSYCH. THERAPIST SALARIES	207	0	$0	$0	$0		$0
RECREATIONAL THERAPIST SALARIES	208	0	$0	$0	$0		$0
RESPIRATORY THERAPIST SALARIES	209	0	$0	$0	$0		$0
SPEECH THERAPIST SALARIES	210	0	$0	$0	$0		$0
RESIDENT ACTIVITIES SALARIES	211	0	$0	$0	$0		$0
SOCIAL WORKER SALARIES	212	0	$0	$0	$0		$0
OTHER IHC SALARIES (SPECIFY)	213	0	$0	$0	$0		$0
EMPLOYEE BENEFITS	219		$0	$0	$0		$0
OWNER/RELATED PARTY COMPENSATION - SCHEDULE C	221		$0	$0	$0		$0
OWNER/RELATED PARTY EMPLOYEE BENEFITS	225		$0	$0	$0		$0
CONTRACTED LABOR	230	0	$0	$0	$0		$0
DIETARY CONSULTANT	231		$0	$0	$0		$0
MEDICAL RECORDS - CONSULTANT	232		$0	$0	$0		$0
OCCUPATIONAL THERAPY - CONSULTANT	233		$0	$0	$0		$0
PHARMACIST - CONSULTANT	234		$0	$0	$0		$0
PHYSICAL THERAPY - CONSULTANT	235		$0	$0	$0		$0
RESPIRATORY - CONSULTANT	236		$0	$0	$0		$0
SPEECH THERAPY - CONSULTANT	237		$0	$0	$0		$0
OTHER CONSULTANT (SPECIFY)	238		$0	$0	$0		$0

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DO NOT CROSS OUT OR RETITLE LINES

SRS PROVIDER NUMBER 0
EDS PROVIDER NUMBER 0

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

SCHEDULE A **EXPENSE STATEMENT**

INDIRECT HEALTH CARE COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
UTILITIES	251		$0	$0	$0		$0
FOOD	252		$0	$0	$0		$0
DIETARY SUPPLIES	253		$0	$0	$0		$0
LINEN & BEDDING MATERIAL	254		$0	$0	$0		$0
LAUNDRY & LINEN SUPPLIES	255		$0	$0	$0		$0
HOUSEKEEPING SUPPLIES	256		$0	$0	$0		$0
RESIDENT ACTIVITY SUPPLIES	257		$0	$0	$0		$0
RESIDENT TRANSPORTATION	258		$0	$0	$0		$0
BARBER AND BEAUTY	259		$0	$0	$0		$0
NURSE AIDE TRAINING	260		$0	$0	$0		$0
OTHER HEALTH CARE TRAINING	261		$0	$0	$0		$0
OTHER (PLEASE SPECIFY)	281		$0	$0	$0		$0
TOTAL INDIRECT HEALTH CARE COST CENTER	280	0	$0	$0	$0	$0	$0

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DO NOT CROSS OUT OR RETITLE LINES

SRS PROVIDER NUMBER 0
EDS PROVIDER NUMBER 0

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

SCHEDULE A **EXPENSE STATEMENT**

DIRECT HEALTH CARE COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
LICENSED MENTAL HEALTH TECH SALARIES	301	0	$0	$0	$0		$0
LICENSED PRACTICAL NURSE SALARIES	302	0	$0	$0	$0		$0
MEDICATION AIDE SALARIES	303	0	$0	$0	$0		$0
NURSE AIDE SALARIES	304	0	$0	$0	$0		$0
REGISTERED NURSE (RN) SALARIES	305	0	$0	$0	$0		$0
RESTORATIVE/REHAB AIDE SALARIES	306	0	$0	$0	$0		$0
EMPLOYEE BENEFITS	319		$0	$0	$0		$0
OWNER/RELATED PARTY COMPENSATION - SCHEDULE C	321		$0	$0	$0		$0
OWNER/RELATED PARTY EMPLOYEE BENEFITS	325		$0	$0	$0		$0
CONTRACTED NURSING LABOR	330	0	$0	$0	$0		$0
NURSING CONSULTANTS	331		$0	$0	$0		$0
NURSING SUPPLIES	351		$0	$0	$0		$0
TOTAL DIRECT HEALTH CARE COST CENTER	390	0	$0	$0	$0	$0	$0
TOTAL RATE FORMULA COSTS	399	0	$0	$0	$0	$0	$0

OWNERSHIP COST CENTER							
INTEREST - REAL ESTATE	401		$0	$0	$0		$0
RENT/LEASE EXPENSE	402		$0	$0	$0		$0
AMORTIZED LEASEHOLD IMPROVEMENT	403		$0	$0	$0		$0
DEPRECIATION EXPENSE	404		$0	$0	$0		$0
TOTAL OWNERSHIP COST CENTER	490		$0	$0	$0	$0	$0

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EXCEL VERSION

DO NOT CROSS OUT OR RETITLE LINES

SRS PROVIDER NUMBER 0
EDS PROVIDER NUMBER 0

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

SCHEDULE A **EXPENSE STATEMENT**

NON-REIMBURSABLE & NON-RESIDENT RELATED EXPENSE ITEMS	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
BAD DEBTS	501		$0	$0	$0		
PROVISION FOR INCOME TAXES	502		$0	$0	$0		
NONWORKING OWNERS/OFFICERS - SCHEDULE C	503		$0	$0	$0		
DONATIONS	504		$0	$0	$0		
FUND RAISING/PROMO & NON-REIMBURSABLE ADVERTISING	505		$0	$0	$0		
LIFE INSURANCE - OWNERS/OFFICERS	506		$0	$0	$0		
OXYGEN CONCENTRATORS & CYLINDERS	507		$0	$0	$0		
DRUGS - PHARMACEUTICALS	508		$0	$0	$0		
VENDING MACHINES	509		$0	$0	$0		
BOARD OF DIRECTORS EXPENSE	510		$0	$0	$0		
RESIDENT PURCHASES	511		$0	$0	$0		
OTHER (PLEASE SPECIFY)	512		$0	$0	$0		
OTHER (PLEASE SPECIFY)	513		$0	$0	$0		
OTHER (PLEASE SPECIFY)	514		$0	$0	$0		
TOTAL NON-REIMBURSABLE	590		$0	$0	$0		
TOTAL	599	0	$0	$0	$0	$0	$0

ATTACH A DETAILED DEPRECIATION SCHEDULE AND THE DETAILED WORKING TRIAL BALANCE USED TO PREPARE THIS COST REPORT

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EXCEL VERSION

		SRS PROVIDER NUMBER	0
		EDS PROVIDER NUMBER	0

SCHEDULE B — **EXPENSE RECONCILIATION**

	LN#	(1) BOOKS	(2) FED TAX RETURN	(3) COST REPORT
TOTAL EXPENSES PER BOOKS	601	$0		
TOTAL EXPENSES PER FEDERAL TAX RETURN	602		$0	
TOTAL EXPENSES PER COST REPORT (LINE 599, COLUMN 2)	603			$0
EXPENSES ON BOOKS OR FEDERAL TAX RETURN NOT ON COST REPORT				
SPECIFY	604	$0	$0	
SPECIFY	605	$0	$0	
EXPENSES ON COST REPORT NOT ON BOOKS OR FEDERAL TAX RETURN				
SPECIFY	606			$0
SPECIFY	607			$0
TOTAL (SHOULD BE EQUAL)	608	$0	$0	$0

SCHEDULE C — **STATEMENT OF OWNERS AND RELATED PARTIES**

LIST ALL OWNERS OF PROVIDERS WITH 5% OWNERSHIP INTEREST & ALL RELATED PARTIES.
SUMMARIZE THE AMOUNT AND NATURE OF TRANSACTIONS WITH ALL OWNERS & RELATED PARTIES.
FOR FURTHER CLARIFICATION SEE KAR 30-10-1a AND 30-10-24.

NAME, SSN, ADDRESS (CITY & STATE)	(1) % OWNERSHIP	(2) % TIME DEVOTED	(3) TOTAL AMT INCURRED	(4) TITLE, FUNCTION OR DESCRIPTION - TRANSACTION	(5) DISTRIBUTION AMOUNT	(5) DISTRIBUTION LINE#
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
					$0	
TOTALS (SHOULD BE EQUAL)			$0		$0	

CALCULATIONS MUST EQUAL THE OWNER/RELATED PARTY LINES OF 121, 122, 221, AND 321.

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SRS PROVIDER NUMBER 0
EDS PROVIDER NUMBER 0

SCHEDULE D **STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE**

	LENDER'S NAME	LENDER'S ADDRESS	ITEMS FINANCED	REPORTED ON LINE	ORIGINATION DATE (1a)	DURATION (months) (1b)	INTEREST RATE (2)	ORIGINAL LOAN AMOUNT (3)	UNPAID BALANCE (4)	TOTAL ANNUAL PAYMENTS (5)	INTEREST EXPENSE (6)
651											
652											
653											
654											
655											
656											
657											
658											
659											
660											
661											
662											
663											
664											
665											
666											
667 TOTALS:									$0		$0
LINE 169											
LINE 401									$0		$0

TOTAL OF COLUMN 6 MUST AGREE WITH THE SUM OF LINES 169 & 401. ENTRIES IN COLUMN 4 MUST AGREE WITH THE BALANCE SHEET. ATTACH A COPY OF LOAN AGREEMENTS AND AMORTIZATION SCHEDULES FOR ALL LOANS OF $5,000 OR MORE IF NOT ALREADY SUBMITTED.

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			SRS PROVIDER NUMBER		0
			EDS PROVIDER NUMBER		0
SCHEDULE E	**BALANCE SHEET**				
		BEGINNING OF PERIOD		END OF PERIOD	
ASSETS	LN#	(1)	(2)	(3)	(4)
CASH	701		$0		$0
ACCOUNTS RECEIVABLE	702	$0		$0	
LESS: ALLOWANCE FOR DOUBTFUL ACCOUNT	703	$0	$0	$0	$0
INVENTORIES & SUPPLIES	704		$0		$0
ALL LOANS TO OFFICERS, OWNERS, AND RELATED PARTIES	705		$0		$0
ALL ASSETS NOT RELATED - RESIDENT CARE	706		$0		$0
ASSETS HELD FOR INVESTMENT	707		$0		$0
NURSING HOME PLANT & EQUIPMENT:					
BUILDING	708	$0		$0	
LESS: ACCUMULATED DEPRECIATION	709	$0	$0	$0	$0
EQUIPMENT	710	$0		$0	
LESS: ACCUMULATED DEPRECIATION	711	$0	$0	$0	$0
LEASEHOLD IMPROVEMENTS	712	$0		$0	
LESS: ACCUMULATED DEPRECIATION	713	$0	$0	$0	$0
LAND	714		$0		$0
OTHER	715		$0		$0
OTHER	716		$0		$0
TOTAL ASSETS	719		$0		$0
LIABILITIES & OWNER'S EQUITY					
ACCOUNTS PAYABLE	721		$0		$0
OTHER CURRENT LIABILITIES	722		$0		$0
ALL LOANS FROM OFFICERS, OWNERS AND RELATED PARTIES	723		$0		$0
MORTGAGE PAYABLE	724		$0		$0
OTHER LONG TERM LIABILITIES	725		$0		$0
OWNER'S EQUITY OR FUND BALANCE (LIST APPROPRIATE ACCOUNTS & AMOUNTS - SEE INSTRUCTIONS)					
	727		$0		$0
	728		$0		$0
	729		$0		$0
TOTAL LIABILITIES & OWNER'S EQUITY	730		$0		$0

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		SRS PROVIDER NO	0
		EDS PROVIDER NO	0
SCHEDULE F BEGINNING & ENDING RESIDUAL BALANCES RECONCILIATION			
BALANCE AT BEGINNING OF PERIOD - LINE 727, 728, & 729, COLUMN 2	751		$0
INCREASES:			
REVENUE PER LINE 822, COLUMN 1	752	$0	
INVESTMENT BY OWNER	753	$0	
TRANSFERS FROM CENTRAL OFFICE	754	$0	
COMMON STOCK SOLD	755	$0	
OTHER (SPECIFY)	756	$0	
OTHER (SPECIFY)	757	$0	
TOTAL INCREASES	758		$0
DECREASES:			
EXPENSES PER SCHEDULE A, LINE 599, COLUMN 2	761	$0	
WITHDRAWAL BY OWNERS NOT IN SCHEDULE A	762	$0	
TRANSFERS TO CENTRAL OFFICE	763	$0	
DIVIDENDS PAID TO STOCKHOLDERS	764	$0	
DEPRECIATION EXPENSE IN EXCESS OF STRAIGHT LINE	765	$0	
OTHER (SPECIFY)	766	$0	
OTHER (SPECIFY)	767	$0	
TOTAL DECREASES	768		$0
BALANCE AT END OF PERIOD - LINE 727, 728, & 729, COLUMN 4	769		$0

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		SRS PROVIDER NUMBER		0
		EDS PROVIDER NUMBER		0
SCHEDULE G **REVENUE STATEMENT**				
	LN#	REV PER BOOKS OR FED TAX RETURN (1)	ADJUSTMENT TO EXPENSE ACCOUNTS (2)	LINE NUMBER OF RELATED EXPENSE (3)
ROUTINE DAILY SERVICE:				
PRIVATE PAY RESIDENTS	801	$0		
MEDICAID RESIDENTS & PATIENT LIABILITY	802	$0		
MEDICARE RESIDENTS (PART A)	803	$0		
VETERAN ADMINISTRATION RESIDENTS	804	$0		
OTHER RESIDENTS (SPECIFY)	805	$0		
PHARMACY - DRUGS & MEDICATIONS	806	$0		
ROUTINE NURSING SUPPLIES SOLD TO PRIVATE PAY RESIDENTS	807	$0		
REVENUE FROM MEALS SOLD TO GUESTS & EMPLOYEES	808	$0	$0	
BEAUTY/BARBER SHOP	809	$0	$0	
RESIDENT PURCHASES/NON ROUTINE ITEMS SOLD	810	$0	$0	
PURCHASE DISCOUNTS, RETURNS, REFUNDS & ALLOWANCES	811	$0	$0	
OTHER SUPPLIES SOLD	812	$0	$0	
PROGRAM REIMBURSEMENTS & TAX CREDITS	813	$0	$0	
INVESTMENT/INTEREST INCOME	814	$0	$0	
VENDING MACHINE REVENUE	815	$0	$0	
CHILD DAY CARE INCOME	816	$0	$0	
ADULT DAY CARE/TREATMENT INCOME	817	$0		
MEDICARE PART B	818	$0		
HOME HEALTH CARE REVENUE	819	$0	$0	
NON-NURSING FACILITY RESIDENTIAL INCOME	820	$0	$0	
OTHER (SPECIFY)	821	$0	$0	
TOTALS	822	$0	$0	

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SRS PROVIDER NO 0
EDS PROVIDER NO 0

SCHEDULE H(1) STATEMENT OF RELATED ADULT CARE HOME INFORMATION

851 DO ANY OF THE OWNERS, RELATED PARTIES OR EMPLOYEES HAVE INTEREST, DIRECTLY OR INDIRECTLY, IN ANY OTHER ADULT CARE HOME FACILITY LOCATED IN KANSAS (EXCEPT MINOR STOCK OWNERSHIP, LESS THAN 5%, AS A PASSIVE INVESTMENT IN UNRELATED PUBLICLY HELD CORPORATION? ☐ YES ☐ NO

IF YOUR ANSWER IS NO, DO NOT COMPLETE THE REST OF THIS SCHEDULE, BUT GO TO SCHEDULE H(2). IF YOUR ANSWER IS YES, LIST BELOW ALL ADULT CARE HOME FACILITIES LOCATED IN KANSAS IN WHICH AN INTEREST EXISTS OR THAT ARE UNDER COMMON CONTROL OR OWNERSHIP. ATTACH SCHEDULE IF NECESSARY.

	(1) RELATED PROVIDER'S NAME	(2) MEDICAID PROVIDER #	(3) DESCRIBE RELATIONSHIP: OWNERSHIP/MANAGEMENT/DIRECTORS
855			
856			
857			
858			
859			
860			
861			
862			
863			
864			
865			

IF PROVIDER IS A CORPORATION, IS IT A PUBLICLY HELD CORPORATION? ☐ YES ☐ NO
IF YES, ATTACH A COPY OF THE ANNUAL REPORT TO STOCKHOLDERS AND A FORM 10-K.

SCHEDULE H(2) STATEMENT OF NON-RESIDENT RELATED ACTIVITIES

INDICATE BELOW IF YOU PARTICIPATE IN ANY NON-RESIDENT RELATED ACTIVITES AT THE FACILITY FOR WHICH YOU ARE REPORTING. ATTACH AN ADDITIONAL SCHEDULE IF NECESSARY.

	(1) NON-RESIDENT RELATED ACTIVITY?	(2) WERE ADJUSTMENTS MADE ON SCHEDULE A FOR THIS ACTIVITY?
866	CHILD DAY-CARE ☐ YES ☐ NO	☐ YES ☐ NO
867	ASSIST. LIVING/RHC ☐ YES ☐ NO	☐ YES ☐ NO
868	HOME HEALTH CARE ☐ YES ☐ NO	☐ YES ☐ NO
869	HOME DELIVERED MEALS ☐ YES ☐ NO	☐ YES ☐ NO
870	OTHER (PLEASE SPECIFY) _____	☐ YES ☐ NO
	_____	☐ YES ☐ NO
	_____	☐ YES ☐ NO

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	SRS PROVIDER NO	0
	EDS PROVIDER NO	0

SCHEDULE I FIXED ASSET, DEPRECIATION & AMORTIZATION QUESTIONNAIRE

901	DOES THE PROVIDER LEASE OR RENT ANY PART OF THE PHYSICAL FACILITY FROM ANY OTHER ENTITY?	☐ YES ☐ NO
902	IF YES, DO ANY OWNERS OF THE PHYSICAL FACILITY HAVE AN INTEREST, DIRECTLY OR INDIRECTLY, IN THE PROVIDER?	☐ YES ☐ NO

IF YES, PROVIDE THE OWNERSHIP INFORMATION REQUESTED BELOW. IF NO, GO TO QUESTION 913.

	NAME OF OWNERS OF PHYSICAL FACILITY	% OF OWNERSHIP	DESCRIBE NATURE OF RELATIONSHIP WITH PROVIDER. IF NONE, WRITE "NONE"
905			
906			
907			
908			
909			

IF THE OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW THE INSTRUCTIONS FOR LINES 902-909 FOR COMPLEX CAPITAL STRUCTURES.

911	HAVE COPIES OF ALL LEASE AGREEMENTS (INCLUDING AMENDMENTS) BEEN SUBMITTED WITH A PREVIOUS COST REPORT? **IF NO, SUBMIT COPIES OF DOCUMENTS NOT PREVIOUSLY SUBMITTED**	☐ YES ☐ NO
912	DOES THE LEASE CONTAIN AN OPTION TO PURCHASE THE LEASED PROPERTY?	☐ YES ☐ NO
913	IS THE PHYSICAL FACILITY OWNED BY THE PROVIDER?	☐ YES ☐ NO
914	IF OWNED, WAS THE PURCHASE AN ARMS LENGTH TRANSACTION? (ATTACH A STATEMENT OUTLINING DETAILS OF THE PURCHASE)	☐ YES ☐ NO
915	WAS THE STRAIGHT LINE DEPRECIATION METHOD USED? IF NO, HAVE YOU RECALCULATED THE DEPRECIATION USING THE STRAIGHT LINE METHOD AND MADE THE APPROPRIATE ADJUSTMENTS TO THE DEPRECIATION EXPENSE REPORTED ON THE EXPENSE STATEMENT?	☐ YES ☐ NO ☐ YES ☐ NO
916	DID YOU ATTACH A DETAILED DEPRECIATION SCHEDULE & WORKING TRIAL BALANCE TO THIS COST REPORT? **IF NO, SUBMIT COPIES OF DOCUMENT NOW**	☐ YES ☐ NO

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SRS PROVIDER NUMBER 0
EDS PROVIDER NUMBER 0

SCHEDULE J EMPLOYEE TURNOVER REPORT

LN#	SALARY CLASSIFICATION	(2) BEGINNING # OF EMPLOYEES	(3) EMPLOYEES HIRED	(4) EMPLOYEES TERMINATED	(5) ENDING # OF EMPLOYEES	(6) HOW MANY FROM (5) ARE: FULL-TIME	PART-TIME	(7) EMPLOYEES RETAINED	% TURN-OVER	% RE-TENTION
951	ADMINISTRATOR	0	0	0	0				NA	NA
952	CO-ADMINISTRATOR	0	0	0	0				NA	NA
953	OTHER ADMINISTRATIVE	0	0	0	0				NA	NA
954	PLANT OPERATING	0	0	0	0				NA	NA
955	DIETARY	0	0	0	0				NA	NA
956	LAUNDRY	0	0	0	0				NA	NA
957	HOUSEKEEPING	0	0	0	0				NA	NA
958	OON	0	0	0	0				NA	NA
959	REGISTERED NURSES	0	0	0	0				NA	NA
960	LPN	0	0	0	0				NA	NA
961	LICENSED M/H TECH	0	0	0	0				NA	NA
962	AIDES	0	0	0	0				NA	NA
963	PHYSICAL THERAPIST	0	0	0	0				NA	NA
964	SPEECH THERAPIST	0	0	0	0				NA	NA
965	OCCUPATIONAL THERAPIST	0	0	0	0				NA	NA
966	RESPIRATORY THERAPIST	0	0	0	0				NA	NA
967	PSYCH THERAPIST	0	0	0	0				NA	NA
968	RECREATION THERAPIST	0	0	0	0				NA	NA
969	RESIDENT ACTIVITY	0	0	0	0				NA	NA
970	SOCIAL WORKER	0	0	0	0				NA	NA
971	MEDICAL RECORDS	0	0	0	0				NA	NA
972	OTHER HEALTH CARE	0	0	0	0				NA	NA
973	TOTAL ALL CLASSIFICATION	0	0	0	0	0	0	0	NA	NA

ATTENTION

COMPLETE THE COST REPORT ACCORDING TO THE INSTRUCTIONS AND ATTACH REQUIRED DOCUMENTS.

1. HAVE TWO COPIES OF PAGE 16 BEEN PRINTED AND SIGNED BY THE OWNER/AUTHORIZED AGENT AND THE PREPARER?
2. ARE ALL COST REPORT SCHEDULES COMPLETE?
3. ARE THE DISKETTES FOR THE COST REPORT AND THE CENSUS REPORT (AU-3902) ENCLOSED?
   PLEASE NOTE THAT YOU DO NOT NEED TO INCLUDE HARD COPIES OF THE COST REPORT
4. ARE THE FOLLOWING DOCUMENTS ATTACHED TO THE COST REPORT, IF APPLICABLE?
   SUBMIT ONLY ONE COPY OF EACH APPLICABLE ITEM

(a) WORKING TRIAL BALANCE AND SUPPORTING SCHEDULES USED TO PREPARE THE COST REPORT
(b) DEPRECIATION SCHEDULE
(c) CENTRAL OFFICE COSTS AND ALLOCATION SCHEDULES
(d) LOAN AGREEMENTS AND AMORTIZATION SCHEDULES (FOR LOANS OF $5,000 AND MORE)
(e) DISKETTE OF CENSUS SHEETS (AU-3902)
(f) DOCUMENTATION OR RESOLUTION STATING PERSON'S AUTHORITY TO SIGN DECLARATION STATEMENT IF NOT AN OWNER OR PARTNER
(g) WORK PAPER FOR THERAPY EXPENSE ADJUSTEMENTS
(h) COST ALLOCATION SCHEDULES FOR OTHER NON NURSING FACILITY PROGRAMS

EXCEL VERSION

MS-2004

DECLARATION OF PREPARER:

I HAVE COMPILED THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS PREPARED FOR
D 0
FOR THE COST REPORT PERIOD BEGINNING 1/0/1900
AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION, THAT I HAVE REQUESTED ALL NECESSARY AND AVAILABLE MATERIAL AND THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PREPARER'S SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

PREPARER'S ADDRESS (STREET, CITY, STATE, ZIP)	PHONE #
	FAX #

PREPARER'S EMAIL ADDRESS

DECLARATION OF OWNER; PARTNER; OR OFFICER OF THE CORPORATION, CITY, OR COUNTY WHICH IS THE PROVIDER:

I HEREBY CERTIFY THAT I HAVE READ THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I CERTIFY THAT NO MATERIAL OR INFORMATION I HAVE ACCESS TO WOULD PRODUCE FINDINGS CONTRARY TO THOSE IN THE ACCOMPANYING COST REPORT INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

SIGNATURE AND TITLE OF OWNER, PARTNER, OR OFFICER OF THE CORPORATION, CITY OR COUNTY WHICH IS THE PROVIDER. IF PERSON SIGNING IS NOT AN OWNER OR PARTNER, PLEASE ATTACH DOCUMENTATION OR A RESOLUTION SHOWING THEIR AUTHORITY TO SIGN. (UNLESS ONE HAD BEEN PREVIOUSLY SENT AND ON FILE)

SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

NOV 2 3 2005

30-10-18. Rates of reimbursement. (a) Rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, using base-year cost information submitted by the provider and retained for cost auditing and analysis.

(A) The base year utilized for cost information shall be reestablished at least once every seven years.

(B) A factor for inflation may be applied to the base-year cost information.

(C) For each provider currently in new enrollment, re-enrollment, or change of ownership status, the base year shall be determined in accordance with subsections (c), (d), and (e) of this regulation, respectively.

(2) Per diem rates shall be limited by cost centers, except where there are special level-of-care facilities approved by the United States department of health and human services. The upper payment limits shall be determined by the median in each cost center plus a percentage of the median, using base-year cost information. The percentage factor applied to the median shall be determined by the secretary.

(A) The cost centers shall be as follows:

(i) Operating;

(ii) indirect health care; and

(iii) direct health care.

(B) The property component shall consist of the real and

personal property fee as specified in K.A.R. 30-10-25.

(C) The upper payment limit for the direct health care cost center shall be a statewide base limit calculated on each facility's case mix adjusted base-year costs.

(i) A facility-specific, direct health care cost center upper payment limit shall be calculated by adjusting the statewide base limit by that facility's average case mix index.

(ii) Resident assessments used to determine additional reimbursement for ventilator-dependent residents shall be excluded from the calculation of the facility's average case mix index.

(3) Each provider shall receive an adjusted rate for each quarter if there is a change from the previous quarter in the facility's average medicaid case mix index.

(4) Resident assessments that cannot be classified shall be assigned to the lowest case mix index.

(5) To establish a per diem rate for each provider, a factor for incentive may be added to the allowable per diem cost.

(6) Resident days in the rate computation.

(A) Resident days shall be determined from census information corresponding to the base-year cost information submitted by the provider.

(B) Total resident days shall be used to calculate the per diem costs used to determine the upper payment limit and rates in the direct health care cost center. Total resident days shall be

used to calculate the per diem costs used to determine the upper payment limit and rates for food and utilities in the indirect health care cost center.

(C) Resident days used to calculate the upper payment limits and rates in the operating cost center and indirect health care cost center, less food and utilities, shall be subject to an 85 percent minimum occupancy requirement based on the following:

(i) Each provider that has been in operation for 12 months or longer and has an occupancy rate of less than 85 percent for the cost report period shall have the resident days calculated at the minimum occupancy of 85 percent.

(ii) The 85 percent minimum occupancy requirement shall be applied to the resident days and costs reported for the 13th month of operation and after. The 85 percent minimum occupancy requirement shall be applied to the interim rate of a new provider, unless the provider is allowed to file a projected cost report.

(iii) The minimum occupancy rate shall be determined by multiplying the total number of licensed beds by 85 percent. In order to participate in the Kansas medical assistance program, each nursing facility provider shall obtain proper certification for all licensed beds.

(iv) Each provider with an occupancy rate of 85 percent or greater shall have actual resident days for the cost report period used in the rate computation.

(7) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(8) The effective date of the rate for existing providers shall be in accordance with K.A.R. 30-10-19.

(b) Comparable service, private pay rate limitations.

(1) For each nursing facility and nursing facility for mental health, the per diem rate for care shall not exceed the rate charged for the same type of service to residents not under the Kansas medical assistance program. Private pay rates reported to the agency on other than a per diem basis shall be converted to a per diem equivalent.

(2) The agency shall maintain a registry of private pay per diem rates submitted by providers.

(A) Providers shall notify the agency of changes in the private pay rate and the effective date of that change so that the registry can be updated.

(i) Private pay rate information submitted with the cost reports shall not constitute notification and shall not be acceptable.

(ii) Providers may send private pay rate notices by certified mail so that there is documentation of receipt by the agency.

(B) The private pay rate registry shall be updated based on the notification from the providers.

(C) The effective date of the private pay rate in the

registry shall be the later of the effective date of the private pay rate or the first day of the following month in which complete documentation of the private pay rate is received by the agency.

(i) If the private pay rate effective date is other than the first day of the month, the effective date in the registry shall be the first day of the closest month. If the effective date is after the 15th, the effective date in the register shall be the first day of the following month.

(ii) For new facilities or new providers coming into the medicaid program, the private pay rate effective date shall be the issued certification date.

(3) The average private pay rate for comparable services shall be included in the registry. The average private pay rate may consist of the following variables:

(A) Room rate differentials. The weighted average private pay rate for room differentials shall be determined as follows:

(i) Multiply the number of private pay residents in private rooms, semiprivate rooms, wards, and all other room types by the rate charged for each type of room. Sum the resulting products of each type of room. Divide the sum of the products by the total number of private pay residents in all rooms. The result, or quotient, is the weighted average private pay rate for room differentials.

(ii) Each provider shall submit documentation to show the

calculation of the weighted average private pay rate when there are room rate differentials.

(iii) Failure to submit the documentation shall limit the private pay rate in the registry to the semiprivate room rate.

(B) Level-of-care rate differentials. The weighted average private pay rate for level-of-care differentials shall be determined as follows:

(i) Multiply the number of private pay residents in each level of care by the rate they are charged to determine the product for each level of care. Sum the products for all of the levels of care. Divide the sum of the products by the total number of private pay residents in all levels of care. The result, or quotient, is the weighted average private pay rate for the level-of-care differentials.

(ii) Each provider shall submit documentation to show the calculation of the weighted average rate when there are level-of-care rate differentials.

(iii) Failure to submit the documentation may delay the effective date of the average private pay rate in the registry until the complete documentation is received.

(C) Extra charges to private pay residents for items and services specified in K.A.R. 30-10-15a may be included in the weighted average private pay rate if the same items and services are allowable in the Kansas medical assistance program rate.

(i) Each provider shall submit documentation to show the calculation of the weighted average extra charges.

(ii) Failure to submit the documentation may delay the effective date of the weighted average private pay rate in the registry until the complete documentation is received.

(4) The weighted average private pay rate shall be based on what the provider receives from the resident. If the private pay charges are consistently higher than what the provider receives from the residents for services, then the average private pay rate for comparable services shall be based on what is actually received from the residents. The weighted average private pay rate shall be reduced by the amount of any discount received by the residents.

(5) The private pay rate for medicare skilled beds shall not be included in the computation of the average private pay rate for nursing facility services.

(6) When providers are notified of the effective date of the Kansas medical assistance program rate, the following procedures shall be followed:

(A) If the private pay rate indicated on the agency register is lower, then the Kansas medical assistance program rate, beginning with its effective date, shall be calculated as follows:

(i) If the average medicaid case mix index is greater than the average private pay case mix index, the Kansas medical assistance program rate shall be the lower of the private pay

rate adjusted to reflect the medicaid case mix or the calculated Kansas medical assistance rate.

(ii) If the average medicaid case mix index is less than or equal to the average private pay case mix index, the Kansas medical assistance program rate shall be the average private pay rate.

(B) Providers who are held to a lower private pay rate and subsequently notify the agency in writing of a different private pay rate shall have the Kansas medical assistance program rate adjusted on the later of the first day of the month following the date upon which complete private pay rate documentation is received or the effective date of a new private pay rate.

(c) Rate for new construction or a new facility to the program.

(1) The per diem rate for newly constructed nursing facilities or a new facility to the Kansas medical assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-17.

(2) The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to the base-year period.

(3) The provider shall remain in new enrollment status until the base year is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider.

(4) Any factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

(5) No rate shall be paid until a nursing facility financial and statistical report is received and processed to determine a rate.

(d) Change of provider.

(1) The payment rate for the first 24 months of operation shall be based on the base-year historical cost data of the previous owner or provider. If base-year data is not available, data for the most recent calendar year available preceding the base-year period shall be adjusted to the base-year period and used to determine the rate. If the 85 percent minimum occupancy requirement was applied to the previous provider's rate, the 85 percent minimum occupancy requirement shall also be applied to the new provider's rate.

(2) Beginning with the first day of the 25th month of operation, the payment rate shall be based on the historical cost data for the first calendar year submitted by the new provider. The data shall be adjusted to the base-year period.

(3) The provider shall remain in change-of-provider status until the base year is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider.

(4) Any factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change-of-provider status.

(e) Determination of the rate for nursing facility providers reentering the medicaid program.

(1) The per diem rate for each provider reentering the medicaid program shall be determined from either of the following:

(A) A projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more; or

(B) the base-year cost report filed with the agency or the most recent cost report filed preceding the base year, if the provider has actively participated in the program during the most recent 24 months.

(2) If the per diem rate for a provider reentering the program is determined in accordance with paragraph (e)(1)(A), the cost data shall be adjusted to the base-year period.

(3) The provider shall remain under reenrollment status until the base year is reestablished. During this time, the cost data used to determine the initial rates shall be used to determine all subsequent rates for the provider.

(4) Any factor for inflation that is applied to cost data for established providers shall be applied to the cost data for

providers in reenrollment status.

(5) If the per diem rate for a provider reentering the program is determined in accordance with paragraph (e)(1)(A), a settlement shall be made in accordance with subsection (f).

(f) Per diem rate errors.

(1) If the per diem rate, whether based upon projected or historical cost data, is audited by the agency and found to contain an error, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider with an identified overpayment is no longer enrolled in the medicaid program, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation, unless other arrangements have been made to reimburse the agency. A net settlement may occur if a provider has more than one facility involved in settlements.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit of the provider's cost reports. Written notice of this per diem rate change and of the audit findings shall be sent to the provider. Retroactive adjustment of the rate paid from a projected cost report shall apply to the same period of time covered by the projected rate.

(3) Each provider shall have 30 days from the date of the audit report cover letter to request an administrative review of

an audit adjustment that results in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

(4) An interim settlement, based on a desk review of the historical cost report covering the projected cost report period, may be determined after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on the rate after an audit of the historical cost report.

(5) A new provider that is not allowed to submit a projected cost report for an interim rate shall not be entitled to a retroactive settlement for the first year of operation.

(g) Out-of-state providers.

(1) The rate for out-of-state providers certified to participate in the Kansas medical assistance program shall be the rate approved by the agency.

(2) Out-of-state providers shall obtain prior authorization by the agency.

(h) Reserve days as specified in K.A.R. 30-10-21 shall be paid at 67 percent of the Kansas medical assistance program per diem rate.

(i) Determination of rate for ventilator-dependent resident.

(1) The request for additional reimbursement for a ventilator-dependent resident shall be submitted to the agency in

writing for prior approval. Each request shall include a current care plan for the resident, the most current resident assessment, and an itemized expense list for implementing that care plan. The additional reimbursement shall not include the cost of durable medical equipment.

(2) All of the following conditions shall be met in order for a resident to be considered ventilator-dependent.

(A) The resident is not able to breathe without mechanical ventilation.

(B) The resident uses a ventilator for life support 24 hours a day, seven days a week.

(C) The resident has a tracheostomy or endotracheal tube.

(3) The provider shall be reimbursed at the Kansas medical assistance program daily rate determined for the nursing facility plus an additional amount approved by the agency for the ventilator-dependent resident. The provider shall submit a budget with the detail of the expenditures requested to care for the ventilator-dependent resident. The additional reimbursement shall be negotiated based on the prevailing cost of the individual care plan and subject to an upper payment limit that is based on the comparable rate from the medicare prospective payment system.

(4) No additional amount above that figured at the Kansas medical assistance program daily rate shall be allowed until the

service has been authorized by the agency.

(5) The criteria shall be reviewed quarterly to determine if the resident is ventilator-dependent. If a resident is no longer ventilator-dependent, the provider shall not receive additional reimbursement beyond the Kansas medical assistance program daily rate determined for the facility.

(6) The additional reimbursement for the ventilator-dependent resident shall be offset to the cost center of benefit on the nursing facility financial and statistical report.

(j) This regulation shall be effective on and after April 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended, T-87-29, Nov. 1, 1986; amended May 1, 1987; amended, T-89-5, Jan. 21, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended Sept. 30, 1994; amended Dec. 29, 1995; amended Jan. 1, 1999; amended June 28, 2002; amended Dec. 31, 2002; amended, T-30-5-30-03, July 1, 2003; amended July 25, 2003; amended, T-30-12-29-04, Dec. 29, 2004; amended April 1, 2005.)

30-10-19. Rates; effective dates. (a) Effective date of per diem rates for ongoing providers filing calendar year cost reports. The effective date of a new rate that is based on information and data in the nursing facility cost report for the calendar year shall be July 1.

(b) Effective date of the per diem rate for a new provider operating on the rate from cost data of the previous provider.

(1) The effective date of the per diem rate for a new provider shall be the date of certification by the state licensing agency.

(2) The effective date of the per diem rate based on the first historical cost report filed in accordance with K.A.R. 30-10-17 shall be the first day of the 25th month of operation. Any rates paid after the effective date of the rate based on the first historical cost report shall be adjusted to the new rate from the historical cost report.

(c) Effective date of the per diem rate from a projected cost report.

(1) The effective date of the per diem rate based on a projected cost report for a new provider, as set forth in K.A.R. 30-10-18 (c) and (e), shall be the date of certification by the state licensing agency.

(2) The interim rate determined from the projected cost report filed by the provider shall be established by the agency and given to the fiscal agent on or by the first day of the

third month after the receipt of a complete and workable cost report.

(3) The effective date of the final rate, determined after an audit of the historical cost report filed for the projected cost report period, shall be the date of certification by the state licensing agency.

(4) The second effective date for a provider filing an historic cost report covering a projected cost report period shall be the first day of the month following the last day of the period covered by the report, which is the date that the inflation factor is applied in determining prospective rates.

(d) Each provider shall receive an adjusted rate quarterly if there are changes in the facility's medicaid case mix index as described in K.A.R. 30-10-18.

(e) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended July 1, 2002; amended, T-30-5-30-03, July 1, 2003; amended July 25, 2003; amended May 1, 2005.)

30-10-20. Payment of claims. (a) Payment to participating providers. Each participating provider shall be paid, at least monthly, a per diem rate for nursing facility services, excluding resident liability, rendered to eligible residents if all of the following conditions are met:

(1) The agency is billed on the paper claim form or electronic claim submission furnished by the contractor serving as the fiscal agent for the medicaid/medikan program.

(2) The paper claim form or electronic claim submission is verified by the administrator of the facility or a designated key staff member.

(3) The claim is filed no more than 12 months after the time the services were rendered pursuant to K.S.A. 39-708a, and amendments thereto.

(4) The claim does not include services for the date of discharge.

(b) Resident's liability. The resident's liability for services shall be the amount determined by the local agency office in which a medicaid/medikan resident or the resident's agent applies for care. The resident's liability begins on the first day of each month and shall be applied in full before any liability incurred by the medicaid/medikan program. The unexpended portion of the resident's liability payment shall be refunded to the resident or to the resident's agent if the resident dies or otherwise permanently leaves the facility.

Providers shall not charge fees or finance charges related to late payment of resident liability.

(c) The payment of claims may be suspended if there has been an identified overpayment and the provider is financially insolvent. (d) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992; amended April 1, 1995; amended May 1, 2005.)

This exhibit is reserved for future use.

30-10-22

30-10-22. This rule and regulation shall expire on January 30, 1991. (Authorized by and implementing K.S.A. 1983 Supp. 39-708c; effective May 1, 1985; revoked, T-30-10-1-90, Oct. 1, 1990; revoked Jan. 30, 1991.)

30-10-23a. Non-reimbursable costs. (a) Costs not related to resident care, as set forth in K.A.R. 30-10-1a, shall not be considered in computing reimbursable costs. In addition, the following expenses or costs shall not be allowed:

(1) Fees paid to non-working directors and the salaries of non-working officers;

(2) bad debts;

(3) donations and contributions;

(4) fund-raising expenses;

(5) taxes, as follows:

(A) Federal income and excess profit taxes, including any interest or penalties paid on them;

(B) state or local income and excess profits taxes;

(C) taxes from which exemptions are available to the provider;

(D) taxes on property that is not used in providing covered services;

(E) taxes levied against any resident and collected and remitted by the provider;

(F) self-employment taxes applicable to individual proprietors, partners, or members of a joint venture; and

(G) interest or penalties paid on federal and state payroll taxes;

(6) insurance premiums on lives of owners and related parties;

(7) the imputed value of services rendered by non-paid workers and volunteers;

(8) utilization review;

(9) costs of social, fraternal, civic, and other organizations that concern themselves with activities unrelated to their members' professional or business activities;

(10) oxygen, and oxygen concentrators, tanks, and cylinders;

(11) vending machines and related supplies;

(12) board of director costs;

(13) resident personal purchases;

(14) advertising for resident utilization;

(15) public relations expenses;

(16) penalties, fines, and late charges;

(17) prescription drugs as defined in K.A.R. 30-10-1a;

(18) dental services;

(19) radiology;

(20) lab work;

(21) items or services provided only to non-medicaid/medikan residents and reimbursed from third party payors;

(22) automobiles and related accessories in excess of $25,000.00 each. Buses and vans for resident transportation shall be reviewed for reasonableness and may exceed $25,000.00 in costs;

(23) provider-owned or related party-owned, -leased, or -chartered airplanes and related expenses;

(24) therapeutic beds or mattresses;

(25) bank overdraft charges or other penalties;

(26) personal expenses not directly related to the provision of long-term resident care in a nursing facility;

(27) management fees paid to a related organization that are not clearly derived from the actual cost of materials, supplies, or services provided directly to an individual nursing facility;

(28) business expenses not directly related to the care of residents in a long-term care facility. These expenses shall include business investment activities, stockholder and public relations activities, and farm and ranch operations;

(29) legal and other costs associated with litigation , unless the litigation is decided in the provider's favor ; and

(30) lobbying expenses and political contributions.

(b) Purchase discounts, allowances, and refunds shall be deducted from the cost of the items purchased. Refunds of prior years' expenses shall be deducted from the related expenses.

(c) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1988; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended July 1, 2002; amended Dec. 31, 2002; amended May 1, 2005.)

30-10-23b. Costs allowed with limitations. (a) The following amortized expenses or costs shall be allowed with limitations:

(1) The provider shall amortize loan acquisition fees and standby fees over the life of the related loan if the loan is related to resident care.

(2) Only the taxes specified below shall be allowed as amortized costs:

(A) Taxes in connection with financing, refinancing, or refunding operations; and

(B) special assessments on land for capital improvements over the estimated useful life of those improvements.

(3) Any start-up cost of a provider with a newly constructed facility or a facility that has been closed for 24 months or more shall be recognized if the cost meets the following criteria:

(A) Is incurred within 90 days of the opening of the facility and related to developing the ability to care for residents;

(B) is amortized over a period of at least 60 months;

(C) is consistent with the facility's federal income tax return, and internal and external financial reports, with the exception of paragraph (a)(3)(B) above; and

(D) is identified in the cost report as a start-up expense, which may include the following:

(i) Administrative and nursing salaries;

(ii) utilities;

(iii) taxes, as identified in paragraphs (a)(2)(A) and (B);

(iv) insurance;

(v) mortgage interest;

(vi) employee training costs; and

(vii) any other allowable costs incidental to the operation of the facility.

(4) Each cost that can properly be identified as an organization expense or can be capitalized as a construction expense shall be appropriately classified and excluded from the start-up cost.

(5) Organization and other corporate costs, as defined in K.A.R. 30-10-1a, of a provider that is newly organized shall be amortized over a period of at least 60 months beginning with the date of organization.

(A) The costs shall be reasonable and limited to the preparation and filing of documents required by the various governmental entities, the costs of preparing sale or lease contracts, and the associated legal and professional fees.

(B) The costs shall not include expenses of resolving contested issues of title or disputes arising from the performance of contracts or agreements related to the purchase or sale of a property or business.

(b) Membership dues and costs incurred as a result of membership in professional, technical, or business-related

organizations shall be allowable. However, similar expenses set forth in paragraph (a)(9) of K.A.R. 30-10-23a shall not be allowable.

(c) The provider shall include the costs associated with services, facilities, and supplies furnished to the nursing facility by related parties, as defined in K.A.R. 30-10-1a, in the allowable cost of the facility at the actual cost to the related party, except that the allowable cost to the nursing facility provider shall not exceed the lower of the actual cost or the market price.

(d) If a provider pays an amount in excess of the market price for supplies or services, the agency shall use the market price to determine the allowable cost under the medicaid/medikan program in the absence of a clear justification for the premium.

(e) The net cost of job-related training and educational activities shall be an allowable cost. The allowable cost shall include the net cost of "orientation" and "on-the-job training."

(f) Resident-related transportation costs shall include only reasonable costs that are directly related to resident care and substantiated by detailed, contemporaneous expense and mileage records. Transportation costs only remotely related to resident care shall not be allowable. Estimates shall not be acceptable.

(g) Lease payments.

(1) Lease payments shall be reported in accordance with the

financial accounting statements of the financial accounting standards board.

(2) Sale-leaseback transactions shall have the costs limited to the amount that the provider would have included in reimbursable costs if the provider had retained legal title to the facilities and equipment. These costs shall include mortgage interest, taxes, depreciation, insurance, and maintenance costs. The lease cost shall not be allowable if it exceeds the ownership costs before the sale-leaseback transaction.

(h) If the expenses reported for the current period are not paid within one year after the invoice date, the expenses shall be disallowed.

(i) This regulation shall be effective on and after May 1, 2005. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Dec. 29, 1995; amended Aug. 15, 2003; amended May 1, 2005.)

30-10-23c. Revenues. A statement of revenue shall be required as part of the cost report forms. (a) Revenue shall be reported in accordance with general accounting rules as recorded in the accounting records of the facility and as required in the detailed revenue schedule in the uniform cost report.

(b) The cost of non-covered services provided to residents shall be deducted from the related expense item. The net expense shall not be less than zero.

(c) Revenue received for a service that is not related to resident care shall be used to offset the cost of providing that service, if the cost incurred cannot be determined or is not furnished to the agency by the provider. The cost report line item which includes the non-resident related costs shall not be less than zero. Miscellaneous revenue with insufficient explanation in the cost report shall be offset.

(d) Expense recoveries credited to expense accounts shall not be reclassified as revenue to increase the costs reported in order to qualify for a higher rate. The effective date of this regulation shall be November 2, 1992. (Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by 1992 SB 182, Sec. 5; effective May 1, 1985; amended May 1, 1987; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992.)

30-10-24. Compensation of owners, related parties, and administrators. (a) Non-working owners and related parties. Remunerations paid to non-working owners or other related parties, as defined in K.A.R. 30-10-1a, shall not be considered an allowable cost regardless of the name assigned to the transfer or accrual or the type of provider entity making the payment. Each payment shall be separately identified and reported as owner compensation in the non-reimbursable and non-resident-related expense section of the cost report.

(b) Services related to resident care.

(1) If owners with five percent or more ownership interest or related parties actually perform a necessary function directly contributing to resident care, a reasonable amount shall be allowed for such resident care activity. The reasonable amount allowed shall be the lesser of the following:

(A) The reasonable cost that would have been incurred to pay a non-owner employee to perform the resident-related services actually performed by owners or other related parties, limited by a schedule of salaries and wages based on the state civil service salary schedule in effect when the cost report is processed until the subsequent cost report is filed; or

(B) the amount of cash and other assets actually withdrawn by the owner or related parties.

(2) The resident-related functions shall be limited to those functions that are normally performed by non-owner employees common to the industry and for which cost data is available. The job titles for administrative and supervisory duties performed by an owner or related party shall be limited to the work activities included in the schedule of the owner or related party salary limitations.

(3) The salary limit shall be prorated in accordance with subsection (c) of this regulation. The limitation shall not exceed the highest salary limit on the civil-service-based chart.

(4) The owner or related party shall be professionally

qualified for those functions performed that require licensure or certification.

(5) Cash and other assets actually withdrawn shall include only those amounts or items actually paid or transferred during the cost reporting period in which the services were rendered and reported to the internal revenue service.

(6) The owner or related party shall pay any liabilities established in cash within 75 days after the end of the accounting period.

(c) Allocation of owner or related party total work time for resident-related functions. When any owner or related party performs a resident-related function for less than a full-time-equivalent work week, defined as 40 hours per week, the compensation limit shall be prorated. The time spent on each function within a facility or within all facilities in which the owner or related party has an ownership or management interest shall be prorated separately by function, but shall not exceed 100 percent of that person's total work time. Time spent on other non-related business interests or work activities shall not be included in calculations of total work time.

(d) Reporting owner or related party compensation on cost report. The provider shall report owner or related party compensation on the owner compensation line in the appropriate cost center for the work activity involved. Any compensation paid to employees who have an ownership interest of five percent or more, including employees at the central office of a chain organization, shall be deemed owner compensation. Providers with any professionally qualified owner or related party employees performing duties other than those for which they are professionally qualified shall report the cost for these duties in the operating cost center.

(e) Owner-administrator compensation limitation.

(1) Reasonable limits shall be determined by the agency for owner-administrator compensation based upon the current civil service salary schedule.

(2) This limitation shall apply to the salaries of each administrator and co-administrator of that facility and to owner compensation reported in the operating cost center . This limitation shall apply to the salaries of the administrator and co-administrator, regardless of whether they have any ownership interest in the business entity.

(3) Each salary in excess of the owner or related party limitations determined in accordance with subsections (b) and (c) of this regulation shall be transferred to the owner compensation line in the operating cost center and shall be subject to the owner-administrator compensation limitation. The provider shall include all owner-administrator compensation in excess of the limitation in the administrative costs used to compute the incentive factor.

(f) Management consultant fees. Fees for consulting services provided by owners and related parties shall be deemed owner's compensation subject to the owner-administrator compensation limit. The provider shall report fees on the owner compensation line in the operating cost center if the actual cost of the service is not submitted with the adult care home financial and statistical report:

(1) Related parties as defined in K.A.R. 30-10-1a;

(2) current owners of the provider agreement and operators of the facility;

(3) current owners of the facility in a lessee-lessor relationship;

(4) management consulting firms owned and operated by former business associates of the current owners in this and other states;

(5) owners who sell and enter into management contracts with the new owner to operate the facility; and

(6) accountants, lawyers, and other professional people who have common ownership interests in other facilities, in this or

other states, with the owners of the facility from which the consulting fee is received.

(g) Costs not related to resident care. An allowance shall not be made for costs related to investigation of investment opportunities, travel, entertainment, goodwill, or administrative or managerial activities performed by owners or other related parties that are not directly related to resident care.

(h) This regulation shall be effective on and after July 1, 2002. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Dec. 29, 1995; amended July 1, 2002.)

30-10-25. Real and personal property fee. (a) A real and personal property fee shall be developed by the agency in lieu of an allowable cost for ownership or lease expense, or both. The fee shall be facility-specific and shall not change as a result of change of ownership, a change in lease, or re-enrollment in the medicaid program by providers . An inflation factor may be applied to the fee on an annual basis.

(1) The real and personal property fee shall include an appropriate component for the following:

(A) Rent or lease expense;

(B) interest expense on a real estate mortgage;

(C) amortization of leasehold improvements; and

(D) depreciation on buildings and equipment.

(b)(1) The real and personal property fee shall be determined based on one of the following methodologies:

(A) For providers enrolled in the Kansas medical assistance program with a real and personal property fee for each facility, the real and personal property fee shall be the sum of the property allowance and value factor.

(B) For providers reenrolling in the Kansas medical assistance program or providers enrolling for the first time but operating in a facility that was previously enrolled in the program, the real and personal property fee shall be the sum of the last effective property allowance and the last effective value factor for the facility.

(C) The real and personal property fee for a newly constructed nursing facility or a nursing facility that enters the Kansas medical assistance program and has not had a fee established previously shall be calculated based on the following methodology:

(i) A projected real and personal property fee shall be

calculated using a projected cost report by dividing the total of the four real and personal property fee components reported in the ownership cost center by the greater of the total resident days reported or 85 percent of the licensed capacity for the cost report period.

(ii) An historical real and personal property diem shall be calculated using an audited historical cost report by dividing the total of the four line items reported in the ownership cost center by the greater of the total resident days reported or 85 percent of the licensed capacity for the cost report period.

(iii) A settlement between the projected and historical rates, which shall include the real and personal property fee, shall be made in accordance with K.A.R. 30-10-18 (e).

(2) The real and personal property fee shall be subject to an upper payment limit. The upper payment limit for the real and personal property fee shall be determined by the median real and personal property fee plus a percentage of the median. The percentage factor applied shall be determined by the secretary.

(c)(1) The depreciation and amortization component of the real and personal property fee shall meet these criteria:

(A) Be identifiable and recorded in the provider's accounting records;

(B) be based on the historical cost of the asset as established in this regulation; and

(C) be prorated over the estimated useful life of the asset using the straight-line method.

(2) (A) Appropriate recording of depreciation shall include the following:

(i) Identification of the depreciable assets in use;

(ii) the assets' historical costs;

(iii) the method of depreciation;

(iv) the assets' estimated useful life; and

(v) the assets' accumulated depreciation.

(B) Each provider shall report gains and losses on the sale of depreciable personal property on the cost report at the time of the sale. The provider shall record trading of depreciable property in accordance with the income tax method of accounting for the basis of property acquired. Under the income tax method, gains and losses arising from the trading of assets shall not be recognized in the year of trade, but shall be used to adjust the basis of the newly acquired property.

(3) The cost basis shall not include costs attributable to the negotiation or final purchase of the facility, which may include legal fees, accounting fees, travel costs, and the cost of feasibility studies.

(d) Any provider may request that the agency re-base the real and personal property fee. Providers shall submit re-base requests for completed capital improvement projects or phases of capital improvements projects. The following methodology shall be used to determine a revised real and personal property fee based on the re-base request.

(1) Re-base requests shall be reviewed to determine a revised real and personal property fee if the provider meets the following capital expenditure thresholds:

(A) $25,000.00 for facilities with 50 or fewer beds; or

(B) $50,000.00 for facilities with 51 or more beds.

(2) The per diem based on the interest expense, depreciation expense, and amortization of leasehold improvements shall be added to the real and personal property fee in effect on the date that the re-base is made effective. Interest expense

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reported in the operating cost center shall not be included in the request for a re-base of the real and personal property fee. Interest on loans for real and personal property that is included in a re-base shall be reported with mortgage interest in the ownership cost center.

(3) The resident days used in the denominator of the real and personal property fee calculation shall be based on the total resident days used to compute the rate that is paid at the time the request is made to re-base the property fee. The resident days shall be subject to the 85 percent minimum occupancy requirement, including any new beds documented in the request for a re-base.

(4) The revised real and personal property fee shall be subject to the upper payment limit in effect on the date the re-base is made effective.

(5) Effective dates for re-based real and personal property fees.

(A) If the number of beds of an existing nursing facility is increased by the construction of a new addition to the existing facility, the real and personal property fee established through the re-base shall be effective according to either of the following schedules:

(i) On the first day of the month in which the new beds were certified if the certification date was on or before the 15th of the month; or

(ii) on the first day of the month following the month in which the beds were certified if the certification date is on or after the 16th of the month.

(B) If the capital expenditure that is the basis for the re-base request is not related to an increased number of beds, the real and personal property fee established through the re-base shall be effective according to either of the following schedules:

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(i) On the first day of the month in which the complete documentation is received, if the request is received on or before the 15th of the month; or

(ii) on the first day of the month following the month in which the complete documentation is received, if the request is received on or after the 16th of the month.

(C) Complete documentation shall include the following:

(i) The depreciation or amortization schedule reflecting the expense, including the construction-in-progress subsidiary ledger;

(ii) the loan agreement;

(iii) the amortization schedule for interest;

(iv) invoices;

(v) receipts for contractor fees; and

(vi) receipts for other costs associated with the capital expenditure.

(6) Invoices or contractor statements dated more than two years before the date the re-base request is received shall not be allowed.

(f) This regulation shall be effective on and after July 1, 2002. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended May 1, 1988; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997; amended Jan. 1, 1999; amended July 1, 2002.)

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30-10-26. Interest expense. (a) Only necessary and proper interest on working capital or personal property loans shall be an allowable expense. This shall not include interest on real estate or personal property covered by the real and personal property fee in accordance with K.A.R. 30-10-25.

(b) The interest expense shall be incurred on indebtedness established with either of the following:

(1) Lenders or lending organizations not related to the borrower; or

(2) partners, stockholders, home office organizations, or related parties, if the following conditions are met:

(A) The terms and conditions of payment of the loans shall resemble terms and conditions of an arm□s-length transaction by a prudent borrower with a recognized, local lending institution with the capability of entering into a transaction of the required magnitude. A signed promissory note and loan amortization schedule shall be submitted with the cost report. Allowable interest expense shall be limited to the annual expense submitted on the loan amortization schedule, unless the loan principal is retired before the end of the amortization period.

(B) The provider shall demonstrate, to the satisfaction of the agency, a primary business purpose for the loan other than increasing the per diem rate.

(C) The transaction shall be recognized and reported by all parties for federal income tax purposes.

(c) When the general fund of a nursing facility "borrows" from a donor-restricted fund, this interest expense shall be an allowable cost. In addition, if a nursing facility operated by members of a religious order borrows from the order, interest paid to the order shall be an allowable cost.

(d) The interest expense shall be reduced by the investment income from restricted or unrestricted idle funds or funded reserve accounts, except when that income is from gifts and grants, whether restricted or unrestricted, that are held in a separate account and not commingled with other funds. Income from the provider's qualified pension fund shall not be used to reduce interest expense.

(e) Interest earned on restricted or unrestricted reserve accounts of industrial revenue bonds or sinking fund accounts shall be offset against interest expense and limited to the interest expense on the related debt.

(f) Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost or the cost basis recognized for program purposes shall not be considered to be reasonably related to resident care.

(g) This regulation shall take effect on and after January 1, 1999. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Jan. 1, 1999.)

30-10-27. Central office costs. (a) Allocation of central office costs shall be reasonable, conform to general accounting rules, and allowed only to the extent that the central office is providing a service normally available in the nursing facility. Central office costs shall not be recognized or allowed to the extent that they are unreasonably in excess of similar nursing facilities in the program. The burden of furnishing sufficient evidence to establish a reasonable level of costs shall be on the provider. All expenses reported as central office costs shall be limited to the actual resident-related costs of the central office.

(1) The provider shall report cost of ownership or the arm's-length lease expense, utilities, maintenance, property taxes, insurance, and other plant operating costs of the central or regional office space for resident-related activities report as central office costs.

(2) The provider shall report all administrative expenses incurred by central and regional offices as central office costs. These may include the following:

(A) Salaries;

(B) benefits;

(C) office supplies;

(D) printing, management, and consultant fees;

(E) telephones and other forms of communications;

(F) travel and vehicle expenses;

(G) allowable advertising;

(H) licenses and dues; and

(I) legal, accounting, data processing, insurance, and interest expenses.

The administrative expenses reported as central office costs

shall not be directed to individual facilities operated by the provider or reported on any other line of the cost report.

(3) Non-reimbursable costs in K.A.R. 30-10-23a, costs allowed with limitations in K.A.R. 30-10-23b, and the revenue offsets in K.A.R. 30-10-23c shall apply to central office costs.

(4) Estimates of central office costs shall not be allowable.

(b) Central office salary and other limitations.

(1) Salaries of employees performing the duties for which they are professionally qualified shall be allocated to the direct health care cost center or the indirect health care cost center as appropriate for the duties performed. Professionally qualified employees shall include licensed and registered nurses, dietitians, and others that may be designated by the secretary.

(2) Salaries of chief executives, corporate officers, department heads, and other employees with ownership interests of five percent or more shall be deemed owner's compensation, and the provider shall report these salaries as owner's compensation in the operating cost center.

(3) The provider shall include the salary of an owner or related party performing a resident-related service for which the person is professionally qualified in the appropriate cost center for that service, subject to the owner or related party salary limitations.

(4) The provider shall report salaries of all other central office personnel performing resident-related administrative functions in the operating cost center.

(5) All providers operating a central office shall complete and submit detailed schedules of all salaries and expenses incurred in each fiscal year. Failure to submit detailed central office expenses and allocation methods shall result in an incomplete cost report. The provider shall submit methods for allocating costs to all facilities in this and other

states for prior approval. Changes in these methods shall not be permitted without prior approval.

(6) A central office cost limit may be established by the agency within the overall operating cost center upper payment limit.

(7) The provider may allocate and report bulk purchases by the central office staff in the appropriate cost center of each facility if sufficiently documented. Questionable allocations shall be transferred to the central office cost line within the operating cost center.

(c) This regulation shall be effective on and after July 1, 2002. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1985; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Dec. 29, 1995; amended July 1, 2002.)

30-10-28. Resident days. (a) Calculation of resident days.

(1) "Resident day" shall have the meaning set forth in K.A.R. 30-10-1a.

(2) If both admission and discharge occur on the same day, that day shall be considered to be a day of admission and shall count as one resident day.

(3) If the provider does not make refunds on behalf of a resident for unused days in case of death or discharge, and if the bed is available and actually used by another resident, these unused days shall not be counted as a resident day.

(4) Any bed days paid for by the resident, or any other party on behalf of the resident, before an admission date shall not be counted as a resident day.

(5) The total resident days for the cost report period shall be precise and documented; an estimate of the days of care provided shall not be acceptable.

(6) In order to facilitate accurate and uniform reporting of resident days, the accumulated method format set forth in data specifications in diskettes furnished by the agency shall be used for all residents beginning January 1, 1999. The monthly reporting, using the diskette, shall be submitted to the agency as supportive documentation for the resident days shown on the cost report forms and shall be submitted at the time the cost report and required documents are submitted to the agency. Monthly census summaries shall include reporting for nursing facility or nursing facility-mental health, other residential days with shared nursing facility or nursing facility-mental health costs, and day care hours. Each provider shall keep these monthly records for each resident, whether a Kansas medical assistance program recipient or a non-recipient. If the provider fails to keep accurate records of resident days in accordance with the accumulated method format, the assumed occupancy rate shall be 100 percent.

(7) The provider shall report the total number of Kansas medical assistance program resident days in addition to the total resident days on the uniform cost report form.

(8) The provider shall report the total number of other residential days with shared nursing facility or nursing facility-mental health costs on the uniform cost report form.

(b) Respite care days shall be counted as resident days and reported on the monthly census forms.

(c) Day care and day treatment shall be counted as one resident day for 18 hours of service. The total hours of service provided for all residents during the cost reporting year shall be divided by 18 hours to convert to resident days.

(d) This regulation shall take effect on and after January 1, 1999. (Authorized by and implementing K.S.A. 1997 Supp. 39-708c; effective May 1, 1985; amended May 1, 1987; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Jan. 1, 1999.)

30-10-29. (Authorized by and implementing K.S.A. 1994 Supp. 39-708c, as amended by L. 1995, Ch. 153, Sec. 1; effective, T-86-42, Dec. 18, 1985; effective, T-87-5, May 1, 1986; effective May 1, 1987; amended May 1, 1988; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended May 1, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Dec. 29, 1995; revoked June 28, 2002.)

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Methods and Standards for Establishing Payment Rates-
Skilled Nursing and Intermediate Care Facility Rates
(NFs and NFs/MH)

Audits

1. The State uses a standardized nursing facility desk review program and a standardized field audit program.

2. The State shall perform a desk review of all cost reports within six months after receipt.

3. The State shall provide for periodic audits of the financial and statistical records of participating providers.

4. Installment recoupments shall be allowed if the Department determines that a lump sum recoupment could result in the provider being unable to provide a standard level of care. Any payment schedules in excess of twelve months shall be approved by the Secretary.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Under the Medicaid program, the State of Kansas pays nursing facilities (NF), nursing facilities for mental health (NFMH), and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The narrative explanation of the nursing facility reimbursement formula is divided into twelve sections. The sections are: Cost Reports, Rate Determination, Quarterly Case Mix Index Calculation, Resident Days, Inflation Factors, Upper Payment Limits, Quarterly Case Mix Rate Adjustment, Real and Personal Property Fee, Incentive Factors, Rate Effective Date, Retroactive Rate Adjustments, and Comparable Private Pay Rates.

1) Cost Reports

The Nursing Facility Financial and Statistical Report (MS2004) is the uniform cost report. It is included in Kansas Administrative Regulation (K.A.R.) 30-10-17. It organizes the commonly incurred business expenses of providers into three reimbursable cost centers (operating, indirect health care and direct health care). Ownership costs (i.e., mortgage interest, depreciation, lease and amortization of leasehold improvements) are reported but reimbursed through the real and personal property fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers' accounting records.

All cost reports are desk reviewed by agency auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

Calendar Year End Cost Reports:

All providers that have operated a facility for 12 or more months on December 31 shall file a calendar year cost report. The requirements for filing the calendar year cost report are found in K.A.R. 30-10-17.

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

calendar year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator for the months during the calendar year in which the new operator was not involved in running the facility. The cost report information from the old and new operators shall be combined to prepare a 12-month calendar year end cost report.

Projected Cost Reports:

The filing of projected cost reports are limited to: 1) newly constructed facilities; 2) existing facilities new to the Medicaid program; or 3) a provider re-entering the Medicaid program that has not actively participated or billed services for 24 months or more. The requirements are found in K.A.R. 30-10-17.

2) Rate Determination

Rates for Existing Nursing Facilities

Medicaid rates for Kansas NFs are determined using a prospective, facility-specific rate-setting system. The rate is determined from the base cost data submitted by the provider. The current base cost data is the combined calendar year cost data from each available report submitted by the current provider during 2003, 2004, and 2005.

If the current provider has not submitted a calendar year report between 2003 and 2005, the cost data submitted by the previous provider for that same period will be used as the base cost data. Once the provider completes their first 24 months in the program, their first calendar year cost report will become the provider's base cost data.

The allowable expenses are divided into three cost centers. The cost centers are Operating, Indirect Health Care and Direct Health Care. They are defined in K.A.R. 30-10-18.

The allowable historic per diem cost is determined by dividing the allowable resident related expenses in each cost center by resident days. Before determining the per diem cost, each year's cost data is adjusted from the midpoint of that year to the midpoint of the rate payment period. The resident days and inflation factors used in the rate determination will be explained in greater detail in the following sections.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

The inflated allowable historic per diem cost for each cost center is then compared to the cost center upper payment limit. The allowable per diem rate is the lesser of the inflated allowable historic per diem cost in each cost center or the cost center upper payment limit. Each cost center has a separate upper payment limit. If each cost center upper payment limit is exceeded, the allowable per diem rate is the sum of the three cost center upper payment limits. There is also a separate upper payment limit for owner, related party, administrator, and co-administrator compensation. The upper payment limits will be explained in more detail in a separate section.

The case mix of the residents adjusts the Direct Health Care cost center. The reasoning behind a case mix payment system is that the characteristics of the residents in a facility rather than the characteristics of the facility should determine the payment rate. The idea is that certain resident characteristics can be used to predict future costs to care for residents with those same characteristics. For these reasons, it is desirable to use the case mix classification for each facility in adjusting provider rates.

There are add-ons to the allowable per diem rate. The add-ons consist of the incentive factor and the real and personal property fee. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. The add-ons plus the allowable per diem rate equal the total per diem rate.

Rates for New Construction and New Facilities (New Enrollment Status)

The per diem rate for newly constructed nursing facilities, or new facilities to the Kansas Medical Assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-17.

The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to the midpoint of the rate payment period. This adjustment will be based on the Data Resources, Inc., National Skilled Nursing Facility Market Basket Without Capital Index (DRI Index). The DRI indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to the midpoint of the rate payment period. The provider shall remain in new enrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Rates for Facilities Recognized as a Change of Provider (Change of Provider Status)

The payment rate for the first 24 months of operation shall be based on the base cost data of the previous owner or provider. This base cost data shall include data from each calendar year cost report that was filed by the previous provider from 2003 to 2005. If base cost data is not available the most recent calendar year data for the previous provider shall be used. Beginning with the first day of the 25th month of operation the payment rate shall be based on the historical cost data for the first calendar year submitted by the new provider.

All data used to set rates for facilities recognized as a change-of-provider shall be adjusted to the midpoint of the rate payment period. This adjustment will be based on the Data Resources, Inc., National Skilled Nursing Facility Market Basket Without Capital Index (DRI Index). The DRI indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to the midpoint of the rate payment period. The provider shall remain in change-of-provider status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change of provider status.

Rates for Facilities Re-entering the Program (Reenrollment Status)

The per diem rate for each provider reentering the Medicaid program shall be determined from a projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more. The per diem rate for all other providers reentering the program shall be determined from the base cost data filed with the agency or the most recent cost report filed preceding calendar year 2003.

All cost data used to set rates for facilities reentering the program shall be adjusted to the midpoint of the rate payment period. This adjustment will be based on the Data Resources, Inc., National Skilled Nursing Facility Market Basket Without Capital Index (DRI Index). The DRI indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to the midpoint of the rate payment period. The provider shall remain in reenrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied

to cost data for established providers shall be applied to the adjusted cost data for each provider in reenrollment status.

3) Quarterly Case Mix Index Calculation

Providers are required to submit to the agency the uniform assessment instrument, which is the Minimum Data Set (MDS), for each resident in the facility. The MDS assessments are maintained in a computer database.

The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model is used as the resident classification system to determine all case- mix indices, using data from the MDS submitted by each facility. Standard Version 5.12b case mix indices developed by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) shall be the basis for calculating facility average case mix indices to be used to adjust the Direct Health Care costs in the determination of upper payment limits and rate calculation. Resident assessments that cannot be classified will be assigned the lowest CMI for the State.

Each resident in the facility on the first day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the first day of each calendar quarter. This RUG-III group shall be translated to the appropriate CMI. From the individual resident case mix indices, three average case mix indices for each Medicaid nursing facility shall be determined four times per year based on the assessment information available on the first day of each calendar quarter.

The facility-wide average CMI is the simple average, carried to four decimal places, of all resident case mix indices. The Medicaid-average CMI is the simple average, carried to four decimal places, of all indices for residents, including those receiving hospice services, where Medicaid is known to be a per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. The private-pay/other average CMI is the simple average, carried to four decimal places, of all indices for residents where neither Medicaid nor Medicare were known to be the per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. Case mix indices for ventilator-dependent residents for whom additional reimbursement has been determined shall be excluded from the average CMI calculations.

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The resident listing cut-off for calculating the average CMIs will be the first day of the quarter before the rate is effective. The following are the dates for the resident listings and the quarter in which the average Medicaid CMIs will be used in the quarterly rate-setting process.

Rate Effective Date:	Cut-Off Date:
July 1	April 1
October 1	July 1
January 1	October 1
April 1	January 1

The resident listings will be mailed to providers prior to the dates the quarterly case mix adjusted rates are determined. This will allow the providers time to review the resident listings and make corrections before they are notified of new rates. The cut off schedule may need to be modified in the event accurate resident listings and Medicaid CMI scores cannot be obtained from the MDS database.

4) Resident Days

Facilities with 60 beds or less:

For facilities with 60 beds or less, the allowable historic per diem costs for all cost centers are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data.

Facilities with more than 60 beds:

For facilities with more than 60 beds, the allowable historic per diem costs for the Direct Health Care cost center and for food and utilities in the Indirect Health Care cost center are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data. The allowable historic per diem cost for the Operating and Indirect Health Care Cost Centers less food and utilities is subject to an 85% minimum occupancy rule. For these providers, the greater of the actual resident days for the cost report period(s) used to establish the base cost data or the 85% minimum occupancy based on the number of licensed bed days during the cost report period(s) used to establish the base cost data is used as the total resident days in the rate calculation for the Operating cost center and the

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Indirect Health Care cost center less food and utilities. All licensed beds are required to be certified to participate in the Medicaid program.

There are two exceptions to the 85% minimum occupancy rule for facilities with more than 60 beds. The first is that it does not apply to a provider who is allowed to file a projected cost report for an interim rate. Both the rates determined from the projected cost report and the historic cost report covering the projected cost report period are based on the actual resident days for the period.

The second exception is for the first cost report filed by a new provider who assumes the rate of the previous provider. If the 85% minimum occupancy rule was applied to the previous provider's rate, it is also applied when the rate is assigned to the new provider. However, when the new provider files a historic cost report for any part of the first 12 months of operation, the rate determined from the cost report will be based on actual days and not be subject to the 85% minimum occupancy rule for the months in the first year of operation. The 85% minimum occupancy rule is then reapplied to the rate when the new provider reports resident days and costs for the 13th month of operation and after.

5) Inflation Factors

Inflation will be applied to the allowable reported costs from the calendar year cost report(s) used to determine the base cost data from the midpoint of each cost report period to the midpoint of the rate payment period. The inflation will be based on the Data Resources, Inc., National Skilled Nursing Facility Market Basket Without Capital Index (DRI Index).

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

The inflation factor will not be applied to the following costs:

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

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The inflation factor for the real and personal property fees will be based on the Data Resources, Inc., National Skilled Nursing Facility Total Market Basket Index (DRI Index). An additional 12 months of inflation will be applied to the real and personal property fees in effect June 1.

6) Upper Payment Limits

There are three types of upper payment limits that will be described. One is the owner/related party/administrator/co-administrator limit. The second is the real and personal property fee limit. The last type of limit is an upper payment limit for each cost center. The upper payment limits are in effect during the payment rate period unless otherwise specified by a State Plan amendment.

Owner/Related Party/Administrator/Co-Administrator Limits:

Since salaries and other compensation of owners are not subject to the usual market constraints, specific limits are placed on the amounts reported. First, amounts paid to non-working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have their compensation limited by the percent of their total work time to a standard work week. A standard work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled, "Statement of Owners and Related Parties." This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in excess of the Kansas Civil Service based salary chart are transferred to the Operating cost center where the excess is subject to the Owner/Related Party/Administrator/Co-Administrator per diem compensation limit.

The Schedule C is an array of non-owner administrator and co-administrator salaries. The schedule includes the calendar year 2006 historic cost reports in the

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database from all active nursing facility providers. The salary information in the array is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than 12 months with more than 60 beds. The Schedule C for the owner/related party/administrator/co-administrator per diem compensation limit is the first schedule run during the rate setting.

The Schedule C is used to set the per diem limitation for all non-owner administrator and co-administrator salaries and owner/related party compensation in excess of the civil service based salary limitation schedule. The per diem limit for a 50-bed or larger home is set at the 90th percentile on all salaries reported for non-owner administrators and co-administrators. A limitation table is then established for facilities with less than 50 beds. This table begins with a reasonable salary per diem for an administrator of a 15-bed or less facility. The per diem limit for a 15-bed or less facility is inflated based on the State of Kansas annual cost of living allowance for classified employees for the rate period. A linear relationship is then established between the compensation of the administrator of the 15-bed facility and the compensation of the administrator of a 50-bed facility. The linear relationship determines the per diem limit for the facilities between 15 and 50 beds.

The per diem limits apply to the non-owner administrators and co-administrators and the compensation paid to owners and related parties who perform an administrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service based salary chart in other cost centers that are transferred to the operating cost center.

Real and Personal Property Fee Limit

The property component of the reimbursement methodology consists of the real and personal property fee that is explained in more detail in a later section. The upper payment limit will be 105% of the median determined from a total resident day-weighted array of the inflated property fees.

Cost Center Upper Payment Limits

The Schedule B computer run is an array of all per diem costs for each of the three cost centers-Operating, Indirect Health Care, and Direct Health Care. The schedule includes a per diem determined from the base cost data from all active nursing facility providers. Projected cost reports are excluded when calculating the limit.

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The per diem expenses for the Operating cost center and the Indirect Health Care cost center less food and utilities are subject to the 85% minimum occupancy for facilities over 60 beds. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs are adjusted by the owner/related party/administrator/co-administrator limit.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted from the midpoint of the cost report period to the midpoint of the rate payment period. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based on the DRI Index.

Certain costs are exempt from the inflation application when setting the upper payment limits. They include owner/related party compensation, interest expense, and real and personal property taxes.

The final results of the Schedule B run are the median compilations. These compilations are needed for setting the upper payment limit for each cost center. The median for each cost center is weighted based on total resident days. The upper payment limits will be set using the following:

Operating	110% of the median
Indirect Health Care	115% of the median
Direct Health Care	120% of the median

Direct Health Care Cost Center Limit:

The Kansas reimbursement methodology has a component for a case mix payment adjustment. The Direct Health Care cost center rate component and upper payment limit are adjusted by the facility average CMI.

For the purpose of setting the upper payment limit in the Direct Health Care cost center, the facility cost report period CMI and the statewide average CMI will be calculated. The facility cost report period CMI is the resident day-weighted average of the quarterly facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/20XX-12/31/20XX financial and statistical reporting period would use the facility-wide average case mix

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indices for quarters beginning 04/01/XX, 07/01/XX, 10/01/XX and 01/01/XY. The statewide average CMI is the resident day-weighted average, carried to four decimal places, of the facility cost report period case mix indices for all Medicaid facilities.

The statewide average CMI and facility cost report period CMI are used to set the upper payment limit for the Direct Health Care cost center. The limit is based on all facilities with a historic cost report in the database. There are three steps in establishing the base upper payment limit.

The first step is to normalize each facility's inflated Direct Health Care costs to the statewide average CMI. This is done by dividing the facility's cost report period CMI by the statewide average CMI for the cost report year, then multiplying this answer by the facility's inflated costs. This step is repeated for each cost report year for which data is included in the base cost data.

The second step is to determine per diem costs and array them to determine the median. The per diem cost is determined by dividing the total of each provider's base direct health care costs by the total days provided during the base cost data period. The median is located using a day-weighted methodology. That is, the median cost is the per diem cost for the facility in the array at which point the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all providers. The facility with the median resident day in the array sets the median inflated direct health care cost. For example, if there are 8 million resident days, the facility in the array with the 4 millionth day would set the median.

The final step in calculating the base Direct Health Care upper payment limit is to apply the percentage factor to the median cost. For example, if the median cost is $60 and the upper payment limit is based on 120% of the median, then the upper payment limit for the statewide average CMI would be $72 (**D**=120% x $60).

7) Quarterly Case Mix Rate Adjustment

The allowance for the Direct Health Care cost component will be based on the average Medicaid CMI in the facility. The first step in calculating the allowance is to determine the Allowable Direct Health Care Per Diem Cost. This is the lesser of the facility's per diem cost from the base cost data period or the Direct Health Care upper payment limit. Because the direct health care costs were previously adjusted for the

statewide average CMI, the Allowable Direct Health Care Per Diem Cost corresponds to the statewide average CMI.

The next step is to determine the Medicaid acuity adjusted allowable Direct Health Care cost. The Medicaid CMI is divided by the statewide average CMI for the cost data period. This answer, is then multiplied by the Allowable Direct Health Care per diem cost. The result is referred to as the Medicaid Acuity Adjustment.

The Medicaid Acuity Adjustment is calculated quarterly to account for changes in the Medicaid CMI. To illustrate this calculation take the following situation: The Direct Health Care per diem limit is $72.00 with a statewide average CMI of 1.000, and the facility's direct health care per diem costs are $60.00, and its current Medicaid CMI is 0.9000. Since the per diem costs are less than the limit the Allowable Direct Heath Care Cost is $60.00, and this is matched with the statewide average CMI of 1.0000. To calculate the Medicaid Acuity Adjustment, first divide the Medicaid CMI by the statewide average CMI, then multiply the answer by the Allowable Direct Health Care Cost. In this case that would result in $54.00 (0.9000/1.0000 x $60.00). Because the facility's current Medicaid CMI is less than the statewide average CMI the Medicaid Acuity Adjustment moves the direct health care per diem down proportionally. In contrast, if the Medicaid CMI for the next quarter rose to 1.1000, the Medicaid Acuity Adjustment would be $66.00 (1.1000/1.0000 x $60.00). Again the Medicaid Acuity Adjustment changes the Allowable Direct Health Care Per Diem Cost to match the current Medicaid CMI.

8) Real And Personal Property Fee

The property component of the reimbursement methodology consists of the real and personal property fee (property fee). The property fee is paid in lieu of an allowable cost of mortgage interest, depreciation, lease expense and/or amortization of leasehold improvements. The fee is facility specific and does not change as a result of a change of ownership, change in lease, or with re-enrollment in the Medicaid program. The original property fee was comprised of two components, a property allowance and a property value factor. The differentiation of fee into these components was eliminated effective July 1, 2002. At that time each facility's fee was re-established based on the sum of the property allowance and value factor.

The property fees in effect on June 1, were inflated with 12 months of inflation effective July 1. The inflation factor was from the Data Resources, Inc.-WEFA, National

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Skilled Nursing Facility Total Market Basket Index (DRI Index). The providers received the lower of the inflated property fee or the upper payment limit.

For providers re-enrolling in the Kansas Medical Assistance program or providers enrolling for the first time but operating in a facility that was previously enrolled in the program, the property fee shall be the sum of the last effective property allowance and the last effective value factor for that facility. The property fee will be inflated and then compared to the upper payment limit. The property fee will be the lower of the facility-specific inflated property fee or the upper payment limit.

Providers entering the Kansas Medical Assistance program for the first time, who are operating in a building for which a fee has not previously been established, shall have a property fee calculated from the ownership costs reported on the cost report. This fee shall include appropriate components for rent or lease expense, interest expense on real estate mortgage, amortization of leasehold improvements, and depreciation on buildings and equipment. The process for calculating the property fee for providers entering the Kansas Medical Assistance program for the first time is explained in greater detail in (K.A.R. 30-10-25).

There is a provision for changing the property fee. This is for a rebasing when capital expenditure thresholds are met ($25,000 for homes under 51 beds and $50,000 for homes over 50 beds). The original property fee remains constant but the additional factor for the rebasing is added. The property fee rebasing is explained in greater detail in (K.A.R. 30-10-25). The rebased property fee is subject to the upper payment limit.

9) Incentive Factors

An incentive factor will be awarded to both NF and NF-MH providers that meet certain outcome measures criteria. The criteria for NF and NF-MH providers will be determined separately based on arrays of outcome measures for each provider group.

Nursing Facility Quality and Efficiency Incentive Factor:

The Nursing Facility Quality and Efficiency Incentive Factor is a per diem add-on ranging from zero to three dollars. It is designed to encourage quality care and efficiency. The incentive factor is determined by five outcome measures: case-mix adjusted nurse staffing ratio; operating expense; staff turnover rate; staff retention rate; and occupancy rate. The most recent cost report data for each provider will be used to

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determine the outcome measures. Each provider is awarded points based on their outcome measures and the total points for each provider determine the per diem incentive factor included in the provider's rate calculation.

Providers may earn up to two incentive points for their case mix adjusted nurse staffing ratio. They will receive two points if their case-mix adjusted staffing ratio equals or exceeds 4.46, which is 120% of the statewide NF median of 3.72. They will receive one point if the ratio is less than 120% of the NF median but greater than or equal to 4.09, which is 110% of the statewide NF median. Providers with staffing ratios below 110% of the NF median will receive no points for this incentive measure.

Providers may earn up to two points for their occupancy outcome measures. If they have total occupancy greater than or equal to 90% they will earn one point. If they have Medicaid occupancy greater than or equal to 60% they will also earn one point. Providers that meet both of these criteria will receive a total of two incentive points for occupancy outcomes and providers that fail to meet either criterion will receive zero points for occupancy.

Providers may earn one point for low operating expenses. Providers with per diem operating expenses below $20.77, 90% of the statewide median per diem operating expense ($23.08), will earn one point.

Providers may earn up to two points for their turnover rate outcome measure. Providers with direct health care staff turnover equal to or below 51%, the 75th percentile statewide, will earn two points as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers with direct health care staff turnover equal to or below 77%, the 50th percentile statewide, will earn one point as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs.

Finally, providers may earn up to two points for their retention rate outcome measure. Providers with staff retention rates at or above 72%, the 75th percentile statewide will earn two points. Providers with staff retention rates at or above 63%, the 50th percentile statewide will earn one point.

The table below summarizes the incentive factor outcomes and points:

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Quality/Efficiency Outcome:	Incentive Points:
1) CMI adjusted staffing ratio >= 120% (4.46) of state median (3.72), or CMI adjusted staffing ratio between 110% (4.09) and 120%	2, or 1
2) Total occupancy >= 90% Medicaid occupancy >= 60%	1 1
3) Operating expenses < $20.77, 90% of state median ($23.08)	1
4) Staff turnover rate <= 75th percentile, 51% Staff turnover rate <= 50th percentile, 77% Contracted labor < 10% of total direct health care labor costs	2, or 1
5) Staff retention >= 75th percentile, 72% Staff retention >= 50th percentile, 63%	2, or 1
Total Incentive Points Available	9

The Schedule E is an array containing the incentive points awarded to each provider for each quality and efficiency incentive outcome. The total of these points will be used to determine each provider's incentive factor based on the following table.

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-9 points	$3.00
Tier 2: 5 points	$2.00
Tier 3: 4 points	$1.00
Tier 4: 0-3 points	$0.00

Nursing Facility for Mental Health Quality and Efficiency Incentive Factor:

The Quality and Efficiency Incentive plan for Nursing Facilities for Mental Health (NFMH) will be established separately from NF. NFMH serve people who often do not need the NF level of care on a long term basis. There is a desire to provide incentive for NFMH to work cooperatively and in coordination with Community Mental Health Centers to facilitate the return of persons to the community.

The Quality and Efficiency Incentive Factor is a per diem add-on ranging from zero to two dollars. It is designed to encourage quality care, efficiency and cooperation with discharge planning. The incentive factor is determined by five outcome measures: case-mix adjusted nurse staffing ratio; operating expense; staff turnover rate; staff retention rate; and occupancy rate. Each provider is awarded points based on their outcome measures and the total points for each provider determine the per diem incentive factor included in the provider's rate calculation.

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Providers may earn up to two incentive points for their case mix adjusted nurse staffing ratio. They will receive two points if their case-mix adjusted staffing ratio equals or exceeds 3.49, which is 120% of the statewide NFMH median of 2.91. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.20, which is 110% of the statewide NFMH median. Providers with staffing ratios below 110% of the NFMH median will receive no points for this incentive measure.

NFMH providers may earn one point for low occupancy outcomes measures. If they have total occupancy less than or equal to 90% they will earn a point.

NFMH providers may earn one point for low operating expense outcomes measures. They will earn a point if their per diem operating expenses are below $20.46, or 90% of the statewide median of $22.73

NFMH providers may earn up to two points for their turnover rate outcome measure. Providers with direct health care staff turnover equal to or below 36%, the 75th percentile statewide, will earn two points as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers with direct health care staff turnover equal to or below 51%, the 50th percentile statewide, will earn one point as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs.

Finally, NFMH providers may earn up to two points for their retention rate outcome measure. Providers with staff retention rates at or above 78%, the 75th percentile statewide will earn two points. Providers with staff retention rates at or above 72%, the 50th percentile statewide will earn one point.

The table below summarizes the incentive factor outcomes and points:

Quality/Efficiency Outcome:	Incentive Points:
1) CMI adjusted staffing ratio >= 120% (3.49) of state median (2.91), or CMI adjusted staffing ratio between 110% (3.20) and 120%	2, or 1
2) Total occupancy <=90%	1
3) Operating expenses < $20.46, 90% of NFMH median ($22.73)	1
4) Staff turnover rate <= 75th percentile, 36% Staff turnover rate <= 50th percentile, 51%	2, or 1

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5) Staff retention >= 75th percentile, 78% Staff retention >= 50th percentile, 72%	2, or 1
Total Incentive Points Available	8

The Schedule E is an array containing the incentive points awarded to each NFMH provider for each quality and efficiency incentive outcome. The total of these points will be used to determine each provider's incentive factor based on the following table.

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 7-8 points	$3.00
Tier 2: 5-6 points	$2.00
Tier 3: 3-4 points	$1.00
Tier 4: 0-2 points	$0.00

10) Rate Effective Date

Rate effective dates are determined in accordance with K.A.R. 30-10-19. The rate may be revised for an add-on reimbursement factor (i.e., rebased property fee), desk review adjustment or field audit adjustment.

11) Retroactive Rate Adjustments

Retroactive adjustments, as in a retrospective system, are made for the following three conditions:

A retroactive rate adjustment and direct cash settlement is made if the agency determines that the base year cost report data used to determine the prospective payment rate was in error. The prospective payment rate period is adjusted for the corrections.

If a projected cost report is approved to determine an interim rate, a settlement is also made after a historic cost report is filed for the same period.

All settlements are subject to upper payment limits. A provider is considered to be in projection status if they are operating on a projected rate and they are subject to the retroactive rate adjustment.

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12) Comparable Private Pay Rates

The last factor considered in determining a provider's Medicaid per diem payment rate is their private pay rate. Providers are reimbursed the lower of the calculated Medicaid rate or their private pay rate. The agency maintains a registry of private pay rates. It is the responsibility of the providers to send in private pay rate updates so that the registry is updated. When new Medicaid rates are determined, if the private pay rate reflected in the registry is lower, then the provider is held to that private pay rate until the provider sends notification that it has a higher private pay rate.

Case Mix Adjustments to Private Pay Rates:

Private pay rates submitted to the agency are adjusted up if a provider's average private pay/other CMI is lower than its Medicaid average CMI. This is accomplished by multiplying the provider's average private pay rate in the private pay registry by the ratio of their Medicaid average CMI to their average private pay/other CMI. This ensures that providers' Medicaid rates are not limited to a lower private pay rate that may be attributed to the lower acuity of the private pay residents. There is no adjustment to private pay rates if the facility's Medicaid average CMI is less than its average private pay/other CMI. There is also no adjustment to private pay rates if the facility's total Medicaid rate is less than its average private pay rate.

INFLATION TABLE
EFFECTIVE 07/01/07

REPORT YEAR END (RYE)	MIDPOINT OF RYE	MIDPOINT OF RYE INDEX	MIDPOINT OF RATE PERIOD	MIDPOINT OF RATE PERIOD INDEX	HISTORICAL INFLATION FACTOR % *
12-03	06-03	1.439	12-07	1.674	16.331%
12-04	06-04	1.478	12-07	1.674	13.261%
12-05	06-05	1.525	12-07	1.674	9.770%
01-06	07-05	1.547	12-07	1.674	8.209%
02-06	08-05	1.547	12-07	1.674	8.209%
03-06	09-05	1.547	12-07	1.674	8.209%
04-06	10-05	1.568	12-07	1.674	6.760%
05-06	11-05	1.568	12-07	1.674	6.760%
06-06	12-05	1.568	12-07	1.674	6.760%
07-06	01-06	1.581	12-07	1.674	5.882%
08-06	02-06	1.581	12-07	1.674	5.882%
09-06	03-06	1.581	12-07	1.674	5.882%
10-06	04-06	1.593	12-07	1.674	5.085%
11-06	05-06	1.593	12-07	1.674	5.085%
12-06	06-06	1.593	12-07	1.674	5.085%
01-07	07-06	1.609	12-07	1.674	4.040%
02-07	08-06	1.609	12-07	1.674	4.040%
03-07	09-06	1.609	12-07	1.674	4.040%
04-07	10-06	1.622	12-07	1.674	3.206%
05-07	11-06	1.622	12-07	1.674	3.206%
06-07	12-06	1.622	12-07	1.674	3.206%
07-07	01-07	1.634	12-07	1.674	2.448%
08-07	02-07	1.634	12-07	1.674	2.448%
09-07	03-07	1.634	12-07	1.674	2.448%
10-07	04-07	1.646	12-07	1.674	1.701%
11-07	05-07	1.646	12-07	1.674	1.701%
12-07	06-07	1.646	12-07	1.674	1.701%
01-08	07-07	1.663	12-07	1.674	0.661%
02-08	08-07	1.663	12-07	1.674	0.661%
03-08	09-07	1.663	12-07	1.674	0.661%
04-08	10-07	1.674	12-07	1.674	0.000%
05-08	11-07	1.674	12-07	1.674	0.000%
06-08	12-07	1.674	12-07	1.674	0.000%

* = (Midpoint of rate period index / Midpoint of rye index) -1

COST CENTER LIMITATIONS EFFECTIVE 07/01/07

COST CENTER	UPPER LIMIT
Operating	$27.06
Indirect Health Care	$39.69
Direct Health Care	$77.24 *
Real and Personal Property Fee	$7.92

* = Base limit for a facility average case mix index of .9513

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/07
NF ONLY

	QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 120% (4.46) of state median (3.72), or CMI adjusted staffing ratio between 110% (4.09) and 120%	2, or 1
2	Total occupancy >= 90% Medicaid occupancy >= 60%	1 1
3	Operating expenses < 90% of state median, $20.77	1
4	Staff turnover rate <= 75th percentile, 51% Staff turnover rate <= 50th percentile, 77% Contracted labor < 10% of total direct health care labor costs	2, or 1
5	Staff retention >= 75th percentile, 72% Staff retention >= 50th percentile, 63%	2, or 1
	Total Incentive Points Available	9

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-9 points	$3.00
Tier 2: 5 points	$2.00
Tier 3: 4 points	$1.00
Tier 4: 0-3 points	$0.00

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/07
NF-MH ONLY

	QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 120% (3.49) of NF-MH median (2.91), or CMI adjusted staffing ratio between 110% (3.20) and 120%	2, or 1
2	Total occupancy <= 90%	1
3	Operating expenses < 90% of NF-MH median, $20.46	1
4	Staff turnover rate <= 75th percentile, 36% Staff turnover rate <= 50th percentile, 51% Contracted labor < 10% of total direct health care labor costs	2, or 1
5	Staff retention >= 75th percentile, 78% Staff retention >= 50th percentile, 72%	2, or 1
	Total Incentive Points Available	8

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-8 points	$3.00
Tier 2: 5 points	$2.00
Tier 3: 4 points	$1.00
Tier 4: 0-3 points	$0.00

JAN 2 3 2008

OWNER/RELATED PARTY SALARY LIMITATIONS
EFFECTIVE 07/01/07

Job Classification		Salary Range**	Bed Capacity 0-59	60-120	121+	0-99	100	Any Size
Administrator	*	23	33,613					
	*	28		42,869				
	*	31			49,670			
Co-Administrator	*	19	27,622					
	*	22		31,970				
	*	24			41,538			
Accountant II		24						41,538
Attorney II		31						49,670
Bookkeeper		15						22,755
Secretary II		15						22,755
Gen. Maint. & Repair Tech II		17						25,064
Physical Plant Supervisor I (1-2 Fac.)		23						33,613
Physical Plant Supervisor II (3+ Fac.)		25						37,045
Cook		11						18,741
Food Service Supervisor II		17						25,064
Housekeeping/Laundry Worker		9						16,952
Director of Nursing (RN III)	*	25				37,045		
Director of Nursing (RN IV)	*	28					42,869	
Registered Nurse (RN II)	*	22						31,970
Licensed Practical Nurse (LPN)	*	18						26,333
LPN Supervisor	*	20						29,016
Health Care Assistant (Nurse Aides)	*	12						19,656
Mental Health Aide		12						19,656
Physical Therapist II	*	27						40,851
Physical Therapist Aide		13						20,592
Occupational Therapist II	*	26						38,875
Speech Pathologist/Audiologist I	*	26						38,875
Activity Therapy Tech.		14						21,674
Activity Therapist I	*	22						31,970
Social Worker	*	22						31,970
Medical Records Administrator		24						41,538
Medical Records Technician		19						27,622
Central Office Staff (3+ Facilities)								
Chief Executive Officer		36						63,357
Chief Operating Officer		34						57,450
All Other Chief Officers		31						49,670

* License/Registration/Certificate Requirement
** Step 5 of the salary range has been used to set the limits.

OWNER/ADMINISTRATOR LIMITATION TABLE EFFECTIVE 07/01/07

Number of Beds	Total Bed Days	Maximum Owner/Admin Compensation	Limit PPD	F/Y	Amount	Cost of Living State Emp.
15	5,475	$21,782	$3.98	76	10,000	---
16	5,840	23,485	$4.02	77	10280	2.800%
17	6,205	25,188	$4.06	78	10537	2.500%
18	6,570	26,891	$4.09	79	11301	7.250%
19	6,935	28,594	$4.12	80	11781	4.250%
20	7,300	30,297	$4.15	81	12617	7.100%
21	7,665	32,000	$4.17	82	13248	5.000%
22	8,030	33,703	$4.20	83	14109	6.500%
23	8,395	35,406	$4.22	84	14426	2.250%
24	8,760	37,109	$4.24	85	15147	5.000%
25	9,125	38,812	$4.25	86	15933	5.190%
26	9,490	40,515	$4.27	87	16411	3.000%
27	9,855	42,218	$4.28	88	16575	1.000%
28	10,220	43,921	$4.30	89	17238	4.000%
29	10,585	45,624	$4.31	90	17755	3.000%
30	10,950	47,327	$4.32	91	18021	1.500%
31	11,315	49,030	$4.33	92	18021	0.000%
32	11,680	50,733	$4.34	93	18111	0.500%
33	12,045	52,436	$4.35	94	18202	0.500%
34	12,410	54,139	$4.36	95	18407	1.125%
35	12,775	55,842	$4.37	96	18591	1.000%
36	13,140	57,545	$4.38	97	18591	0.000%
37	13,505	59,248	$4.39	98	18777	1.000%
38	13,870	60,951	$4.39	99	19059	1.500%
39	14,235	62,654	$4.40	00	19250	1.000%
40	14,600	64,357	$4.41	01	19250	0.000%
41	14,965	66,060	$4.41	02	19683	2.250%
42	15,330	67,763	$4.42	03	19683	0.000%
43	15,695	69,466	$4.43	04	19978	1.500%
44	16,060	71,169	$4.43	05	20577	3.000%
45	16,425	72,872	$4.44	06	20834	1.250%
46	16,790	74,575	$4.44	07	21355	2.500%
47	17,155	76,278	$4.45	08	21782	2.000%
48	17,520	77,981	$4.45			
49	17,885	79,684	$4.46			
50	18,250	81,395	$4.46	90th Percentile PPD Administrator & Co-Administrator Salary.		

CASE MIX INDEX TABLE EFFECTIVE 07/01/07

RUG-III GROUP	CODE	CMI
EXTENSIVE SERVICES		
Extensive Special Care 3 / ADL>6	SE3	2.10
Extensive Special Care 2 / ADL>6	SE2	1.79
Extensive Special Care 1 / ADL>6	SE1	1.54
SPECIAL REHABILITATION		
Rehab all levels / ADL 17-18	RAD	1.66
Rehab all levels / ADL 14-16	RAC	1.31
Rehab all levels / ADL 10-13	RAB	1.24
Rehab all levels / ADL 4-9	RAA	1.07
SPECIAL CARE		
Special Care / ADL 17-18	SSC	1.44
Special Care / ADL 15-16	SSB	1.33
Special Care / ADL 4-14	SSA	1.28
CLINICALLY COMPLEX		
Clinically Complex w/ Depression / ADL 17-18	CC2	1.42
Clinically Complex / ADL 17-18	CC1	1.25
Clinically Complex w/ Depression / ADL 12-16	CB2	1.15
Clincally Complex / ADL 12-16	CB1	1.07
Clinically Complex w/ Depression / ADL 4-11	CA2	1.06
Clincally Complex / ADL 4-11	CA1	0.95

RUG-III GROUP	CODE	CMI
IMPAIRED COGNITION		
Cognitive Impairment w/ Nursing Rehab / ADL 6-10	IB2	0.88
Cognitive Impairment / ADL 6-10	IB1	0.85
Cognitive Impairment w/ Nursing Rehab / ADL 4-15	IA2	0.72
Cognitive Impairment / ADL 4-5	IA1	0.67
BEHAVIOR PROBLEMS		
Behavior Problem w/ Nursing Rehab / ADL 6-10	BB2	0.86
Behavior Problem / ADL 6-10	BB1	0.82
Behavior Problem w/ Nursing Rehab / ADL 4-5	BA2	0.71
Behavior Problem / ADL 4-5	BA1	0.60
REDUCED PHYSICAL FUNCTIONS		
Physical Function w/ Nursing Rehab / ADL 16-18	PE2	1.00
Reduced Physcial Function / ADL 16-18	PE1	0.97
Physical Function w/ Nursing Rehab / ADL 11-15	PD2	0.91
Reduced Physcial Function / ADL 11-15	PD1	0.89
Physical Function w/ Nursing Rehab / ADL 9-10	PC2	0.83
Reduced Physical Function ADL 9-10	PC1	0.81
Physical Function w/ Nursing Rehab / ADL 6-8	PB2	0.65
Reduced Physical Function ADL 6-8	PB1	0.63
Physical Function w/ Nursing Rehab / ADL 4-5	PA2	0.62
Reduced Physcial Function / ADL 4-5	PA1	0.59

COMPILATION OF COST CENTER LIMITATIONS
EFFECTIVE 07/01/07

	BEFORE INFLATION					***AFTER INFLATION***				
	OPER	IDHC	DHC	RPPF	TOTAL	OPER	IDHC	DHC	RPPF	TOTAL
MEDIAN	21.97	30.57	57.32	7.30	116.27	24.60	34.51	64.37	7.54	130.44
MEAN	22.85	32.14	58.38	6.89	120.27	25.65	36.26	65.86	7.12	134.89
WTMN	22.45	31.73	59.16	7.49	120.83	25.17	35.78	66.72	7.74	135.41
# OF PROV	336					336				

JAN 2 3 2008

COMPILATION OF ADMINISTRATOR, CO-ADMIN OWNER EXPENSE - O/A LIMIT
EFFECTIVE 07/01/07

	ADMINISTRATOR		CO-ADMINISTRATOR		TOTAL ADMN & CO-ADMN		OWNER	
	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD
HIGH	175,387	7.32	67,374	2.90	175,387	7.32	425,646	11.57
99th	149,640	6.35	67,374	2.90	149,640	6.35	425,646	11.02
95th	97,979	5.15	67,374	2.90	105,153	5.24	161,114	6.49
90th	82,300	4.42	49,815	2.79	88,286	4.46	120,325	5.20
85th	76,433	4.22	49,815	2.79	80,173	4.22	112,000	3.90
80th	72,101	3.85	47,445	1.63	73,610	3.87	93,327	3.38
75th	67,755	3.59	47,445	1.63	70,857	3.65	69,958	3.13
70th	65,499	3.41	42,215	1.57	66,742	3.45	65,358	2.60
65th	63,009	3.21	42,215	1.57	64,148	3.27	56,625	2.50
60th	60,532	3.10	42,154	1.43	61,233	3.14	51,554	2.25
55th	58,574	3.01	42,154	1.43	59,430	3.03	47,390	1.92
50th	56,312	2.82	42,140	1.24	56,809	2.87	36,050	1.74
40th	52,331	2.56	39,082	1.10	52,709	2.59	24,747	1.43
30th	48,517	2.40	37,895	0.83	48,911	2.42	17,461	0.84
20th	42,374	2.01	34,890	0.70	42,394	2.07	8,165	0.44
10th	31,633	1.70	31,647	0.70	32,577	1.74	1,549	0.03
1st	11,681	0.82	26,193	0.55	11,681	0.67	374	-0.06
LOW	2,355	0.47	17,200	0.48	2,355	0.47	-1,412	-0.15
MEAN	58,051	2.98	39,838	1.33	59,397	3.02	53,797	2.30
WTMN	65,991	2.69	39,564	1.10	68,192	2.74	66,169	2.23
# of Prov	311		12		312		72	

JAN 2 3 2008

COMPILATION OF INCENTIVE POINTS AWARDED
EFF. 07/01/07

NURSING FACILITY

INCENTIVE POINTS AWARDED	# OF PROVIDERS	PERCENTAGE
0	15	4.6%
1	66	20.2%
2	62	19.0%
3	64	19.6%
4	46	14.1%
5	32	9.8%
6	23	7.1%
7	17	5.2%
8	1	0.3%
9	0	0.0%
TOTALS	326	100.0%

NURSING FACILITY MENTAL HEALTH

INCENTIVE POINTS AWARDED	# OF PROVIDERS	PERCENTAGE
0	2	18.2%
1	1	9.1%
2	1	9.1%
3	3	27.3%
4	2	18.2%
5	2	18.2%
6	0	0.0%
7	0	0.0%
8	0	0.0%
TOTALS	11	100.0%

KANSAS
DEPARTMENT ON AGING

Kathleen Sebelius, Governor
Kathy Greenlee, Secretary
www.agingkansas.org

June 22, 2007

«ADMIN_NAME», Administrator
«FAC_NAME»
«FAC_ADDRES»
«CITY», KS «ZIP»

Provider #: 104«PROV_NUM»01
EDS Provider #: «EDS_PROV_N»

Dear «ADMIN_NAME»:

We forwarded the per diem rate shown on the enclosed Case Mix Payment Schedule for the first quarter of state fiscal year 2008 to our fiscal agent, Electronic Data Systems of Kansas. The rate will become effective July 1, 2007.

The Kansas Department on Aging (KDOA), administers the Medicaid nursing facility services payment program on behalf of the Kansas Health Policy Authority. The rate was calculated by applying the appropriate Medicaid program policies and regulations to the cost report (Form MS 2004) data.

For each nursing facility and nursing facility for mental health, the per diem rate for care shall not exceed the rate charged for the same type of service to residents not under the Kansas medical assistance program. If the private pay rate indicated on the agency register is lower, then the Kansas medical assistance program rate, beginning with its effective date, shall be calculated as follows: If the average Medicaid case mix index is greater than the average private pay/other case mix index, the Kansas medical assistance program rate shall be the lower of the private pay rate adjusted to reflect the Medicaid case mix index or the calculated Kansas medical assistance program rate. If the average Medicaid case mix index is less than or equal to the average private pay/other case mix index, the Kansas medical assistance program rate shall be the average private pay rate. The effective date of the private pay rate in the registry shall be the later of the effective date of the private pay rate or the first day of the following month in which complete documentation of the private pay rate is received by the agency. **SEE KANSAS ADMINISTRATIVE REGULATION (KAR) 30-10-18(b).**

If you disagree with this rate, you have the right to request a fair hearing appeal in accordance with K.A.R. 30-7-64 et seq. Your written request for such an appeal should be delivered to or otherwise mailed so that it is received by the **Department of Administration, Office of Administrative Hearings, 1020 South Kansas Ave, Topeka, Kansas 66612-1311** within 30 days from the date of this letter. (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if this notice letter is mailed rather than hand delivered.) Failure to timely request or pursue such an appeal may adversely affect your rights on any related judicial review proceeding.

If you have questions regarding the Medicaid rate, other than those involving cost report adjustments, write to Chris Chase or call her at (785) 296-0703. She can also be reached via electronic mail at Chrisc@Aging.state.ks.us. For questions concerning desk review adjustments please contact Craig Kammen, Audit Manager, at (785) 296-6457 or by email at CraigKammen@aging.state.ks.us.

Sincerely,

Dave Halferty, Senior Manager
Nursing Facilities and CARE Division
Program and Policy Commission

DH:ckc
Enclosures

New England Building, 503 S. Kansas Avenue, Topeka, KS 66603-3404
Voice: (785) 296-4986 • Toll-Free: (800) 432-3535 • Fax: (785) 296-0256
TTY (Hearing Impaired): (785) 291-3167 • E-Mail: wwwmail@aging.state.ks.us

June 22, 2007

Administrator

«FAC_NAME»
«FAC_ADDRES»
«CITY», KS «ZIP»

Provider #: 154«PROV_NUM»01
EDS Provider #: «EDS_PROV_N»

Dear Administrator:

We forwarded the per diem rate shown on the enclosed Case Mix Payment Schedule for the first quarter of state fiscal year 2008 to our fiscal agent, Electronic Data Systems of Kansas. The rate will become effective July 1, 2007.

The Kansas Department on Aging (KDOA), administers the Medicaid nursing facility services payment program on behalf of SRS. The rate was calculated by applying the appropriate Medicaid program policies and regulations to the cost report (Form MS 2004) data shown on the enclosed payment schedule.

For each nursing facility and nursing facility for mental health, the per diem rate for care shall not exceed the rate charged for the same type of service to residents not under the Kansas medical assistance program. If the private pay rate indicated on the agency register is lower, then the Kansas medical assistance program rate, beginning with its effective date, shall be calculated as follows: If the average Medicaid case mix index is greater than the average private pay/other case mix index, the Kansas medical assistance program rate shall be the lower of the private pay rate adjusted to reflect the Medicaid case mix index or the calculated Kansas medical assistance program rate. If the average Medicaid case mix index is less than or equal to the average private pay/other case mix index, the Kansas medical assistance program rate shall be the average private pay rate. The effective date of the private pay rate in the registry shall be the later of the effective date of the private pay rate or the first day of the following month in which complete documentation of the private pay rate is received by the agency. **SEE KANSAS ADMINISTRATIVE REGULATION (KAR) 30-10-18(b).**

If you disagree with the rate in the attached payment schedule, you have the right to request a fair hearing appeal in accordance with K.A.R. 30-7-64 et seq. Your written request for such an appeal should be delivered to or otherwise mailed so that it is received by the **Department of Administration, Office of Administrative Hearings, 1020 South Kansas Ave, Topeka, Kansas 66612-1311** within 30 days from the date of this letter. (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if this notice letter is mailed rather than hand delivered.) Failure to timely request or pursue such an appeal may adversely affect your rights on any related judicial review proceeding.

If you have questions regarding the Medicaid rate, other than those on desk review adjustments, write to me or call at (785) 291-3202. For questions concerning desk review adjustments please contact Craig Kammen, Audit Manager, at (785) 296-6457 or by email at CraigKammen@aging.state.ks.us.

Sincerely,

Gayla Carr Schmitz
Management Systems Analyst

Enclosures

KANSAS MEDICAID / MEDIKAN

Current Provider Information

Provider Number	EDS Provider Number	Medicaid CMI	0.8898 [a]
Facility Name		Medicare CMI	1.3840
Address		Private Pay/Other CMI	1.0150
City/State/Zip			
Administrator			

Cost Report Statistics

Calendar Year Cost Reports Used For Base Data:	12/31/03	12/31/04	12/31/05	
Inflation Factor	16.331%	13.261%	9.770%	
Facility Cost Report Period CMI	0.9385	0.9927	0.9438	
Statewide Average CMI	0.9382	0.9520	0.9638	0.9513 [b]
NF Or NF/MH Beds	60	60	60	
Bed Days Available	21900	21960	21900	
Inpatient Days	15035	20870	21030	
Occupancy Rate	68.7%	95.0%	96.0%	
Medicaid Days	8740	11128	11808	
Calc Days If Appl	0	0	0	

Calculation of Combined Base Year Reimbursement Rate

----Operating----					
Total Reported Costs	461,494	625,144	597,924		
Cost Report Adjustments	0	0	0		
Total Adjusted Costs	461,494	625,144	597,924		
Total Inflated Adjusted Costs	538,861	708,044	656,341		
O/A Limit Adjustment	0	0	0		
Total Combined Base Cost				1,901,246	
Days Used In Division Oper	15,035	20,870	21,030	56,935	
				33.39	Oper Per Diem
				27.06	Oper Per Diem Cost Limitation
				27.06	Oper Per Diem Rate (1)

----Indirect Health Care----					
Total Reported Costs	418,188	550,861	640,388		
Cost Report Adjustments	0	0	0		
Total Adjusted Costs	418,186	550,861	640,388		
Total Inflated Adjusted Costs	486,480	623,911	702,954		
Total Combined Base Cost				1,813,345	
Days Used In Division IDHC	15,035	20,870	21,030	56,935	
				31.85	IDHC Per Diem
				39.69	IDHC Per Diem Cost Limitation
				31.85	IDHC Per Diem Rate (2)

----Direct Health Care----					
Total Reported Costs	860,445	978,125	1,220,544		
Cost Report Adjustments	0	0	0		
Total Adjusted Costs	860,445	978,125	1,220,544		
Total Inflated Adjusted Costs	1,000,964	1,107,834	1,339,791		
Total CMI Adjusted Costs	1,000,644	1,062,414	1,368,183		
Total Combined Base Cost				3,431,241	
Days Used In Division DHC	15,035	20,870	21,030	58,935	
				60.27	Case Mix Adjusted DHC Per Diem
				77.24	DHC Per Diem Cost Limitation
				80.27	Allowable DHC Per Diem Cost [c]
			[c]*([a]/[b])	58.36	Medicaid Acuity Adjustment (3)

----Real And Personal Property Fee----		
	7.55	Real and Personal Property Fee
	0.25	Inflation (3.372%)
	0.00	RPPF Rebase Add On
	7.80	RPPF Before Limit
	7.92	RPPF Limitation
	7.80	Allowable RPPF (4)

Calculation of Medicaid Rate

Operating, IDHC, And DHC Rates (1) +(2) + (3)		115.27
Incentive Factor		0.00
Allowable Real And Personal Property Fee (4)		7.80
Pass Through		0.00
Total Reimbursement Rate Calculated	7/1/2006	123.07
Private Pay Rate (Register)	7/1/2005	127.27
Private Pay Rate (Medicaid Adjustment)	7/1/2005	127.27
Total Medicaid Rate Effective	**7/1/2006**	**123.07**

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

Provider Number:
EDS Provider Number:

Facility Name:

Rate Effective Date:

		Points Possible	Facility Stats	Points Awarded
1	Case Mix Adjusted Nurse Staff Ratio			
	Tier 1: At or Above 120% of NF Statewide Median or 4.48	2		0
	Tier 2: At or Above 110% of NF Statewide Median or 4.09	1		0
	Statewide Median is 3.72 for an average CMI of 0.9772			
			3.72	
	Cost Report Year Data:		12/31/2006	
2	Operating Expense	1		0
	At or Below 90% of NF Statewide Median or $20.77			
			$23.44	
	Cost Report Year Data:		12/31/2006	
3	Staff Turnover			
	Tier 1: At or Below NF 75th Percentile of 51%	2		0
	Tier 2: At or Below NF 50th Percentile of 77%	1		0
	Contracted labor less than 10% of total Direct HC labor costs			
			86%	
	Cost Report Year Data:		12/31/2006	
4	Staff Retention			
	Tier 1: At or Above NF 75th Percentile of 72%	2		0
	Tier 2: At or Above NF 50th Percentile of 63%	1		0
			60%	
	Cost Report Year Data:		12/31/2006	
5	Occupancy Rate			
	Total Occupancy At or Above 90%	1	91.20%	1
	Medicaid Occupancy At or Above 60%	1	38.60%	0
	Cost Report Year Data:		12/31/2006	
	Total Points Awarded			1
	Incentive Factor			0.00

Scoring

Points	Per Diem
6 - 9	$3.00
3	$2.00
4	$1.00
0 - 3	$0.00

JAN 2 3 2008

Kansas Statutes Annotated 39-708c. Powers and duties of secretary of social and rehabilitation services; . . . centralized payment of welfare expenditures. (a) The secretary of social and rehabilitation services shall develop state plans, as provided under the federal social social security act, whereby the state cooperates with the federal government in its program of assisting the states financially in furnishing assistance and services to eligible individuals. The secretary shall undertake to cooperate with the federal government on any other federal program providing federal financial assistance and services in the field of social welfare not inconsistant with this act. The secretary is not required to develop a state plan for participation or cooperation in all federal social security programs or other federal programs that are available. The secretary shall also have the power, but is not required to develop a state plan in regard to assistance and services in which the federal government does not participate.

. . .

(k) All contracts shall be made in the name of "secretary of social and rehabilitation services," and in that name the secretary may sue and be sued on such contracts. The grant of authority under this subsection shall not be construed to be a waiver of any rights retained by the state under the 11th amendment to the United States constitution and shall be subject to and shall not supersede the provisions of any appropriations act of this state.

. . .

(x) The secretary shall establish payment schedules for each group of health care providers. Any payment schedules which are a part of the state medicaid plan shall conform to state and federal law. The secretary shall not be required to make any payments under the state medicaid plan which do not meet requirements for state and federal financial participation.

(1) The secretary shall consider budgetary constraints as a factor in establishing payment schedules so long as the result complies with state and federal law.

(2) The secretary shall establish payment schedules for providers of hospital and adult care home services under the medicaid plan that are reasonable and adequate to meet the costs

which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards. The secretary shall not be required to establish rates for any such facility that are in excess of the minimum necessary to efficiently and economically meet those standards regardless of any excess costs incurred by any such facility.

. . .

KANSAS MEDICAID STATE PLAN

*Substitute per letter dated 8/28/01 *

Attachment 4.19 D
Part I
Subpart C
Exhibit C-7
Page 1 of 1

Method and Standards for Establishing Payment Rates:
Nursing Facilities

Nursing Facility Rate Determination To Comply With Court Order

Effective May 10, 1993, payment will be made in accordance with the Memorandum and Order entered May 10, 1993, and the Order entered May 28, 1993, and any subsequent orders by the United States District Court of the District of Kansas in Case Number 93-4045-RDR.

Methods and Standards for Establishing Payment Rates
Skilled Nursing and Intermediate Care Facility Rates
(NFs and NFs-MH)

Therapeutic Mental Health Treatment Pass-Through
for Special Level of Care Facilities

This provision allows for the pass-through of therapeutic mental health treatment expenses to nursing facilities for mental health that meet certain criteria.

Criteria for Determining Eligible Providers:

Only special level of care facilities classified as nursing facilities for mental health are eligible for this pass-through. A nursing facility for mental health is defined as:

1. A nursing facility licensed by the State of Kansas; and
2. Certified to participate in Medicaid by the Department of Social and Rehabilitation Services that,

pursuant to 42CFR 435.1009, the Center for Medicare and Medicaid identifies as an institution for mental disease.

A nursing facility for mental health will be eligible for the increased rate if:

1. Its established rate using the base year methodology is less than the rate it received during the preceding year, and
2. It demonstrates it is providing specific additional amounts of mental health treatment services above the amount provided during the base year.

Determination of Pass-Through Amount for Eligible Providers:

The per diem rate for a nursing facility for mental health may be increased from the established rate based on documented additional costs associated with providing therapeutic mental health treatment services above the amount provided in the base year which are not otherwise covered by the established rate. The increased amount provided the eligible nursing facility for mental health will be the per diem amount that the facility can document is attributable to increased therapeutic mental health treatment. The increased amount shall not exceed the difference between the allowable per diem costs on the most recent cost report and the base year cost report before inflation. Only costs from indirect and direct health care cost centers shall be included in the per diem calculations. No per diem increases shall be based on increased administrative, property, or plant operating costs. All per diem amounts used in the determination of the pass-through add-on shall be calculated by dividing the expenses reported on the cost report by the actual residents days provided during the cost report period.

**Method and Standards for Establishing Payment Rates:
Nursing Facilities**

Rates When Two Or More Nursing Facilities Merge Under One License

The Kansas Department on Aging maintains a policy wherein if two nursing facilities meet certain policy criteria, KDOA will issue one license for two facilities. Subpart E will explain the methods and standards for establishing payment rates when two or more facilities are merged under one license.

Cost Reports

Providers who have participated in the Medicaid program for 12 months or longer as of December 31 are required to file a calendar year Nursing Facility Financial and Statistical Report (cost report). For facilities that merge under one license, the provider will file one cost report for the facilities for the complete calendar year following the merger and all subsequent calendar years while the facilities remain merged under one license for any portion of the calendar year. The calendar year end cost report will be for 12 months. The cost report will consist of the individual operations of each facility for any part of the calendar year that they operate under separate licenses and the combined operations during any part of the year that they operate under one license. The number of beds, resident days, Medicaid days, and Medicare days will be the total for the facilities merged under one license. All changes in the number of beds during the calendar year will need to be reflected for the merged facilities.

The working trial balances for the merged facilities will need to be combined to fill out the schedules in the cost report. Schedule A, Expense Statement shall reflect the total staff hours and the total direct and in-direct expenditures for the merged facilities. The total revenue and related revenue offsets in Schedule G, Revenue Statement, shall be the total for the merged facilities. For part of the calendar year, the working trial balance may reflect the independent operations for each facility and then following the merger the working trial balance may be consolidated. The working trial balances shall reconcile to the applicable cost report schedules. A schedule that lists all general ledger accounts grouped by cost report line number shall be submitted with the combined cost report.

Rate Determination

Medicaid rates for Kansas NFs and NFs-MH are determined using a prospective, facility-specific rate-setting system. The rate is determined from the base cost data submitted by the provider. When multiple facilities are joined on one license, the reimbursement rates for each facility will be determined in accordance with the methodology found in Subpart C and as though the facilities remained as separate providers. The only time a new rate will be determined from combined cost data is when a base cost data period is established that occurs after the merger or that includes the calendar year that the merger occurred.

**Method and Standards for Establishing Payment Rates:
Nursing Facilities**

Rates When Two Or More Nursing Facilities Merge Under One License

Resident Days Used in Denominator:

Merged Facilities with a Combined Total of 60 Beds or Less:

For merged facilities with a combined total of 60 beds or less, the allowable historic per diem costs for all cost centers is determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data.

Merged Facilities with a Combined Total of More Than 60 Beds:

For merged facilities with a combined total of more than 60 beds, the allowable historic per diem costs for the Direct Health Care cost center and food and utilities in the Indirect Health Care cost center is determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data. The allowable historic per diem cost for the Operating cost center and Indirect Health Care cost center less food and utilities is subject to an 85% minimum occupancy rule. The greater of the actual resident days reported for the merged facilities or days calculated at the 85% minimum occupancy will be used in the denominator of the rate calculation. If the 85% occupancy rule does not apply during the first 12 months of operation of a facility, then actual days will be used for that facility for the period that the rule does not apply. If only one of the facilities did not have the 85% occupancy rule applied then the provider will need to report the number of beds and resident days separate for that facility so that the available bed days for the merged facilities can be determined.

Real and Personal Property Fee (Property Fee) For Merged Facilities:

A combined Real and Personal Property Fee will be determined for facilities merged under one license only when a base cost data period is established that occurs after the merger or that includes the calendar year that the merger occurred. The property fee for two or more facilities that are merged under one license will be based on the day-weighted average property fee for the merged facility. The resident days from the cost data period used to determine the current rates will be used to determine the day weighting.

For example, Facility A has a property fee of $4.00 per day and 10,000 resident days and Facility B has a property fee of $5.00 per day and 15,000 resident days. The day-

weighted average property fee will be $4.60 ($4 x 10,000 days + $5 x 15,000 = $115,000/25,000 total days = $4.60).

Resident Assessments and Case Mix Index

The resident assessment database, based on the minimum data set (MDS), for the facilities merged under one license will be combined beginning with the first quarter after the merger. The facilities will continue to receive separate rates until after a combined rate is determined following the criteria explained in the Rate Determination section. However, the case mix index will be the same for the facilities when determining rates after the MDS data base for each facility are merged in the first quarter after the facilities are under a combined license.

Rates for Facilities Under One License If They Later Decide to Go Back To Separate Licenses

Cost Reports and Rates

If two or more facilities merge under one license and later decide to go back to individual licenses, they will file separate calendar year cost reports for the complete calendar year following the year in which they separate. Rates for each facility will be determined from base year cost data whether that period includes combined reports or not.

Real and Personal Property Fees

If two or more facilities that are merged under one license later decide to split and have individual licenses within five (5) years, the old property fees will be reassigned to the individual facilities. The additional allowance for a property fee rebasing after the property fees were combined would be added to the individual property allowances after the facilities split. The two facilities used in the combining of property fees above had a property fee of $4.60. As an example, if a property fee rebasing took place later that added $.50, the property fee will be $5.10. If Facilities A and B split before five years, the property fee for Facility A will be $4.50 ($4.00 + $.50) and the property fee for Facility B will be $5.50 ($5.00 + $.50).

If the facilities decide to split and go back to individual licenses after five years, each facility will continue to have the same property fee as determined when they merged.

Method and Standards for Establishing Payment Rates:
Nursing Facilities

Rates When Two Or More Nursing Facilities Merge Under One License

Resident Assessments and Case Mix Index

If the merged facilities later decide to split into separate licenses, the MDS database will be maintained for the individual facilities beginning the first quarter after the facilities have separate licenses.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Reserve for future use.

DEC 13 2002

Methods and Standards for Establishing Payment Rates
Skilled Nursing and Intermediate Care Facility Rates
(NFs and NFs-MH)

Reserve for future use

Method and Standards for Establishing Payment Rates:
Nursing Facilities

Kansas Intergovernmental Transfer Program

Provisions for Governmental Facilities - Government Owned and Operated Nursing Facility Proportionate Share Pool: A proportionate share pool is created to increase reimbursement to Medicaid-certified, government owned and operated nursing facilities. "Owned" refers to the common meaning of ownership of the physical structure(s). "Operated" refers to the government's direct and active involvement in a facility's day-to-day operations, as indicated in the provider agreement. "Government" means a unit of local government, such as a city, a county, a city hospital, a county hospital, a hospital district, or a health care facilities and services hospital district. The pool is created subject to availability of funds and subject to the payment limits of 42 CFR 447.272 (payments may not exceed the amount that can reasonably be estimated to be paid under Medicare payment principles).

The proportionate share pool is calculated by comparison of the Kansas Medicaid rates in all Medicaid-certified nursing facilities to the equivalent Medicare rates, whether or not each facility is Medicare certified. The equivalent Medicare rate is adjusted by the wage index published in the Federal Register. When the Case Mix Index utilized for computing the Medicaid rate does not have an equivalent Medicare classification, the Medicaid case mix index (see Attachment 4.19D, Part I, Subpart C, Exhibit C-2, Page 8 Case Mix Index Table) will be adjusted down to the next closest Medicare RUGs classification. The methodology shall adjust for pharmacy, laboratory, radiology, retroactive payment adjustments, and any other factors necessary to equate Medicaid to Medicare payment methodologies. The differences between the facility-specific Medicare rates and Medicaid rates are summed to determine the amount of the pool.

The Department shall submit to HCFA quarterly reports that demonstrate the calculation of the proportionate share pool, and that calculations have not resulted in payments in excess of the amount which could reasonably be paid under Medicare payment principles.

The pool is calculated for each reporting period and distributed on or about 45 days after the end of the period. For example, a distribution would be made on or around May 15th for the quarter ending March 31. Each government owned and operated facility's distribution amount is based on its estimated proportionate share of the pool (based on its share of Medicaid resident days).

Method and Standards for Establishing Payment Rates:
Nursing Facilities

Kansas Intergovernmental Transfer Program

The Kansas Intergovernmental Transfer Program, Attachment 4.19D, Part I, Subpart H of the Kansas Medicaid State Plan, will sunset with Medicaid service days ended June 30, 2005. The distribution of the final transfer is scheduled to be made during the quarter ended September 30, 2005.

Method and Standards for Establishing Payment Rates:
Nursing Facilities

Nursing Facility Rate Determination for Ventilator Dependent Resident

The following are the policies and procedures for determining a rate for a ventilator-dependent resident in a nursing facility.

(1) The request for additional reimbursement for a ventilator-dependent resident shall be submitted to the Kansas Department on Aging (KDOA) in writing for prior approval. Each request shall include the most current Minimum Data Set (MDS) resident assessment.

(2) All of the following criteria shall be present in order for a resident to be considered ventilator dependent:

(A) The resident shall not be able to breathe without a volume ventilator with a backup.

(B) The resident shall use the ventilator 24 hours a day, seven days a week.

(C) The resident shall have a tracheostomy or endotracheal tube.

(3) The provider shall be reimbursed the Kansas Medical Assistance Program daily rate determined for the nursing facility plus an additional per diem amount approved by KDOA for the ventilator-dependent resident. The sum of the nursing facility per diem rate and the additional per diem for the ventilator dependent resident shall equal $450.

The cost of durable medical equipment (DME) shall be reimbursed separately from the per diem rate and in accordance with the DME program in the Kansas Medical Assistance Programs Manual.

The per diem cost of providing services to the ventilator dependent residents shall be reviewed at least every two years to determine the adequacy of the $450 flat rate. Both the direct and indirect costs of providing care shall be included in the review.

(4) No additional amount above the current nursing facility daily rate shall be allowed until the service is prior authorized by KDOA.

Method and Standards for Establishing Payment Rates:
Nursing Facilities

Nursing Facility Rate Determination for Ventilator Dependent Resident

(5) The criteria shall be reviewed quarterly to determine if the resident continues to be ventilator-dependent. If a resident is no longer ventilator-dependent, the provider shall not receive additional reimbursement beyond the Kansas Medical Assistance Program per diem rate determined for the facility.

(6) The additional reimbursement for the ventilator-dependent resident shall be offset to the cost center of benefit on the Nursing Facility Financial and Statistical Report.

Methods and Standards for Establishing Payment Rates- Skilled Nursing and Intermediate Care Facility Rates (NFs and NFs/MH)

Reserve for future use

Methods and Standards for Establishing Payment Rates-Skilled Nursing and Intermediate Care Facility Rates (NFs and NFs/MH)

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Methods and Standards for Establishing Payment Rates- Skilled Nursing and Intermediate Care Facility Rates (NFs and NFs/MH)

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Methods and Standards for Establishing Payment Rates-Skilled Nursing and Intermediate Care Facility Rates (NFs and NFs/MH)

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Attachment 4.19-D
Part I
Subpart N

Methods and Standards for Establishing Payment Rates-Skilled Nursing and Intermediate Care Facility Rates (NFs and NFs/MR)

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Methods and Standards for Establishing Payment Rates- Skilled Nursing and Intermediate Care Facility Rates (NFs and NFs/MH)

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Attachment 4.19-D
Part I
Subpart P

Methods and Standards for Establishing Payment Rates-
Skilled Nursing and Intermediate Care Facility Rates
(NFs and NFs/MH)

This subpart reserved for future use.

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Methods and Standards for Establishing Payment Rates- Skilled Nursing and Intermediate Care Facility Rates (NFs and NFs/MH)

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Methods and Standards for Establishing Payment Rates- Skilled Nursing and Intermediate Care Facility Rates (NFs and NFs/MH)

Appeal Procedures

Pursuant to 42 CFR 447.253(e) the State Medicaid Agency in accordance with federal regulations and with state statutes and regulations provides a fair hearing procedure that allows for an administrative review and an appeal by the facility as to its payment rates before the Administrative Hearings Section of the agency. The appeals procedures are defined in the Kansas Statutes Annotated and Kansas Administrative regulations.

(b) If the lieutenant governor is appointed by the governor under the provision of K.S.A. 75-303 and amendments thereto, the lieutenant governor shall receive a salary to be fixed by the governor or a salary as provided for in subsection (a) of this section, whichever is greater.

History: R.S. 1923, 75-3103; L. 1949, ch. 430, § 1; L. 1953, ch. 383, § 2; L. 1955, ch. 366, § 1; L. 1959, ch. 337, § 3; L. 1961, ch. 413,§ 2; L. 1963, ch. 419, § 7; L. 1967, ch. 449, § 2; L. 1972, ch. 153, § 41; L. 1973, ch. 157, § 20; L. 1974, ch. 361,§92; L. 1978, ch. 350, § 6; L. 1982, ch. 355, § 2; L. 1982, ch. 354,§ 21; L. 1992, ch. 296, § 14; L. 1995, ch. 256, § 14; L. 1998, ch. 196, § 6; June 14.

75-3104. Salary of secretary of state. Except as otherwise provided in K.S.A. 75-3111a and amendments thereto, the secretary of state shall receive for services a salary at a biweekly pay rate of $2,648.45.

History: L. 1949, ch. 431, § 5; L. 1953, ch. 383, § 3; L. 1959, ch. 337, § 4; L. 1961, ch. 413, § 3; L. 1965, ch. 458,§ 30; L. 1967, ch. 443, § 21; L. 1972, ch. 153, § 42; L. 1973, ch. 175,§ 63; L. 1974, ch. 361, § 69; L. 1976, ch. 380, § 18; L. 1978, ch. 350, § 7; L. 1982, ch. 354, § 22; L. 1985, ch. 278, § 16; L. 1992, ch. 296, § 15; L. 1995, ch. 256, § 15; L. 1998, ch. 196, § 7; June 14.

75-3108. Salary of state treasurer. Except as otherwise provided in K.S.A. 75-3111a and amendments thereto, the state treasurer shall receive for services a salary at a biweekly pay rate of $2,648.45.

History: L. 1949, ch. 431, § 7; L. 1953, ch. 383, § 5; L. 1959, ch. 337, § 6; L. 1961, ch. 413, § 5; L. 1965, ch. 458,§ 32; L. 1967, ch. 443, § 23; L. 1972, ch. 153, § 44; L. 1973, ch. 175,§ 68; L. 1974, ch. 361, § 70; L. 1976, ch. 380, § 19; L. 1978, ch. 350, § 8; L. 1982, ch. 354, § 23; L. 1985, ch. 278, § 17; L. 1992, ch. 296, § 16; L. 1995, ch. 256, § 16; L. 1998, ch. 196, § 8; June 14.

75-3110. Salary of attorney general. Except as otherwise provided in K.S.A. 75-3111a and amendments thereto, the attorney general shall receive for services a salary at a biweekly pay rate of $3,045.64.

History: L. 1949, ch. 431, § 2; L. 1953, ch. 383, § 6; L. 1959, ch. 337, § 7; L. 1961, ch. 413, § 6; L. 1965, ch. 458,§ 33; L. 1967, ch. 443, § 24; L. 1972, ch. 153, § 45; L. 1973, ch. 175,§ 64; L. 1974, ch. 361, § 71; L. 1978, ch. 350, § 9; L. 1982, ch. 354, § 24; L. 1985, ch. 278, § 18; L. 1992, ch. 296, § 17; L. 1995, ch. 256, § 17; L. 1998, ch. 196, § 9; June 14.

75-3111a. Percentage increases in annual salaries of governor, lieutenant governor, attorney general, secretary of state, state treasurer and commissioner of insurance. Whenever the rates of compensation of the pay plan for persons in the classified service under the Kansas civil service act are increased for payroll periods chargeable to fiscal years commencing after June 30, 1999, the salary of the governor, the lieutenant governor, the attorney general, the secretary of state, the state treasurer and the commissioner of insurance shall be increased by an amount computed by multiplying the average of the percentage increases in all steps of such pay plan by the salary of the elected state officer which is being received as provided by law and which is in effect prior to the effective date of such increase in the rates of compensation of the pay plan for persons in the classified service under the Kansas civil service act.

History: L. 1982, ch. 354, § 26; L. 1985, ch. 278, § 20; L. 1992, ch. 296, § 18; L. 1995, ch. 256, § 18; L. 1998, ch. 196, § 10; June 14.

Article 33.—SOCIAL AND REHABILITATION SERVICES

75-3306. Appeals to secretary; investigations; subpoenas; hearings, when required; application of Kansas administrative procedure act, exceptions; jurisdiction. (a) The secretary of social and rehabilitation services, except as set forth in the Kansas administrative procedure act and subsections (f), (g), (h) and (i), shall provide a fair hearing for any person who is an applicant, client, inmate, other interested person or taxpayer who appeals from the decision or final action of any agent or employee of the secretary. The hearing shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

It shall be the duty of the secretary of social and rehabilitation services to have available in all intake offices, during all office hours, forms for filing complaints for hearings, and appeal forms with which to appeal from the decision of the agent or employee of the secretary. The forms shall be prescribed by the secretary of social and rehabilitation services and shall have printed on or as a part of them the basic procedure for hearings and ap-

peals prescribed by state law and the secretary of social and rehabilitation services.

(b) The secretary of social and rehabilitation services shall have authority to investigate (1) any claims and vouchers and persons or businesses who provide services to the secretary of social and rehabilitation services or to welfare recipients, (2) the eligibility of persons to receive assistance and (3) the eligibility of providers of services.

(c) The secretary of social and rehabilitation services shall have authority, when conducting investigations as provided for in this section, to issue subpoenas; compel the attendance of witnesses at the place designated in this state; compel the production of any records, books, papers or other documents considered necessary; administer oaths; take testimony; and render decisions. If a person refuses to comply with any subpoena issued under this section or to testify to any matter regarding which the person may lawfully be questioned, the district court of any county, on application of the secretary, may issue an order requiring the person to comply with the subpoena and to testify, and any failure to obey the order of the court may be punished by the court as a contempt of court. Unless incapacitated, the person placing a claim or defending a privilege before the secretary shall appear in person or by authorized representative and may not be excused from answering questions and supplying information, except in accordance with the person's constitutional rights and lawful privileges.

(d) The presiding officer may close any portion of a hearing conducted under the Kansas administrative procedure act when matters made confidential, pursuant to federal or state law or regulation are under consideration.

(e) Except as provided in subsection (d) of K.S.A. 77-511 and amendments thereto and notwithstanding the other provisions of the Kansas administrative procedure act, the secretary may enforce any order prior to the disposition of a person's application for an adjudicative proceeding unless prohibited from such action by federal or state statute, regulation or court order.

(f) Except as provided in this subsection, decisions and final actions relating to the administration of the support enforcement program set forth in K.S.A. 39-753 *et seq.* and amendments thereto shall be exempt from the provisions of the Kansas administrative procedure act and subsection (a). Decisions and final actions relating to the support enforcement program may be reviewed pursuant to this section if the decision or final action relates directly to federal debt set-off activities or the person is specifically permitted by statute to request a fair hearing under this section.

(g) Decisions relating to administrative disqualification hearings shall be exempt from the provisions of the Kansas administrative procedure act and subsection (a).

(h) The department of social and rehabilitation services shall not have jurisdiction to determine the facial validity of a state or federal statute. An administrative law judge from the office of administrative hearings shall not have jurisdiction to determine the facial validity of an agency rule and regulation.

(i) The department of social and rehabilitation services shall not be required to provide a hearing if: (1) The department of social and rehabilitation services lacks jurisdiction of the subject matter; (2) resolution of the matter does not require the department of social and rehabilitation services to issue an order that determines the applicant's legal rights, duties, privileges, immunities or other legal interests; (3) the matter was not timely submitted to the department of social and rehabilitation services pursuant to regulation or other provision of law; or (4) the matter was not submitted in a form substantially complying with any applicable provision of law.

History: L. 1939, ch. 202, § 6; L. 1947, ch. 425, § 7; L. 1949, ch. 447, § 1; L. 1972, ch. 325, § 1; L. 1973, ch. 186, §33; L. 1984, ch. 320, § 1; L. 1988, ch. 356, § 302; L. 1989, ch. 283, § 21; L. 1997, ch. 182, § 77; L. 1997, ch. 182, § 91; July 1, 1998.

75-3365. Sale of certain real estate in Stafford county; proceeds. (a) The secretary of social and rehabilitation services is hereby authorized to sell and convey on behalf of the state of Kansas in the manner provided by this act the following described real estate: The southwest Quarter of Section 24; Township 22, Range 13 in Stafford County, Kansas. The above described property being that which was willed to the state of Kansas by Otto Hitz following the life estate created for Delmar Lee Hitz.

(b) When the real estate described in subsection (a) is sold, the proceeds thereof, after deduction of the expenses of such sale and the cost of the survey and the appraisal of the real estate, shall be deposited in the state treasury to the

may introduce such legislation as it deems necessary in performing its functions of reviewing administrative rules and regulations and agency forms.

(d) All rules and regulations filed each year in the office of secretary of state and all forms used by state agencies and all rules and regulations specifically excluded from the definition of rule and regulation under subsection (4) of K.S.A. 77-415, and amendments thereto, shall be subject to review by the joint committee. The committee may introduce such legislation as it deems necessary in performing its functions of reviewing administrative rules and regulations and agency forms.

(e) The joint committee shall meet on call of the chairperson as authorized by the legislative coordinating council. All such meetings shall be held in Topeka, unless authorized to be held in a different place by the legislative coordinating council. Members of the joint committee shall receive compensation and travel expenses and subsistence expenses or allowances as provided in K.S.A. 75-3212, and amendments thereto, when attending meetings of such committee authorized by the legislative coordinating council.

(f) Amounts paid under authority of this section shall be paid from appropriations for legislative expense and vouchers therefor shall be prepared by the director of legislative administrative services and approved by the chairperson or vice-chairperson of the legislative coordinating council.

History: L. 1977, ch. 321, § 19; L. 1980, ch. 304, § 8; L. 1981, ch. 366, § 4; L. 1983, ch. 307, § 5; L. 1988, ch. 368, § 1; L. 1988, ch. 366, § 44; L. 1995, ch. 93, § 4; July 1.

Law Review and Bar Journal References:

"Judicial Review of Administrative Action—Kansas Perspectives," David L. Ryan, 19 W.L.J. 423, 433 (1980).

"The New Mandamus—State ex rel. Stephan v. Kansas House of Representatives," Henry E. Couchman, Jr., 33 K.L.R. 733, 742, 744 (1985).

Attorney General's Opinions:

Scope and extent of rules and regulations filing act. 82-119.

77-437. Rules and regulations of the secretary of corrections and Kansas adult authority subject to provisions of the rules and regulations filing act. All temporary and permanent rules and regulations of the secretary of corrections and the Kansas adult authority shall be subject to all of the provisions of K.S.A. 77-415 to 77-436, inclusive, and amendments thereto.

History: L. 1978, ch. 120, § 23; L. 1982, ch. 386, § 8; April 29.

77-438. Citation of act. K.S.A. 77-415 to 77-437, inclusive, and acts amendatory thereof or supplemental thereto shall be known and may be cited as the rules and regulations filing act.

History: L. 1982, ch. 386, § 9; April 29.

77-439.

History: L. 1985, ch. 306, § 1; Repealed, L. 1988, ch. 366, § 50; June 1.

Article 5.—ADMINISTRATIVE PROCEDURE ACT

Law Review and Bar Journal References:

"Groundwater Pollution I: The Problem and the Law," Robert L. Glicksman, George Cameron Coggins, 35 K.L.R. 75, 142 (1986).

"1988 Legislative Summary Part I," Ron Smith, 57 J.K.B.A. No. 6, 31, 33, 35, 39 (1988).

"Survey of Kansas Law: Administrative Law," Steve A. Leben, 37 K.L.R. 679 (1989).

"Environmental Issues in Real Estate and Other Business Transactions," David R. Tripp, 60 J.K.B.A. No. 1, 23, 28 (1991).

"The Kansas Water Appropriation Act: A Fifty-Year Perspective," John C. Peck, 43 K.L.R. 735, 753 (1995).

"Loss of Water Rights for Non-Use," John C. Peck and Constance Crittenden Owen, 43 K.L.R. 801, 803 (1995).

"Ethical Dilemmas for the Kansas Government Lawyer," Brian J. Moline, 5 Kan. J.L. & Pub. Pol'y, No. 1, 105, 111, 113 (1995).

Attorney General's Opinions:

Parimutuel racing; refund of deposit of unsuccessful applicant for license; setoffs. 88-120.

Attendants' certificates; forms; requirements; renewal; temporary certificates; fees. 90-12.

GENERAL PROVISIONS

Law Review and Bar Journal References:

"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 56 (1985).

77-501. Title. K.S.A. 77-501 through 77-541 shall be known and may be cited as the Kansas administrative procedure act.

History: L. 1984, ch. 313, § 1; July 1, 1985.

Research and Practice Aids:

Administrative Law and Procedure ⇐ 1 et seq.

C.J.S. Public Administrative Law and Procedure § 2.

Law Review and Bar Journal References:

"Challenging and Defending Agency Actions in Kansas," Steve Leben, 64 J.K.B.A. No. 5, 22, 23 (1995).

Attorney General's Opinions:

Audit records held by the department of revenue; limits on dissemination and use. 95-6.

Professional license or registration disciplinary proceedings; definitions; burden of proof. 95-54.

CASE ANNOTATIONS

1. Act creates only procedural rights and imposes only procedural duties. Expert Environmental Control, Inc. v. Walker, 13 K.A.2d 56, 57, 761 P.2d 320 (1988).

2. Provisions of act not applicable to decisions and actions of Kansas racing commission regarding issuance of licenses (74-8801 et seq.). Kansas Racing Management, Inc. v. Kansas Racing Comm'n, 244 K. 343, 347, 364, 770 P.2d 423 (1989).

3. Authority of Board of Healing Arts to regulate the practice of medicine, review of board's decisions examined. Vakas v. Kansas Bd. of Healing Arts, 248 K. 589, 590, 808 P.2d 1355 (1991).

4. Where action duly revived (60-225), appellate decision, if any, noted as final judgment perfecting demand against estate (59-2238). In re Estate of Rains, 249 K. 178, 183, 815 P.2d 61 (1991).

5. Act for judicial review of agency actions (77-601 et seq.) noted as exclusive means of review unless agency specifically exempted. Kansas Sunset Assocs. v. Kansas Dept. of Health & Environment, 16 K.A.2d 1, 2, 818 P.2d 797 (1991).

6. Noted in opinion holding current statutes (22-3428 et seq.) regarding continued commitment of insanity acquittee unconstitutional; court engrafts new requirements. In re Application of Noel for Discharge Hearing, 17 K.A.2d 303, 314, 838 P.2d 336 (1992).

7. Petition for reconsideration a prerequisite for seeking judicial review (77-529) of decision of Kansas human resources commission (44-1010). United Steelworkers of America v. Kansas Comm'n on Civil Rights, 253 K. 327, 330, 855 P.2d 905 (1993).

8. Cited in review of Kansas water authority's water transfer order on statutory, jurisdictional and administrative procedure grounds. Water District No. 1 v. Kansas Water Authority, 19 K.A.2d 236, 241, 866 P.2d 1076 (1994).

9. Whether defendants misused emergency proceedings provisions of KAPA in administrative license suspension action examined. Lindenman v. Umscheid, 255 K. 610, 613, 875 P.2d 964 (1994).

10. Whether the denial of hearing on emergency suspension until doctor submitted to mental evaluation violated due process examined. Corder v. Kansas Board of Healing Arts, 256 K. 638, 647, 889 P.2d 1127 (1994).

11. Whether court erred by quashing most of subpoena duces tecum as unreasonable and oppressive examined. In re Tax Appeal of Collingwood Grain, Inc., 257 K. 237, 254, 891 P.2d 422 (1995).

77-502. Definitions. As used in this act:

(a) "State agency" means any officer, department, bureau, division, board, authority, agency, commission or institution of this state, except the judicial and legislative branches of state government and political subdivisions of the state, which is authorized by law to administer, enforce or interpret any law of this state.

(b) "Agency head" means an individual or body of individuals in whom the ultimate legal authority of the state agency is vested by any provision of law.

(c) "License" means a franchise, permit, certification, approval, registration, charter or similar form of authorization required by law for a person to engage in a profession or occupation.

(d) "Order" means a state agency action of particular applicability that determines the legal rights, duties, privileges, immunities or other legal interest of one or more specific persons.

(e) "Party to state agency proceedings," or "party" in context so indicating, means:

(1) A person to whom an order is specifically directed; or

(2) a person named as a party to a state agency proceeding or allowed to intervene as a party in the proceeding.

(f) "Person" means an individual, partnership, corporation, association, political subdivision or unit thereof or public or private organization or entity of any character, and includes another state agency.

(g) "Political subdivision" means political or taxing subdivisions of the state, including boards, commissions, authorities, councils, committees, subcommittees and other subordinate groups or administrative units thereof, receiving or expending and supported in whole or in part by public funds.

History: L. 1984, ch. 313, § 2; L. 1988, ch. 356, § 1; July 1, 1989.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 1 et seq.
C.J.S. Public Administrative Law and Procedure § 2.

Attorney General's Opinions:
Examination and registration of cosmetologists and beauty shops; salon or clinic license. 91-151.
Act not applicable to city or county planning and zoning. 95-97.

CASE ANNOTATIONS

1. Whether an ALJ order which awards workers compensation benefits is an order under KAPA subject to review examined. McClure v. Rodricks, 20 K.A.2d 102, 105, 883 P.2d 1228 (1994).

77-503. Application and construction. (a) This act applies only to the extent that other statutes expressly provide that the provisions of this act govern proceedings under those statutes.

(b) This act creates only procedural rights and imposes only procedural duties. They are in addition to those created and imposed by other statutes.

History: L. 1984, ch. 313, § 3; July 1, 1985.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 1 et seq.
C.J.S. Public Administrative Law and Procedure § 2.

Law Review and Bar Journal References:
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 56 (1985).

Attorney General's Opinions:
Act not applicable to city or county planning and zoning. 85-97.

CASE ANNOTATIONS

1. Act creates only procedural rights and imposes only procedural duties. Expert Environmental Control, Inc. v. Walker, 13 K.A.2d 56, 57, 761 P.2d 320 (1988).

77-504. Waiver. Except to the extent precluded by another provision of law, a person may waive any right conferred upon that person by this act.

History: L. 1984, ch. 313, § 4; July 1, 1985.

Research and Practice Aids:
Estoppel ⇐ 52.10(4).
C.J.S. Estoppel § 61.

77-505. Informal settlements. Nothing in this act shall preclude informal settlement of matters that may make unnecessary more elaborate proceedings under this act.

History: L. 1984, ch. 313, § 5; July 1, 1985.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 318; Compromise and Settlement ⇐ 3.
C.J.S. Public Administrative Law and Procedure §§ 52, 70; Compromise and Settlement § 3.

77-506. Conversion of proceedings. (a) At any point in a state agency proceeding the presiding officer or other state agency official responsible for the proceeding:

(1) May convert the proceeding to another type of state agency proceeding if the conversion is appropriate, is in the public interest and does not substantially prejudice the rights of any party; and

(2) if required by any provision of law, shall convert the proceeding to another type of state agency proceeding.

(b) A conversion of a proceeding of one type to a proceeding of another type may be effected only upon notice to all parties to the original proceeding.

(c) If the presiding officer or other state agency official responsible for the original proceeding would not have authority over the new proceeding to which it is to be converted, that officer or official, in accordance with state agency procedure, shall secure the appointment of a successor to preside over or be responsible for the new proceeding.

(d) The record of the original state agency proceeding may be used in the new state agency proceeding.

(e) After a proceeding is converted from one type to another, the presiding officer or other state agency official responsible for the new proceeding shall:

(1) Give such additional notice to parties or other persons as is necessary to satisfy the requirements pertaining to those proceedings;

(2) dispose of the matters involved without further proceedings if sufficient proceedings have already been held to satisfy the requirements pertaining to the new proceedings; and

(3) conduct or cause to be conducted any additional proceedings necessary to satisfy the requirements pertaining to those proceedings.

History: L. 1984, ch. 313, § 6; L. 1988, ch. 356, § 2; July 1, 1989.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 446.
C.J.S. Public Administrative Law and Procedure § 116.

Law Review and Bar Journal References:
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 57, 63 (1985).

77-507. Effective date of act. This act shall take effect on July 1, 1985, and does not govern adjudicative proceedings pending on that date. Subject to K.S.A. 1985 Supp. 77-503, this act governs all state agency adjudicative proceedings commenced after that date. This act also governs state agency adjudicative proceedings conducted on a remand from a court or another state agency after the effective date of this act.

History: L. 1984, ch. 313, § 7; July 1, 1985.

Attorney General's Opinions:
Act not applicable to city or county planning and zoning. 85-97.

77-507a. Effective date of 1988 act. This act shall take effect on July 1, 1989, and does not govern adjudicative proceedings pending on that date. Subject to K.S.A. 77-503 and amendments thereto, this act governs all state agency adjudicative proceedings commenced after that date. This act also governs state agency adjudicative proceedings conducted on a remand from a court or another state agency after the effective date of this act.

History: L. 1988, ch. 356, § 360; July 1, 1989.

CASE ANNOTATIONS

1. Unique circumstances doctrine excused party's untimely petition for reconsideration of workers compensation board

ruling for appellate jurisdiction purposes. In re Tax Appeal of Sumner County, 261 K. 307, 312, 930 P.2d 1385 (1997).

77-508. Hearings, not required in certain circumstances. A hearing shall not be required for a decision:

(a) To issue or not to issue a complaint, summons or similar accusation; or

(b) to initiate or not to initiate an investigation, prosecution or other proceeding before the state agency, another agency or a court.

History: L. 1984, ch. 313, § 8; L. 1988, ch. 356, § 3; L. 1989, ch. 283, § 1; July 1.

Research and Practice Aids:
Administrative Law and Procedure ⇔ 446.
C.J.S. Public Administrative Law and Procedure § 116.

Law Review and Bar Journal References:
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 57 (1985).

77-509.

History: L. 1984, ch. 313, § 9; L. 1986, ch. 362, § 1; L. 1988, ch. 356, § 4; Repealed, L. 1989, ch. 283, § 26; July 1.

77-510.

History: L. 1984, ch. 313, § 10; Repealed, L. 1989, ch. 283, § 26; July 1.

77-511. Time limits for processing application for an order or a request for a hearing; expiration of license, when. (a) Except to the extent that the time limits in this subsection are inconsistent with limits established by another statute, a state agency shall process an application for an order on which a statute provides for a hearing under this act as follows:

(1) Within 30 days after receipt of the application, the state agency shall acknowledge receipt thereof and inform the applicant of the name, official title, mailing address and telephone number of a state agency member or employee who may be contacted regarding the application. As soon as practicable, the state agency shall notify the applicant of any apparent errors or omissions. Failure to detect such errors or omissions does not preclude the state agency from raising them at a later stage of the proceeding.

(2) When practicable, within 90 days after receipt of a completed application, the state agency shall:

(A) Approve or deny the application, in whole or in part, on the basis of emergency or summary proceedings, if those proceedings are available under this act for disposition of the matter; or

(B) commence a formal hearing or a conference hearing in accordance with this act.

(b) Except to the extent that the time limits in this subsection are inconsistent with limits established by another statute, a state agency shall process a request for a hearing as follows:

(1) Within 30 days after receipt of the request, the state agency shall acknowledge receipt thereof and if the state agency has not previously done so, the state agency shall notify the applicant of the name, official title, mailing address and telephone number of a state agency member or employee who may be contacted regarding the request; and

(2) when practicable, within 90 days after receipt of the request the state agency shall commence a formal or conference hearing in accordance with this act unless a statute makes the granting of a hearing discretionary with the state agency and the state agency determines not to conduct a hearing.

(c) A hearing commences when the state agency or presiding officer notifies a party that a prehearing conference or other stage of the hearing will be conducted.

(d) If a timely and sufficient application has been made for renewal of a license with reference to any activity of a continuing nature, the existing license does not expire until the state agency has taken final action upon the application for renewal or, if the state agency's action is unfavorable, until the last day for seeking judicial review of the state agency's action or a later date fixed by the reviewing court.

History: L. 1984, ch. 313, § 11; L. 1986, ch. 362, § 2; L. 1988, ch. 356, § 5; L. 1989, ch. 283, § 2; July 1.

Research and Practice Aids:
Administrative Law and Procedure ⇔ 468.
C.J.S. Public Administrative Law and Procedure § 137.

Attorney General's Opinions:
Parimutuel racing; occupational licenses; commission's jurisdiction when license expires. 91-28.

77-512. Orders affecting licensure; requirements. A state agency may not revoke, suspend, modify, annul, withdraw, refuse to renew, or amend a license unless the state agency first gives notice and an opportunity for a hearing in accordance with this act. This section does not preclude a state agency from (a) taking immediate action to protect the public interest in accordance with K.S.A. 77-536, and amendments thereto, or

(b) adopting rules and regulations, otherwise within the scope of its authority, pertaining to a class of licensees, including rules and regulations affecting the existing licenses of a class of licensees.

History: L. 1984, ch. 313, § 12; L. 1989, ch. 283, § 3; July 1.

Research and Practice Aids:
Licenses ⇐ 38.
C.J.S. Licenses §§ 48 to 63.

CASE ANNOTATIONS

1. Notice requirements under Kansas administrative procedure act examined in review of license revocation. Reed v. Kansas Racing Comm'n, 253 K. 602, 611, 860 P.2d 864 (1993).

FORMAL HEARINGS

77-513. Hearings, applicable procedures. When a statute provides for a hearing in accordance with this act, the hearing shall be governed by K.S.A. 77-513 through 77-532, and amendments thereto, except as otherwise provided by:

(a) A statute other than this act; or

(b) K.S.A. 77-533 through 77-541, and amendments thereto

History: L. 1984, ch. 313, § 13; L. 1986, ch. 362, § 3; L. 1988, ch. 356, § 6; L. 1989, ch. 283, § 4; July 1.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 446.
C.J.S. Public Administrative Law and Procedure § 116.

Law Review and Bar Journal References:
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 57 (1985).
"Challenging and Defending Agency Actions in Kansas," Steve Leben, 64 J.K.B.A. No. 5, 22, 23 (1995).

77-514. Presiding officer. [See Revisor's Note] (a) The agency head or one or more other persons designated by the agency head may be the presiding officer.

(b) Any person serving or designated to serve alone or with others as presiding officer is subject to disqualification for administrative bias, prejudice or interest.

(c) Any party may petition for the disqualification of a person promptly after receipt of notice indicating that the person will preside or promptly upon discovering facts establishing grounds for disqualification, whichever is later.

(d) A person whose disqualification is requested shall determine whether to grant the petition, stating facts and reasons for the determination.

(e) If a substitute is required for a person who is disqualified or becomes unavailable for any other reason, any action taken by a duly appointed substitute for a disqualified or unavailable person is as effective as if taken by the latter.

(f) A state agency may enter into agreements with another state agency to provide hearing officers to conduct proceedings under this act or for other agency proceedings.

(g) Notwithstanding any quorum requirements, if the agency head of a professional or occupational licensing agency is a body of individuals, the agency head, unless prohibited by law, may designate one or more members of the agency head to serve as presiding officer and to render a final order in the proceeding.

History: L. 1984, ch. 313, § 14; L. 1995, ch. 175, § 2; July 1.

Revisor's Note:
CAUTION: Section was amended by L. 1997, ch. 182, § 92, effective July 1, 1998.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 474.
C.J.S. Public Administrative Law and Procedure § 140.

CASE ANNOTATIONS

1. Whether BOTA hearing fundamentally unfair where majority of voting panel members did not participate in evidentiary hearing examined. Sunflower Racing, Inc. v. Board of Wyandotte County Comm'rs, 256 K. 426, 437, 439, 885 P.2d 1233 (1994).

77-515. Participation and representation. (a) Any party may participate in the hearing in person or, if the party is a corporation or other artificial person, by a duly authorized representative.

(b) Whether or not participating in person, any party may be represented at the party's own expense by counsel or, if permitted by law, other representative.

(c) A state agency may require a corporation or other artificial person to participate by counsel.

History: L. 1984, ch. 313, § 15; L. 1986, ch. 362, § 4; July 1.

Attorney General's Opinions:
State board of tax appeals; formal hearings; participation and representation of parties. 93-100.

77-516. Prehearing conference; notice. The presiding officer designated to conduct the hearing may conduct a prehearing conference. If the conference is conducted:

(a) The state agency may assign a presiding officer for the prehearing conference, exercising the same discretion as is provided by K.S.A. 77-

514 and amendments thereto concerning the selection of a presiding officer for a hearing.

(b) The presiding officer for the prehearing conference shall set the time and place of the conference and give reasonable notice to all parties and to all persons who have filed written petitions to intervene in the matter.

(c) The notice shall include:

(1) The names and mailing addresses of all parties and other persons to whom notice is being given by the presiding officer;

(2) the name, official title, mailing address and telephone number of any counsel or employee who has been designated to appear for the state agency;

(3) the official file or other reference number, the name of the proceeding and a general description of the subject matter;

(4) a statement of the time, place and nature of the prehearing conference;

(5) a statement of the legal authority and jurisdiction under which the prehearing conference and the hearing are to be held;

(6) the name, official title, mailing address and telephone number of the presiding officer for the prehearing conference;

(7) a statement that at the prehearing conference the proceeding, without further notice, may be converted into a conference hearing or a summary proceeding for disposition of the matter as provided by this act; and

(8) a statement that a party who fails to attend or participate in a prehearing conference, hearing or other stage of an adjudicative proceeding may be held in default under this act.

(d) The notice may include any other matters that the presiding officer considers desirable to expedite the proceedings.

History: L. 1984, ch. 313, § 16; L. 1988 ch. 356, § 7; July 1, 1989.

77-517. Prehearing conference; procedure; prehearing order. (a) The presiding officer may conduct all or part of the prehearing conference by telephone or other electronic means if each participant in the conference has an opportunity to participate in the entire proceeding while it is taking place.

(b) The presiding officer shall conduct the prehearing conference, as may be appropriate, to deal with such matters as conversion of the proceeding to another type, exploration of settlement possibilities, preparation of stipulations, clarification of issues, rulings on identity and limitation of the number of witnesses, objections to proffers of evidence, determination of the extent to which direct evidence, rebuttal evidence, or cross-examination will be presented in written form, and the extent to which telephone or other electronic means will be used as a substitute for proceedings in person, order of presentation of evidence and cross-examination, rulings regarding issuance of subpoenas, discovery orders and protective orders and such other matters as will promote the orderly and prompt conduct of the hearing. The presiding officer shall issue a prehearing order incorporating the matters determined at the prehearing conference.

(c) If a prehearing conference is not held, the presiding officer for the hearing may issue a prehearing order, based on the pleadings, to regulate the conduct of the proceedings.

History: L. 1984, ch. 313, § 17; July 1, 1985.

77-518. Notice of hearing. [See Revisor's Note] (a) The state agency shall set the time and place of the hearing and give reasonable written notice at least 10 days prior to the hearing to all parties and to all persons who have filed written petitions to intervene in the matter. Service of notices shall be made in accordance with K.S.A. 77-531 and amendments thereto.

(b) The notice shall include a copy of any prehearing order rendered in the matter.

(c) To the extent not included in a prehearing order accompanying it, the notice shall include:

(1) The names and mailing addresses of all parties and other persons to whom notice is being given by the presiding officer;

(2) the name, official title, mailing address and telephone number of any counsel or employee who has been designated to appear for the state agency;

(3) the official file or other reference number, the name of the proceeding and a general description of the subject matter;

(4) a statement of the time, place and nature of the hearing;

(5) a statement of the legal authority and jurisdiction under which the hearing is to be held;

(6) the name, official title, mailing address and telephone number of the presiding officer;

(7) a statement of the issues involved and, to the extent known to the presiding officer, of the matters asserted by the parties; and

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(8) a statement that a party who fails to attend or participate in a prehearing conference, hearing or other stage of an adjudicative proceeding may be held in default under this act.

(d) The notice may include any other matters the presiding officer considers desirable to expedite the proceedings.

(e) The state agency shall cause notice to be given to persons entitled to notice under any provision of law who have not been given notice under subsection (a). Notice under this subsection shall be given in the manner specified by such provision of law or, if no such manner is specified, in a manner to be determined by the agency. If a person other than the agency is directed to give notice under this subsection, the agency shall require that the person furnish proof that the notice has been given. Notice under this subsection may include all types of information provided in subsections (a) through (d) or may consist of a brief statement indicating the subject matter, parties, time, place and nature of the hearing, manner in which copies of the notice to the parties may be inspected and copied and name and telephone number of the presiding officer.

History: L. 1984, ch. 313, § 18; L. 1988, ch. 356, § 8; July 1, 1989.

Revisor's Note:
CAUTION: Section was amended by L. 1997, ch. 182, § 93, effective July 1, 1998.

Research and Practice Aids:
Administrative Law and Procedure ⇨ 452 et seq.
C.J.S. Public Administrative Law and Procedure § 134.

Law Review and Bar Journal References:
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 59 (1985).

CASE ANNOTATIONS

1. Notice requirements under Kansas administrative procedure act examined in review of license revocation. Reed v. Kansas Racing Comm'n, 253 K. 602, 611, 860 P.2d 864 (1993).

77-519. Pleadings, motions, objections, briefs; service. (a) The presiding officer, at appropriate stages of the proceedings, shall give all parties full opportunity to file pleadings, objections and motions, including, but not limited to, motions to dismiss and motions for summary judgment.

(b) The presiding officer, at appropriate stages of the proceedings, may give all parties full opportunity to file briefs, proposed findings of fact and conclusions of law and proposed initial or final orders.

(c) A party shall serve copies of any filed item on all parties, by mail or any other means prescribed by state agency rule and regulation.

History: L. 1984, ch. 313, § 19; L. 1986, ch. 362, § 5; L. 1995, ch. 175, § 3; July 1.

Research and Practice Aids:
Administrative Law and Procedure ⇨ 456, 457.
C.J.S. Public Administrative Law and Procedure §§ 122, 123, 136.

77-520. Default. (a) If a party fails to attend or participate in a prehearing conference, hearing or other stage of an adjudicative proceeding, the presiding officer may serve upon all parties written notice of a proposed default order, including a statement of the grounds.

(b) Within seven days after service of a proposed default order, the party against whom it was issued may file a written motion requesting that the proposed default order be vacated and stating the grounds relied upon. During the time within which a party may file a written motion under this subsection, the presiding officer may adjourn the proceedings or conduct them without the participation of the party against whom a proposed default order was issued, having due regard for the interests of justice and the orderly and prompt conduct of the proceedings.

(c) The proposed default order shall become effective after expiration of the time within which the party may file a written motion under subsection (b) unless a written motion to vacate the order is filed with the agency within such time. Upon receipt of a motion to vacate a proposed default order, the presiding officer shall either vacate the proposed order or issue the default order as proposed. If the presiding officer issues a default order as proposed, the order shall become effective upon service.

(d) After a default order becomes effective, the presiding officer shall conduct any further proceedings necessary to complete the adjudication without the participation of the party in default and shall determine all issues in the adjudication, including those affecting the defaulting party. The presiding officer in lieu of determining the issues affecting the defaulting party may, unless otherwise prohibited by law, dismiss such party's application for an adjudicative proceeding.

History: L. 1984, ch. 313, § 20; L. 1986, ch. 362, § 6; L. 1988, ch. 356, § 9; L. 1991, ch. 277, § 1; April 18.

77-521. Intervention. (a) The presiding officer shall grant a petition for intervention if:

(1) The petition is submitted in writing to the presiding officer, with copies mailed to all parties named in the presiding officer's notice of the hearing, at least three days before the hearing;

(2) the petition states facts demonstrating that the petitioner's legal rights, duties, privileges, immunities or other legal interests may be substantially affected by the proceeding or that the petitioner qualifies as an intervener under any provision of law; and

(3) the presiding officer determines that the interests of justice and the orderly and prompt conduct of the proceedings will not be impaired by allowing the intervention.

(b) The presiding officer may grant a petition for intervention at any time upon determining that the intervention sought is in the interests of justice and will not impair the orderly and prompt conduct of the proceedings.

(c) If a petitioner qualifies for intervention, the presiding officer may impose conditions upon the intervener's participation in the proceedings, either at the time that intervention is granted or at any subsequent time. Conditions may include:

(1) Limiting the intervener's participation to designated issues in which the intervener has a particular interest demonstrated by the petition;

(2) limiting the intervener's use of discovery, cross-examination and other procedures so as to promote the orderly and prompt conduct of the proceedings; and

(3) requiring two or more interveners to combine their presentations of evidence and argument, cross-examination, discovery and other participation in the proceedings.

(d) The presiding officer, at least 24 hours before the hearing, shall issue an order granting or denying each pending petition for intervention, specifying any conditions and briefly stating the reasons for the order. The presiding officer may modify the order at any time, stating the reasons for the modification. The presiding officer shall promptly give notice of an order granting, denying or modifying intervention to the petitioner for intervention and to all parties.

History: L. 1984, ch. 313, § 21; July 1, 1985.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 451.
C.J.S. Public Administrative Law and Procedure § 121.

CASE ANNOTATIONS

1. KCC did not abuse discretion by allowing pipelines to intervene in natural gas litigation. Mobil Exploration & Producing U.S. Inc. v. Kansas Corporation Comm'n, 258 K. 796, 846, 908 P.2d 1276 (1995).

77-522. Discovery; authorization; requests; subpoenas, discovery orders and protective orders. (a) Discovery shall be permitted to the extent allowed by the presiding officer or as agreed to by the parties. Requests for discovery shall be made in writing to the presiding officer and a copy of each request for discovery shall be served on the party or person against whom discovery is sought. The presiding officer may specify the times during which the parties may pursue discovery and respond to discovery requests. The presiding officer may issue subpoenas, discovery orders and protective orders in accordance with the rules of civil procedure.

(b) Subpoenas issued by the presiding officer may be served by a person designated by the presiding officer or any other person who is not a party and is not less than 18 years of age or may be served by certified mail, return receipt requested. Service shall be at the expense of the requesting party. Proof of service shall be shown by affidavit.

(c) Subpoenas and orders issued by the presiding officer may be enforced pursuant to the provisions of the act for judicial review and civil enforcement of agency actions.

History: L. 1984, ch. 313, § 22; L. 1988, ch. 356, § 10; L. 1989, ch. 283, § 5; L. 1995, ch. 175, § 4; July 1.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 464 to 466.
C.J.S. Public Administrative Law and Procedure §§ 124, 129, 132.

Law Review and Bar Journal References:
"Challenging and Defending Agency Actions in Kansas," Steve Leben, 64 J.K.B.A. No. 5, 22, 23, 31, 36 (1995).
"Compliance Through Cooperation," Robert W. Parnacott, 65 J.K.B.A. No. 5, 22 (1996).

Attorney General's Opinions:
Audit records held by the department of revenue; limits on dissemination and use. 95-6.

77-523. Hearing procedure. At a hearing:

(a) The presiding officer shall regulate the course of the proceedings.

(b) To the extent necessary for full disclosure of all relevant facts and issues, the presiding officer shall afford to all parties the opportunity to respond, present evidence and argument, conduct cross-examination and submit rebuttal evidence,

except as restricted by a limited grant of intervention or by the prehearing order.

(c) The presiding officer may, and when required by statute shall, give nonparties an opportunity to present oral or written statements. If the presiding officer proposes to consider a statement by a nonparty, the presiding officer shall give all parties an opportunity to challenge or rebut it and, on motion of any party, the presiding officer shall require the statement to be given under oath or affirmation.

(d) The presiding officer may conduct all or part of the hearing by telephone or other electronic means, if each participant in the hearing has an opportunity to participate in the entire proceeding while it is taking place.

(e) The presiding officer shall cause the hearing to be recorded at the state agency's expense. The state agency is not required, at its expense, to prepare a transcript, unless required to do so by a provision of law. Any party, at the party's expense and subject to such reasonable conditions as the state agency may establish, may cause a person other than the state agency to prepare a transcript from the state agency's record, or cause additional recordings to be made during the hearing.

(f) The hearing is open to public observation, except for the parts that the presiding officer states to be closed pursuant to a provision of law expressly authorizing closure.

History: L. 1984, ch. 313, § 23; L. 1988, ch. 356, § 11; July 1, 1989.

Research and Practice Aids:
Administrative Law and Procedure ⇔ 472 et seq.
C.J.S. Public Administrative Law and Procedure §§ 136, 139.

Law Review and Bar Journal References:
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 59 (1985).

CASE ANNOTATIONS

1. Where parties stipulated to facts and only questions of law remaining BOTA may dispose of appeal without hearing. In re Tax Appeal of Colorado Interstate Gas Co., 258 K. 310, 318, 903 P.2d 154 (1995).

77-524. Evidence; official notice. (a) A presiding officer need not be bound by technical rules of evidence, but shall give the parties reasonable opportunity to be heard and to present evidence, and the presiding officer shall act reasonably without partiality. The presiding officer shall give effect to the rules of privilege recognized by law. Evidence need not be excluded solely because it is hearsay.

(b) All testimony of parties and witnesses shall be made under oath or affirmation and the presiding officer shall have the power to administer an oath or affirmation for that purpose.

(c) Statements presented by nonparties in accordance with paragraph (c) of K.S.A. 77-523 may be received as evidence.

(d) Any part of the evidence may be received in written form if doing so will expedite the hearing without substantial prejudice to the interests of any party.

(e) Documentary evidence may be received in the form of a copy or excerpt. Upon request, parties shall be given an opportunity to compare the copy with the original if available.

(f) Official notice may be taken of (1) any matter that could be judicially noticed in the courts of this state, (2) the record of other proceedings before the state agency, (3) technical or scientific matters within the state agency's specialized knowledge, and (4) codes of standards that have been adopted by an agency of the United States, of this state or of another state or by a nationally recognized organization or association. Parties shall be notified before or during the hearing, or before the issuance of any initial or final order that is based in whole or in part on matters or material noticed, of the specific matters or material noticed and the source thereof, including any staff memoranda and data, and be afforded an opportunity to contest and rebut the matters or material so noticed.

History: L. 1984, ch. 313, § 24; July 1, 1985.

Research and Practice Aids:
Administrative Law and Procedure ⇔ 458 et seq.
C.J.S. Public Administrative Law and Procedure §§ 124, 125.

Law Review and Bar Journal References:
"A Quantitative and Descriptive Survey of Evidence Law in the Kansas Appellate Courts," Stanley D. Davis, 37 K.L.R. 715, 722 (1989).

77-525. Ex parte communications; exemption for certain agencies. (a) A presiding officer serving in an adjudicative proceeding may not communicate, directly or indirectly, regarding any issue in the proceeding while the proceeding is pending, with any party or participant, with any person who has a direct or indirect interest in the outcome of the proceeding or with any person who presided at a previous stage of the proceeding, without notice and opportunity for all parties to participate in the communication.

(b) A member of a multimember panel of presiding officers may communicate with other members of the panel regarding a matter pending before the panel, and any presiding officer may receive aid from staff assistants if the assistants do not:

(1) Receive *ex parte* communications of a type that the presiding officer would be prohibited from receiving; or

(2) furnish, augment, diminish or modify the evidence in the record.

(c) Unless required for the disposition of *ex parte* matters specifically authorized by statute, no party to an adjudicative proceeding, and no person who has a direct or indirect interest in the outcome of the proceeding or who presided at a previous stage of the proceeding, may directly or indirectly communicate in connection with any issue in that proceeding, while the proceeding is pending, with any person serving as presiding officer unless notice and an opportunity are given all parties to participate in the communication.

(d) If, before serving as presiding officer in an adjudicative proceeding, a person receives an *ex parte* communication of a type that could not properly be received while serving, the person, promptly after starting to serve, shall disclose the communication in the manner prescribed in subsection (e).

(e) A presiding officer who receives an *ex parte* communication in violation of this section shall place on the record of the pending matter all written communications received, all written responses to the communications and a memorandum stating the substance of all oral communications received, all responses made and the identity of each person from whom the presiding officer received an *ex parte* communication and shall advise all parties that these matters have been placed on the record. Any party desiring to rebut the *ex parte* communication must be allowed to do so, upon requesting the opportunity for rebuttal within 10 days after notice of the communication.

(f) If necessary to eliminate the effect of an *ex parte* communication received in violation of this section, a presiding officer who receives the communication may be disqualified and the portions of the record pertaining to the communication may be sealed by protective order.

(g) The state agency shall, and any party may, report any willful violation of this section to appropriate authorities for any disciplinary proceedings provided by law. In addition, each state agency, by rule and regulation, may provide for appropriate sanctions, including default, for any violations of this section.

(h) This section shall not apply to adjudicative proceedings before:

(1) The state corporation commission. Such proceedings shall be subject to the provisions of K.S.A. 77-545;

(2) the commissioner of insurance concerning any rate, or any rule, regulation or practice pertaining to the rates over which the commissioner has jurisdiction or adjudicative proceedings held pursuant to the Kansas insurance holding companies act. Such proceedings shall be subject to the provisions of K.S.A. 77-546; and

(3) the director of taxation. Such proceedings shall be subject to the provisions of K.S.A. 77-548.

History: L. 1984, ch. 313, § 25; L. 1986, ch. 362, § 7; L. 1988, ch. 356, § 12; July 1, 1989.

Research and Practice Aids:
Administrative Law and Procedure 473.
C.J.S. Public Administrative Law and Procedure §§ 136, 138, 139.

CASE ANNOTATIONS

1. Board of tax appeals lacks authority to investigate property not in dispute before it. In re Application of Park Comm'rs for Ad Valorem Tax Exemption, 14 K.A.2d 777, 786, 799 P.2d 505 (1990).

77-526. Orders, initial and final; exception for state corporation commission. (a) If the presiding officer is the agency head or designated in accordance with subsection (g) of K.S.A. 77-514, and amendments thereto, the presiding officer shall render a final order.

(b) If the presiding officer is neither the agency head nor designated in accordance with subsection (g) of K.S.A. 77-514, and amendments thereto, the presiding officer shall render an initial order, which becomes a final order unless reviewed in accordance with K.S.A. 77-527 and amendments thereto.

(c) A final order or initial order shall include, separately stated, findings of fact, conclusions of law and policy reasons for the decision if it is an exercise of the state agency's discretion, for all aspects of the order, including the remedy prescribed and, if applicable, the action taken on a petition for stay of effectiveness. Findings of fact, if set forth in language that is no more than mere repetition or paraphrase of the relevant provision of law, shall be accompanied by a concise and explicit statement of the underlying facts of record

to support the findings. The order shall also include a statement of the available procedures and time limits for seeking reconsideration, administrative review or other administrative relief. An initial order shall include a statement of any circumstances under which the initial order, without further notice, may become a final order. If the presiding officer has been designated in accordance with subsection (g) of K.S.A. 77-514, and amendments thereto, the final order shall so state. Any final order, for which a petition for reconsideration is not a prerequisite for seeking judicial review, and any initial order, for which further administrative review is not available, shall state the agency officer to receive service of a petition for judicial review on behalf of the agency.

(d) Findings of fact shall be based exclusively upon the evidence of record in the adjudicative proceeding and on matters officially noticed in that proceeding.

(e) If a substitute presiding officer is appointed pursuant to K.S.A. 77-514 and amendments thereto, the substitute presiding officer shall use any existing record and may conduct any further proceedings appropriate in the interests of justice.

(f) The presiding officer may allow the parties a designated amount of time after conclusion of the hearing for the submission of proposed findings.

(g) A final order or initial order pursuant to this section shall be rendered in writing and served within 30 days after conclusion of the hearing or after submission of proposed findings in accordance with subsection (f) unless this period is waived or extended with the written consent of all parties or for good cause shown. If extended for good cause, such good cause shall be set forth in writing on or before expiration of the 30 days.

(h) The presiding officer shall cause copies of the order to be served on each party and, if the order is an initial order, on the agency head in the manner prescribed by K.S.A. 77-531 and amendments thereto.

(i) Notwithstanding the other provisions of this section, if the presiding officer in a hearing before the state corporation commission is not the agency head, the presiding officer shall not render an initial order but shall make written findings and recommendations to the commission. The commission shall render and serve a final order within 60 days after conclusion of the hearing or after submission of proposed findings in accordance with subsection (f) unless this period is waived or extended with the written consent of all parties or for good cause shown. If extended for good cause, such good cause shall be set forth in writing on or before expiration of the 60 days.

History: L. 1984, ch. 313, § 26; L. 1988, ch. 356, § 13; L. 1995, ch. 175, § 5; July 1.

Research and Practice Aids:

Administrative Law and Procedure ⇔ 489 et seq.

C.J.S. Public Administrative Law and Procedure §§ 147, 148.

Law Review and Bar Journal References:

"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 60 (1985).

CASE ANNOTATIONS

1. Failure to render final or initial order does not deprive agency of jurisdiction. Expert Environmental Control, Inc. v. Walker, 13 K.A.2d 56, 58, 761 P.2d 320 (1988).

2. Cited in review of Kansas water authority's water transfer order on statutory, jurisdictional and administrative procedure grounds. Water District No. 1 v. Kansas Water Authority, 19 K.A.2d 236, 241, 245, 866 P.2d 1076 (1994).

3. Whether contract provision was mandatory subject of bargaining between employer and state employees examined. State Dept. of Administration v. Public Employees Relations Bd., 257 K. 275, 280, 894 P.2d 777 (1995).

77-527. Review of initial order; exceptions to reviewability. [See Revisor's Note] (a) The agency head, upon its own motion may, and upon petition by any party or when required by law shall, review an initial order, except to the extent that:

(1) A provision of law precludes or limits state agency review of the initial order; or

(2) the agency head (A) determines to review some but not all issues, or not to exercise any review, (B) delegates its authority to review the initial order to one or more persons, unless such delegation is expressly prohibited by law, or (C) authorizes one or more persons to review the initial order, subject to further review by the agency head.

(b) A petition for review of an initial order must be filed with the agency head, or with any person designated for this purpose by rule and regulation of the state agency, within 15 days after service of the initial order. If the agency head on its own motion decides to review an initial order, the agency head shall give written notice of its intention to review the initial order within 15 days after its service. If the agency head determines not to review an initial order in response to a petition for review, the agency head shall, within 20 days after filing of the petition for review, serve on each

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party an order stating that review will not be exercised.

(c) The petition for review shall state its basis. If the agency head on its own motion gives notice of its intent to review an initial order, the agency head shall identify the issues that it intends to review.

(d) In reviewing an initial order, the agency head or designee shall exercise all the decision-making power that the agency head or designee would have had to render a final order had the agency head or designee presided over the hearing, except to the extent that the issues subject to review are limited by a provision of law or by the agency head or designee upon notice to all parties.

(e) The agency head or designee shall afford each party an opportunity to present briefs and may afford each party an opportunity to present oral argument.

(f) The agency head or designee shall render a final order disposing of the proceeding or remand the matter for further proceedings with instructions to the person who rendered the initial order. Upon remanding a matter, the agency head or designee may order such temporary relief as is authorized and appropriate.

(g) A final order or an order remanding the matter for further proceedings shall be rendered in writing and served within 30 days after receipt of briefs and oral argument unless that period is waived or extended with the written consent of all parties or for good cause shown.

(h) A final order or an order remanding the matter for further proceedings under this section shall identify any difference between this order and the initial order and shall include, or incorporate by express reference to the initial order, all the matters required by subsection (c) of K.S.A. 77-526, and amendments thereto.

(i) The agency head shall cause copies of the final order or order remanding the matter for further proceedings to be served on each party in the manner prescribed by K.S.A. 77-531, and amendments thereto.

(j) Unless a petition for reconsideration is a prerequisite for seeking judicial review, a final order under this section shall state the agency officer to receive service of a petition for judicial review on behalf of the agency.

History: L. 1984, ch. 313, § 27; L. 1988, ch. 356, § 14; L. 1995, ch. 175, § 6; July 1.

Revisor's Note:
CAUTION: Section was amended by L. 1997, ch. 182, § 94, effective July 1, 1998.

Research and Practice Aids:
Administrative Law and Procedure ⚷ 513.
C.J.S. Public Administrative Law and Procedure §§ 166 to 171.

Law Review and Bar Journal References:
"Loss of Water Rights for Non-Use," John C. Peck and Constance Crittenden Owen, 43 K.L.R. 801, 804 (1995).

CASE ANNOTATIONS

1. School board's refusal to negotiate evaluation procedures for implementing new teacher evaluation criteria determined a prohibited practice under 72-5430(b)(5). U.S.D. No. 314 v. Kansas Dept. of Human Resources, 18 K.A.2d 596, 598, 856 P.2d 1343 (1993).

2. Cited in review of Kansas water authority's water transfer order on statutory, jurisdictional and administrative procedure grounds. Water District No. 1 v. Kansas Water Authority, 19 K.A.2d 236, 241, 866 P.2d 1076 (1994).

3. Whether contract provision was mandatory subject of bargaining between employer and state employees examined. State Dept. of Administration v. Public Employees Relations Bd., 257 K. 275, 280, 894 P.2d 777 (1995).

4. Trial court ruling that agency secretary acted arbitrarily by disregarding presiding officer's witness credibility determination reversed. Tire Disposal Facilitators, Inc. v. State ex rel. Harder, 22 K.A.2d 491, 492, 919 P.2d 362 (1996).

77-528. Stay. A party may submit to the presiding officer or agency head a petition for stay of effectiveness of an initial or final order until the time at which a petition for judicial review would no longer be timely, unless otherwise provided by statute or stated in the initial or final order. The presiding officer or agency head may take action on the petition for stay, either before or after the effective date of the initial or final order.

History: L. 1984, ch. 313, § 28; July 1, 1985.

Research and Practice Aids:
Administrative Law and Procedure ⚷ 674.
C.J.S. Public Administrative Law and Procedure §§ 194, 195.

77-529. Reconsideration. (a) Any party, within 15 days after service of a final order, may file a petition for reconsideration with the agency head, stating the specific grounds upon which relief is requested. The filing of the petition is not a prerequisite for seeking administrative or judicial review except as provided in K.S.A. 44-1010 and 44-1115, and amendments thereto, concerning orders of the Kansas human rights commission, K.S.A. [illegible]-506 and [illegible]-11[illegible], and amendments thereto, concerning orders of the corporation commission and K.S.A. [illegible]-2426, and amendments thereto, concerning orders of the board of tax appeals.

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(b) Within 20 days after the filing of the petition, the agency head shall render a written order denying the petition, granting the petition and dissolving or modifying the final order, or granting the petition and setting the matter for further proceedings. The petition may be granted, in whole or in part, only if the agency head states, in the written order, findings of fact, conclusions of law and policy reasons for the decision if it is an exercise of the state agency's discretion, to justify the order. In proceedings before the Kansas corporation commission, the petition is deemed to have been denied if the agency head does not dispose of it within 30 days after the filing of the petition.

An order under this section shall be served on the parties in the manner prescribed by K.S.A. 77-531 and amendments thereto.

(c) Any order rendered upon reconsideration or any order denying a petition for reconsideration shall state the agency officer to receive service of a petition for judicial review on behalf of the agency.

(d) For the purposes of this section, "agency head" shall include a presiding officer designated in accordance with subsection (g) of K.S.A. 77-514, and amendments thereto.

History: L. 1984, ch. 313, § 29; L. 1988, ch. 356, § 15; L. 1991, ch. 148, § 11; L. 1995, ch. 175, § 7; L. 1997, ch. 132, § 4; July 1.

Research and Practice Aids:

Administrative Law and Procedure ⇐ 480 et seq.

C.J.S. Public Administrative Law and Procedure §§ 161, 162.

Law Review and Bar Journal References:

"Appellate Court Jurisdiction: An Update," Debra S. Byrd, 58 J.K.B.A. No. 1, 21, 23 (1989).

"Loss of Water Rights for Non-Use," John C. Peck and Constance Crittenden Owen, 43 K.L.R. 801, 804 (1995).

"Challenging and Defending Agency Actions in Kansas," Steve Leben, 64 J.K.B.A. No. 5, 22, 25, 33 (1995).

CASE ANNOTATIONS

1. Board of tax appeals may not allow longer time to file petition for reconsideration. In re Tax Appeal of Cessna Aircraft Co., 16 K.A.2d 229, 230, 231, 232, 233, 821 P.2d 328 (1991).

2. Construction and application of time allowed for filing petition with KCCR. United Steelworkers of America v. Kansas Comm'n on Civil Rights, 17 K.A.2d 863, 864, 845 P.2d 89 (1993).

3. Petition for reconsideration a prerequisite for seeking judicial review of decision of Kansas human resources commission (44-1010). United Steelworkers of America v. Kansas Comm'n on Civil Rights, 253 K. 327, 330, 855 P.2d 905 (1993).

4. Whether section's procedural requirements must be ictly complied with to preserve party's right to proceed examined. Sunflower Racing, Inc. v. Board of Wyandotte County Comm'rs, 256 K. 426, 434, 885 P.2d 1233 (1994).

5. Whether motion to reconsider order of Kansas civil service board is permissive tolling limitations period for judicial review examined. State Bank Commissioner v. Emery, 19 K.A.2d 1063, 1064, 1068, 880 P.2d 783 (1994).

6. Unique circumstances doctrine excused party's untimely petition for reconsideration of workers compensation board ruling for appellate jurisdiction purposes. In re Tax Appeal of Sumner County, 261 K. 307, 308, 311, 930 P.2d 1385 (1997).

77-530. Orders, when effective. (a) Unless a later date is stated in a final order or a stay is granted, a final order is effective upon service.

(b) Unless a later date is stated in an initial order or a stay is granted, an initial order shall become effective and shall become the final order: (1) When the initial order is served, if administrative review is unavailable; (2) when the agency head serves an order stating, after a petition for review has been filed, that review will not be exercised; or (3) 30 days after service if no party has filed a petition for review by the agency head, the agency head has not given written notice of its intention to exercise review and review by the agency head is not otherwise required by law.

(c) This section does not preclude a state agency from taking immediate action to protect the public interest in accordance with K.S.A. 77-536 and amendments thereto.

History: L. 1984, ch. 313, § 30; L. 1988, ch. 356, § 16; July 1, 1989.

Research and Practice Aids:

Administrative Law and Procedure ⇐ 496 et seq.

C.J.S. Public Administrative Law and Procedure § 150.

77-531. Service of order. Service of an order or notice shall be made upon the party and the party's attorney of record, if any, by delivering a copy of the order or notice to the person to be served or by mailing a copy of the order or notice to the person at the person's last known address. Delivery of a copy of an order or notice means handing the order or notice to the person or leaving the order or notice at the person's principal place of business or residence with a person of suitable age and discretion who works or resides therein. Service shall be presumed if the presiding officer, or a person directed to make service by the presiding officer, makes a written certificate of service. Service by mail is complete upon mailing. Whenever a party has the right or is required to do some act or take some proceedings within a prescribed period after service of a notice or order

and the notice or order is served by mail, three days shall be added to the prescribed period.

History: L. 1984, ch. 313, § 31; July 1, 1985.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 503 et seq.
C.J.S. Public Administrative Law and Procedure § 152.

77-532. Record. (a) A state agency shall maintain an official record of each formal hearing.

(b) The state agency record consists only of:

(1) Notices of all proceedings;

(2) any prehearing order;

(3) any motions, pleadings, briefs, petitions, requests, and intermediate rulings;

(4) evidence received or considered;

(5) a statement of matters officially noticed;

(6) proffers of proof and objections and rulings thereon;

(7) proposed findings, requested orders and exceptions;

(8) the record prepared for the presiding officer at the hearing, together with any transcript of all or part of the hearing considered before final disposition of the proceeding;

(9) any final order, initial order, or order on reconsideration; and

(10) staff memoranda or data submitted to the presiding officer.

(c) Except to the extent that this act or another statute provides otherwise, the state agency record, excluding matters under paragraph (10) of subsection (b), constitutes the exclusive basis for state agency action in formal hearings and for judicial review thereof.

History: L. 1984, ch. 313, § 32; L. 1988, ch. 356, § 17; July 1, 1989.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 506.
C.J.S. Public Administrative Law and Procedure § 160.

CONFERENCE HEARING

77-533. Conference hearing; use, when. A conference hearing may be used if its use in the circumstances does not violate any provision of law and where there is:

(a) A matter in which there is no disputed issue of material fact; or

(b) a matter in which there is a disputed issue of material fact and the parties agree to a conference hearing.

History: L. 1984, ch. 313, § 33; L. 1988, ch. 356, § 18; July 1, 1989.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 472.
C.J.S. Public Administrative Law and Procedure §§ 136, 139.

Law Review and Bar Journal References:
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 57, 62 (1985).
"Challenging and Defending Agency Actions in Kansas," Steve Leben, 64 J.K.B.A. No. 5, 22, 23 (1995).

77-534. Procedure. The procedures of this act pertaining to formal hearings apply to a conference hearing, except to the following extent:

(a) If a matter is initiated as a conference hearing, no prehearing conference may be held.

(b) The provisions of K.S.A. 77-522 and amendments thereto do not apply to conference hearings insofar as those provisions authorize the issuance and enforcement of subpoenas and discovery orders, but do apply to conference hearings insofar as those provisions authorize the presiding officer to issue protective orders at the request of any party or upon the presiding officer's motion.

(c) Paragraphs (a), (b) and (c) of K.S.A. 77-523 and amendments thereto do not apply; but (1) the presiding officer shall regulate the course of the proceedings; (2) only the parties may testify and present written exhibits; and (3) the parties may offer comments on the issues.

History: L. 1984, ch. 313, § 34; L. 1988, ch. 356, § 19; July 1, 1989.

77-535. Disclosure of material or essential facts. (a) If during a conference hearing the presiding officer has reason to believe that material facts are in dispute, the presiding officer may require any party to state the identity of the witnesses or other sources through whom the party would propose to present proof if the proceeding were converted to a formal hearing, but if disclosure of any fact, allegation or source is privileged or expressly prohibited by any provision of law, the presiding officer may require the party to indicate that confidential facts, allegations or sources are involved, but not to disclose the confidential facts, allegations or sources.

(b) If during a conference hearing a party has reason to believe that essential facts must be obtained in order to permit an adequate presentation of the case, the party may inform the presiding officer regarding the general nature of the facts and the sources from whom the party would

propose to obtain those facts if the proceeding were converted to a formal hearing.

History: L. 1984, ch. 313, § 35; L. 1988, ch. 356, § 20; July 1, 1989.

EMERGENCY PROCEEDINGS

77-536. Emergency proceedings; use, when; procedure. (a) A state agency may use emergency proceedings: (1) In a situation involving an immediate danger to the public health, safety or welfare requiring immediate state agency action or (2) as otherwise provided by law.

(b) The state agency may take only such action as is necessary: (1) To prevent or avoid the immediate danger to the public health, safety or welfare that justifies use of emergency adjudication or (2) to remedy a situation for which use of emergency adjudication is otherwise provided by law.

(c) The state agency shall render an order, including a brief statement of findings of fact, conclusions of law and policy reasons for the decision if it is an exercise of the state agency's discretion, justify the state agency's decision to take the specific action and the determination of: (1) An immediate danger or (2) the existence of a situation for which use of emergency adjudication is otherwise provided by law.

(d) The state agency shall give such notice as is practicable to persons who are required to comply with the order. The order is effective when rendered. Notice under this subsection shall constitute service for the purposes of the act for judicial review and civil enforcement of agency actions.

(e) After issuing an order pursuant to this section, the state agency shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not justify the use of emergency proceedings under subsection (a).

(f) The state agency record consists of any documents regarding the matter that were considered or prepared by the state agency. The state agency shall maintain these documents as its official record.

(g) Unless otherwise required by a provision of law, the state agency record need not constitute the exclusive basis for state agency action in emergency proceedings or for judicial review thereof.

History: L. 1984, ch. 313, § 36; L. 1988, ch. 356, § 21; July 1, 1989.

Research and Practice Aids:
Administrative Law and Procedure ⇨ 470.
C.J.S. Public Administrative Law and Procedure § 134.

Law Review and Bar Journal References:
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 57, 62 (1985).
"Challenging and Defending Agency Actions in Kansas," Steve Leben, 64 J.K.B.A. No. 5, 22, 23, 25 (1995).

CASE ANNOTATIONS

1. Whether defendants misused emergency proceedings provisions of KAPA in administrative license suspension action examined. Lindenman v. Umscheid, 255 K. 610, 613, 620, 875 P.2d 964 (1994).

2. Whether the denial of hearing on emergency suspension until doctor submitted to mental evaluation violated due process examined. Corder v. Kansas Board of Healing Arts, 256 K. 638, 648, 889 P.2d 1127 (1994).

SUMMARY PROCEEDINGS

77-537. Summary proceedings; use, when; right to request hearing; orders, contents. (a) A state agency may use summary proceedings, subject to a party's request for a hearing on the order, if:

(1) The use of those proceedings in the circumstances does not violate any provision of law; and

(2) the protection of the public interest does not require the state agency to give notice and an opportunity to participate to persons other than the parties.

(b) The state agency shall serve each party with a copy of the order in a summary proceeding in the manner prescribed by K.S.A. 77-531, and amendments thereto. The order shall include at least:

(1) A statement of the state agency's action and, if unfavorable action is taken, a brief statement of the reasons for the action;

(2) notice of the time and manner for requesting a hearing on the order, as provided in K.S.A. 77-542; and

(3) notice that, if a hearing is not requested, the order shall become effective upon the expiration of the time for requesting a hearing.

History: L. 1984, ch. 313, § 37; L. 1988, ch. 356, § 22; L. 1989, ch. 283, § 6; L. 1990, ch. 340, § 1; July 1.

Research and Practice Aids:
Administrative Law and Procedure ⇨ 470.
C.J.S. Public Administrative Law and Procedure § 134.

Law Review and Bar Journal References:
"The New Kansas Administrative Procedure and Judicial Review Acts," David L. Ryan, 54 J.K.B.A. 53, 57, 63 (1985).
"Challenging and Defending Agency Actions in Kansas," Steve Leben, 64 J.K.B.A. No. 5, 22, 23 (1995).

77-538 to 77-540.
History: L. 1984, ch. 313, §§ 38 to 40; L. 1988, ch. 356, §§ 23 to 25; Repealed, L. 1989, ch. 283, § 26; July 1.

77-541. Same; record. (a) The state agency record for a summary proceeding consists of any documents regarding the matter that were considered or prepared by the state agency. The state agency shall maintain these documents as its official record.

(b) Unless otherwise required by a provision of law, the agency record need not constitute the exclusive basis for agency action in summary proceedings or for judicial review thereof.

History: L. 1984, ch. 313, § 41; L. 1988, ch. 356, § 26; L. 1989, ch. 283, § 7; July 1.

Research and Practice Aids:
Administrative Law and Procedure ⇐ 506.
C.J.S. Public Administrative Law and Procedure § 160.

77-542. Right to request hearing; statement filed. (a) Any notice of agency action resulting in a right to request a hearing pursuant to the Kansas administrative procedure act must include a statement informing the person that a written request for a hearing must be filed with the agency within 15 days of service of the notice.

(b) The time limit for requesting a hearing established by subsection (a) may be lengthened or shortened as otherwise provided by state or federal law.

History: L. 1990, ch. 340, § 2; July 1.

77-543, 77-544. Reserved.

77-545. State corporation commission; adjudicative proceedings; ex parte communications; file and docket, contents; technical staff, not party to proceedings. (a) This section applies to adjudicative proceedings before the state corporation commission.

(b) (1) After the commission has determined and announced that a hearing should be held, and prior to the issuance of a final order, no parties to the proceeding, or their counsel, shall discuss the merits of the matter or proceeding with the presiding officer unless reasonable notice is given to all parties who have appeared to enable the parties to be present at the conference.

(2) After the commission has determined and announced that a hearing should be held, prior to the issuance of a final order, copies of any written communications from any party regarding the proceeding that are directed to the presiding officer shall be mailed to all parties of record and proof of service shall be furnished to the commission. Communications requested by members of the commission staff from any party and any written communications received by members of the commission staff from any party shall be made a part of the file and the docket and shall be made available to all persons who desire to use them, provided that all commission requests for information from a party shall be mailed to all parties of record.

(3) The person or persons to whom any ex parte communication has been made shall promptly and fully inform the full commission of the substance of the communication, and the circumstances thereof, to enable the commission to take appropriate action.

(c) For purposes of this section, no member of the technical staff shall be considered a party to any proceeding before the commission, regardless of participation in staff investigations with respect to the proceeding or of participation in the proceeding as a witness. Since the purpose of the staff is to aid the commission in the proper discharge of commission duties, the presiding officers shall be free at all times to confer with any staff member with respect to any proceeding. However, no facts that are outside the record, and that reasonably could be expected to influence the decision in any matter pending before the commission, shall be furnished to any presiding officer unless all parties to the proceeding are likewise informed and afforded a reasonable opportunity to respond. Subsection (b) shall apply to staff counsel in regard to any adjudicatory proceeding before the commission.

(d) All letters and written communications that are received by the presiding officer from members of the general public, and that are in the nature of ex parte communications, shall be made a part of the file in the docket and shall be made available to all persons who desire to see them. The deposit of such written communications and letters in the file shall not make them a part of the official record of the case.

History: L. 1988, ch. 356, § 355; July 1, 1989.

77-546. Commissioner of insurance; adjudicative proceedings; ex parte communications; file and docket, contents; technical staff, not party to proceedings. (a) This section applies to adjudicative proceedings before the commissioner of insurance concerning any rate,

or any rule, regulation or practice pertaining to the rates over which the commissioner has jurisdiction and adjudicative proceedings held pursuant to the Kansas insurance holding companies act.

(b) (1) After the commissioner has determined and announced that a hearing should be held, and prior to the issuance of a final order, no parties to the proceeding, or their counsel, shall discuss the merits of the matter or proceeding with the presiding officer unless reasonable notice is given to all parties who have appeared to enable the parties to be present at the conference.

(2) After the commissioner has determined and announced that a hearing should be held, prior to the issuance of a final order, copies of any written communications from any party regarding the proceeding that are directed to the presiding officer shall be mailed to all parties of record and proof of service shall be furnished to the commissioner. Communications requested by the commissioner's staff from any party and any written communication received by the commissioner's staff from any party shall be made a part of the file and the docket and shall be made available to all persons who desire to use them, provided that the commissioner's requests for information from a party shall be mailed to all parties of record.

(3) The person or persons to whom any *ex parte* communication has been made shall promptly and fully inform the commissioner of the substance of the communication, and the circumstances thereof, to enable the commissioner to take appropriate action.

(c) For purposes of this section, no member of the commissioner's technical staff shall be considered a party to any proceeding before the commissioner, regardless of participation in staff investigations with respect to the proceeding or of participation in the proceeding as a witness. Since the purpose of the staff is to aid the commissioner in the proper discharge of the commissioner's duties, the presiding officer shall be free at all times to confer with any staff member with respect to any proceeding. However, no facts that are outside the record, and that reasonably could be expected to influence the decision in any matter pending before the commissioner, shall be furnished to any presiding officer unless all parties to the proceeding are likewise informed and afforded a reasonable opportunity to respond. Subsection (b) shall apply to staff counsel who have participated in the proceeding in regard to any adjudicatory proceeding before the commissioner.

(d) All letters and written communications that are received by the presiding officer from members of the general public, and that are in the nature of *ex parte* communications, shall be made a part of the file in the docket and shall be made available to all persons who desire to see them. The deposit of such written communications and letters in the file shall not make them a part of the official record of the case.

History: L. 1988, ch. 356, § 356; July 1, 1989.

77-547. Same; administrative proceedings; agency head, defined. For purposes of administrative proceedings of the insurance department under the Kansas administrative procedure act, "agency head" means the commissioner of insurance or the assistant commissioner of insurance, when acting on behalf of the commissioner.

History: L. 1988, ch. 356, § 358; July 1, 1989.

77-548. Director of taxation; adjudicative proceedings; ex parte communications; file and docket, contents; technical staff, not party to proceedings. (a) This section applies to adjudicative proceedings before the director of taxation. Informal conferences held pursuant to K.S.A. 79-3226, and amendments thereto, shall not be deemed to be adjudicative proceedings for the purposes of this act.

(b) (1) After the director has determined and announced that a hearing should be held, and prior to the issuance of a final order, no parties to the proceeding, or their counsel, shall discuss the merits of the matter or proceeding with the presiding officer unless reasonable notice is given to all parties who have appeared to enable the parties to be present at the conference.

(2) After the director has determined and announced that a hearing should be held, prior to the issuance of a final order, copies of any written communications from any party regarding the proceeding that are directed to the presiding officer shall be mailed to all parties of record and proof of service shall be furnished to the director. Communications requested by the director's staff from any party and any written communication received by the director's staff from any party shall be made a part of the file and the docket and shall be made available to all persons who desire to use them, provided that the director's requests for information from a party shall be mailed to all parties of record.

(3) The person or persons to whom any *ex parte* communication has been made shall promptly and fully inform the director of the substance of the communication, and the circumstances thereof, to enable the director of any division within the department to take appropriate action.

(c) For purposes of this section, no member of the director's technical staff shall be considered a party to any proceeding before the director, regardless of participation in staff investigations with respect to the proceeding or of participation in the proceeding as a witness. Since the purpose of the staff is to aid the director in the proper discharge of the director's duties, the presiding officer shall be free at all times to confer with any staff member with respect to any proceeding. However, no facts that are outside the record, and that reasonably could be expected to influence the decision in any matter pending before the director, shall be furnished to any presiding officer unless all parties to the proceeding are likewise informed and afforded a reasonable opportunity to respond. Subsection (b) shall apply to staff counsel who have participated in the proceeding in regard to any adjudicatory proceeding before the director.

(d) All letters and written communications that are received by the presiding officer from members of the general public, and that are in the nature of *ex parte* communications, shall be made a part of the file in the docket and shall be made available to all persons who desire to see them. The deposit of such written communications and letters in the file shall not make them a part of the official record of the case.

History: L. 1988, ch. 356, § 357; L. 1997, ch. 126, § 6; July 1.

77-549. Same; application for an order; when proceedings required; agency head defined; final orders. (a) The filing of a return with the director of taxation under article 15, 32, 33, 34, 36, 37, 41, 42 or 47 of chapter 79 of the Kansas Statutes Annotated, and amendments thereto, shall not be deemed an application for an order under the Kansas administrative procedure act.

(b) A determination by the division of taxation or the audit services bureau of the department of revenue concerning tax liability under article 15, 32, 33, 34, 36, 37, 41, 42 or 47 of chapter 79 of the Kansas Statutes Annotated, and amendments thereto, which is made prior to the opportunity for a hearing or prior to the opportunity for an informal conference before the secretary or the secretary's designee on such tax liability, shall not require an adjudicative proceeding under the Kansas administrative procedure act.

(c) For purposes of the Kansas administrative procedure act, the secretary of revenue may designate the director of the division of taxation or other designee as agency head.

(d) Final orders of the director of taxation pursuant to K.S.A. 77-526, and amendments thereto, shall be rendered in writing and served within 120 days after conclusion of the hearing or after submission of proposed findings in accordance with subsection (f) of K.S.A. 77-526, and amendments thereto, unless this period is waived or extended with the written consent of all parties or for good cause shown. If extended for good cause, such good cause shall be set forth in writing on or before the expiration of the 120 days.

History: L. 1988, ch. 356, § 359; L. 1995, ch. 175, § 8; L. 1997, ch. 126, § 7; July 1.

77-550. Division of property valuation; administrative proceedings; agency head, defined. For purposes of administrative proceedings of the division of property valuation under the Kansas administrative procedure act, the secretary of revenue may designate the director of the division of property valuation or other designee as agency head.

History: L. 1994, ch. 139, § 1; L. 1997, ch. 126, § 8; July 1.

77-551. SRS hearings. On and after July 1, 1998: (a) In hearings of the department of social and rehabilitation services under K.S.A. 39-1807, 65-4015, 65-4606, 65-4927, 75-3306 and 75-3340, and amendments thereto, the presiding officer shall be the agency head, one or more members of the agency head or an administrative law judge assigned by the office of administrative hearings.

(b) This section shall be part of and supplemental to the Kansas administrative procedure act.

History: L. 1997, ch. 182, § 90; July 3.

Cross References to Related Sections:
Office of administrative hearings, see 75-37,121 and 75-37,122.

Article 6.—ACT FOR JUDICIAL REVIEW AND CIVIL ENFORCEMENT OF AGENCY ACTIONS

Law Review and Bar Journal References:
"Administrative Law: The Creation of a Presumption of Unreviewability in Cases of Administrative Inaction [Heckler v.

Article 5.—ADMINISTRATIVE PROCEDURE ACT

77-502.

Attorney General's Opinions:

An authority organized pursuant to 12-2901 et seq. is not a municipality. 97-42.

77-514. Presiding officer. (a) The agency head, one or more members of the agency head, an administrative law judge assigned by the office of administrative hearings, or, unless prohibited by K.S.A. 77-551, and amendments thereto, one or more other persons designated by the agency head may be the presiding officer.

(b) Any person serving or designated to serve alone or with others as presiding officer is subject to disqualification for administrative bias, prejudice or interest.

(c) Any party may petition for the disqualification of a person promptly after receipt of notice indicating that the person will preside or promptly upon discovering facts establishing grounds for disqualification, whichever is later.

(d) A person whose disqualification is requested shall determine whether to grant the petition, stating facts and reasons for the determination.

(e) If a substitute is required for a person who is disqualified or becomes unavailable for any other reason, any action taken by a duly appointed substitute for a disqualified or unavailable person is as effective as if taken by the latter.

(f) If the office of administrative hearings cannot provide a presiding officer, a state agency may enter into agreements with another state agency to provide presiding officers to conduct proceedings under this act.

(g) Notwithstanding any quorum requirements, if the agency head of a professional or occupational licensing agency is a body of individuals, the agency head, unless prohibited by law, may designate one or more members of the agency head to serve as presiding officer and to render a final order in the proceeding.

History: L. 1984, ch. 313, § 14; L. 1995, ch. 175, § 2; L. 1997, ch. 182, § 92; July 1, 1998.

77-518. Notice of hearing. (a) The presiding officer for the hearing shall set the time and place of the hearing and give reasonable written notice at least 10 days prior to the hearing to all parties and to all persons who have filed written petitions to intervene in the matter. Service of notices shall be made in accordance with K.S.A. 77-531 and amendments thereto.

(b) The notice shall include a copy of any prehearing order rendered in the matter.

(c) To the extent not included in a prehearing order accompanying it, the notice shall include:

(1) The names and mailing addresses of all parties and other persons to whom notice is being given by the presiding officer;

(2) the name, official title, mailing address and telephone number of any counsel or employee who has been designated to appear for the state agency;

(3) the official file or other reference number, the name of the proceeding and a general description of the subject matter;

(4) a statement of the time, place and nature of the hearing;

(5) a statement of the legal authority and jurisdiction under which the hearing is to be held;

(6) the name, official title, mailing address and telephone number of the presiding officer;

(7) a statement of the issues involved and, to the extent known to the presiding officer, of the matters asserted by the parties; and

(8) a statement that a party who fails to attend or participate in a prehearing conference, hearing or other stage of an adjudicative proceeding may be held in default under this act.

(d) The notice may include any other matters the presiding officer considers desirable to expedite the proceedings.

(e) The state agency shall cause notice to be given to persons entitled to notice under any provision of law who have not been given notice under subsection (a) by the presiding officer. Notice under this subsection shall be given in the manner specified by such provision of law or, if no such manner is specified, in a manner to be determined by the agency. If a person other than the agency is directed to give notice under this subsection, the agency shall require that the person furnish proof that the notice has been given. Notice under this subsection may include all types of information provided in subsections (a) through (d) or may consist of a brief statement indicating the subject matter, parties, time, place and nature of the hearing, manner in which copies of the notice to the parties may be inspected and copied and name and telephone number of the presiding officer.

History: L. 1984, ch. 313, § 18; L. 1988, ch. 356, § 8; L. 1997, ch. 182, § 93; July 1, 1998.

CASE ANNOTATIONS

2. Not necessary to furnish additional notice following amendment of rate application where description of proceeding did not become misleading. Farmland Industries, Inc. v. Kansas Corporation Comm'n, 24 K.A.2d 172, 174, 943 P.2d 470 (1997).

77-522.

Attorney General's Opinions:

Application of open meetings act and administrative procedure act to proceedings for determination of benefits of KPERS member before hearing officer and board of trustees. 97-40.

Open public records; board of accountancy; correspondence. 97-76.

77-523.

Attorney General's Opinions:

Application of open meetings act and administrative procedure act to proceedings for determination of benefits of KPERS member before hearing officer and board of trustees. 97-40.

77-527. Review of initial order; exceptions to reviewability. (a) The agency head, upon its own motion may, and upon petition by any party or when required by law shall, review initial order, except to the extent that:

(1) A provision of law precludes or limits state ency review of the initial order; or

(2) the agency head (A) determines to review some but not all issues, or not to exercise any review, (B) delegates its authority to review the initial order to one or more persons, unless such delegation is expressly prohibited by law, or (C) authorizes one or more persons to review the initial order, subject to further review by the agency head.

(b) A petition for review of an initial order must be filed with the agency head, or with any person designated for this purpose by rule and regulation of the state agency, within 15 days after service of the initial order. If the agency head on its own motion decides to review an initial order, the agency head shall give written notice of its intention to review the initial order within 15 days after its service. If the agency head determines not to review an initial order in response to a petition for review, the agency head shall, within 20 days after filing of the petition for review, serve on each party an order stating that review will not be exercised.

(c) The petition for review shall state its basis. If the agency head on its own motion gives notice of its intent to review an initial order, the agency d shall identify the issues that it intends to review.

(d) In reviewing an initial order, the agency head or designee shall exercise all the decision-making power that the agency head or designee would have had to render a final order had the agency head or designee presided over the hearing, except to the extent that the issues subject to review are limited by a provision of law or by the agency head or designee upon notice to all parties.

(e) The agency head or designee shall afford each party an opportunity to present briefs and may afford each party an opportunity to present oral argument.

(f) The agency head or designee shall render a final order disposing of the proceeding or remand the matter for further proceedings with instructions to the person who rendered the initial order. Upon remanding a matter, the agency head or designee may order such temporary relief as is authorized and appropriate.

(g) A final order or an order remanding the matter for further proceedings shall be rendered in writing and served within 30 days after receipt of briefs and oral argument unless that period is waived or extended with the written consent of all parties or for good cause shown.

(h) A final order or an order remanding the matter for further proceedings under this section shall identify any difference between this order and the initial order and shall state the facts of record which support any difference in findings of fact, state the source of law which supports any difference in legal conclusions, and state the policy reasons which support any difference in the exercise of discretion. A final order under this section shall include, or incorporate by express reference to the initial order, all the matters required by subsection (c) of K.S.A. 77-526, and amendments thereto.

(i) The agency head shall cause copies of the final order or order remanding the matter for further proceedings to be served on each party in the manner prescribed by K.S.A. 77-531, and amendments thereto.

(j) Unless a petition for reconsideration is a prerequisite for seeking judicial review, a final order under this section shall state the agency officer to receive service of a petition for judicial review on behalf of the agency.

History: L. 1984, ch. 313, § 27; L. 1988, ch. 356, § 14; L. 1995, ch. 175, § 6; L. 1997, ch. 182, § 94; July 1, 1998.

77-529. Reconsideration. (a) (1) Except as otherwise provided by paragraph (2), any party, within 15 days after service of a final order, may file a petition for reconsideration with the agency head, stating the specific grounds upon which relief is requested. The filing of the petition is not a prerequisite for seeking administrative or judicial review except as provided in K.S.A. 44-1010 and 44-1115, and amendments thereto, concerning orders of the Kansas human rights commission, K.S.A. 55-606 and 66-118b, and amendments thereto, concerning orders of the corporation commission and K.S.A. 74-2426, and amendments thereto, concerning orders of the board of tax appeals.

(2) Any party applying for an exemption under: (A) Section 13, of article 11 of the Kansas Constitution, or (B) K.S.A. 79-201a *Second*, and amendments thereto, for property constructed or purchased, in whole or in part, with the proceeds of revenue bonds under the authority of K.S.A. 12-1740 to 12-1749, inclusive, and amendments ereto, may file a petition for reconsideration h the state board of tax appeals within 30 days er service of a final order.

(b) Within 20 days after the filing of the petition, the agency head shall render a written order denying the petition, granting the petition and dissolving or modifying the final order, or granting the petition and setting the matter for further proceedings. The petition may be granted, in whole or in part, only if the agency head states, in the written order, findings of fact, conclusions of law and policy reasons for the decision if it is an exercise of the state agency's discretion, to justify the order. In proceedings before the Kansas corporation commission, the petition is deemed to have been denied if the agency head does not dispose of it within 30 days after the filing of the petition.

An order under this section shall be served on the parties in the manner prescribed by K.S.A. 77-531 and amendments thereto.

(c) Any order rendered upon reconsideration or any order denying a petition for reconsideration shall state the agency officer to receive service of a petition for judicial review on behalf of the agency.

(d) For the purposes of this section, "agency ad" shall include a presiding officer designated ccordance with subsection (g) of K.S.A. 77-4, and amendments thereto.

History: L. 1984, ch. 313, § 29; L. 1988, ch. 356, § 15; L. 1991, ch. 148, § 11; L. 1995, ch. 175, § 7; L. 1997, ch. 132, § 4; L. 1998, ch. 146, § 4; July 1.

CASE ANNOTATIONS

7. Supplemental issues in appellants' petition for reconsideration, with one exception, raised with sufficient specificity to meet statutory requirements. Citizens' Utility Ratepayer Bd. v. Kansas Corporation Comm'n, 24 K.A.2d 222, 227, 943 P.2d 494 (1997).

Article 6.—ACT FOR JUDICIAL REVIEW AND CIVIL ENFORCEMENT OF AGENCY ACTIONS

77-601.

Attorney General's Opinions:

Administrative procedures; separation of powers doctrine considered. 97-39.

CASE ANNOTATIONS

45. BOTA members replaced; previous order reversed on reconsideration upholding sales tax assessment; judicial deference due decision considered. In re Tax Appeal of Atchison Cablevision, 262 K. 223, 225, 936 P.2d 721 (1997).

46. Tariff properly construed in case alleging discrimination in failure to disclose and apply tariff to plaintiff manufacturer. Grindsted Products, Inc. v. Kansas Corporation Comm'n, 262 K. 294, 302, 937 P.2d 1 (1997).

77-603.

CASE ANNOTATIONS

12. When prison disciplinary proceedings subject to judicial review examined. Anderson v. McKune, 23 K.A.2d 803, 809, 937 P.2d 16 (1997).

77-618.

CASE ANNOTATIONS

10. Trial court did not err by considering affidavit not admitted during administrative hearing. Zorn v. Kansas Dept. of Revenue, 24 K.A.2d 749, 750, 953 P.2d 1053 (1998).

77-621.

CASE ANNOTATIONS

62. BOTA members replaced; previous order reversed on reconsideration upholding sales tax assessment; judicial deference due decision considered. In re Tax Appeal of Atchison Cablevision, 262 K. 223, 225, 936 P.2d 721 (1997).

63. Tariff properly construed in case alleging discrimination in failure to disclose and apply tariff to plaintiff manufacturer. Grindsted Products, Inc. v. Kansas Corporation Comm'n, 262 K. 294, 302, 937 P.2d 1 (1997).

64. Board's denial of application for reinstatement of license to practice medicine affirmed. Vakas v. Kansas Bd. of Healing Arts, 262 K. 889, 892, 941 P.2d 381 (1997).

65. Workers compensation board's finding reviewed for substantial competent evidence; uncontradicted evidence should generally be regarded as conclusive. Nance v. Harvey County, 23 K.A.2d 899, 901, 931 P.2d 1245 (1997).

66. A negative finding of fact is not appealable unless bias, passion or prejudice is found. Nance v. Harvey County, 263 K. 542, 551, 952 P.2d 411 (1997).

30-7-64

30-7-64. Definitions. (a) "Appellant" means an individual or entity that has requested a fair hearing from an agency decision affecting the individual or entity.

(b) "Applicant" means an individual who has applied for or requested assistance or benefits from a program administered by the agency.

(c) "Recipient" means an individual who is receiving assistance or benefits from a program administered by the agency. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

30-7-65 (1)

30-7-65. Notice to recipients of intended action. (a) (1) "Adequate notice" means a written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific policies supporting the action, explanation of the individual's right to request a fair hearing, and the circumstances under which assistance is continued if a hearing is requested.

(2) "Timely" means that the notice is mailed at least 10 days, including Saturdays, Sundays and legal holidays, before the date upon which the action would become effective.

(b) When the agency intends to take action to discontinue, terminate, suspend, or reduce assistance, timely and adequate notice shall be given by the agency, except as set forth in subsection (c) of this regulation.

(c) Under the following circumstances, timely notice shall not be required, but an adequate notice shall be sent by the agency not later than the date of action :

(1) when the agency has factual information confirming the death of a recipient or of the ADC payee and there is no relative available to serve as a new payee;

(2) when the agency receives a clear written statement signed by a recipient that the recipient no longer wishes assistance or that gives information which requires termination or reduction of assistance, and the recipient has indicated, in writing, an understanding that termination or reduction of assistance will be

the consequence of supplying the information;

(3) when the recipient has been admitted or committed to an institution, and further payments to that individual are not authorized by program regulations as long as the person resides in the institution;

(4) when the recipient has been placed in skilled nursing care, intermediate care, or long-term hospitalization;

(5) when the recipient's whereabouts are unknown and agency mail directed to the recipient has been returned by the post office indicating no known forwarding address. The check shall, however, be made available to the recipient if the recipient's whereabouts become known during the payment period covered by a returned check;

(6) when the agency has established that a recipient has been accepted for assistance in a new jurisdiction;

(7) when a child is removed from the home as a result of a judicial determination, or voluntarily placed in foster care by the child's legal guardian;

(8) when a change in the level of medical care is prescribed by the recipient-patient's physician;

(9) when a special allowance granted for a specific period is terminated and the recipient was informed in writing at the time the allowance was granted that it would automatically terminate at the end of the specified period;

(10) when the agency takes action because of information the recipient furnished in a monthly status report or because the

recipient has failed to submit a complete or a timely monthly status report without good cause; or

(11) when the recipient is disqualified due to fraud through:

(A) a court of appropriate jurisdiction;

(B) a disqualification hearing process in accordance with K.A.R. 30-7-102; or

(C) waiver of an administrative disqualification hearing in accordance with K.A.R. 30-7-103.

(d) This regulation shall take effect on and after January 1, 1997. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended July 1, 1991; amended Jan. 1, 1997.)

30-7-66 (1)

30-7-66. Continuation of assistance. (a) If the recipient requests a hearing within the timely notice period as required by K.A.R. 30-7-65, assistance shall not be suspended, reduced, discontinued, or terminated, (but is subject to recovery by the agency if its action is sustained), until an initial decision of the hearing officer is rendered in the matter, unless:

(1) The request for fair hearing concerns the suspension of program payments to a provider or the termination of a provider from program participation;

(2) the request for a fair hearing concerns a discontinued program or service;

(3) a determination is made by the hearing officer that the sole issue is one of federal or state law, regulation or policy, or change in federal or state law, regulation or policy and not one of incorrect grant computation; or

(4) a change affecting the recipient's assistance occurs while the hearing decision is pending and the recipient fails to request a hearing after notice of the change.

(b) The agency shall promptly inform the recipient in writing if assistance is to be discontinued pending the hearing decision.

(c) In any case where action was taken without timely notice, if the recipient requests a hearing within 10 days of the mailing of the notice of the action, and the agency determines that the action resulted from other than the application of federal or

state law or policy or a change in federal or state law, assistance shall be reinstated and continued until a decision is rendered in the matter except as set forth in (a)(1), (2), (3), or (4). The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

30-7-67

30-7-67. Administrative hearings section, hearing officer. The administrative hearings section shall administer the agency's fair hearing program. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

30-7-68. Request for fair hearing. (a) Unless preempted by federal law, a request for fair hearing shall be in writing and received by the agency within 30 days from the date the order or notice of action is mailed. Pursuant to K.S.A. 1988 Supp. 77-531, an additional three days shall be allowed if the notice or order is mailed.

(b) A request for fair hearing involving food stamps shall be received by the agency within 90 days from the date the notice of action is mailed. Pursuant to K.S.A. 1988 Supp. 77-531, an additional three days shall be allowed if the notice or order is mailed.

(c) The freedom to request a fair hearing shall not be limited or interfered with by the agency. The effective date of this regulation shall be January 1, 1990. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1989, Ch. 283, Sec. 21; effective July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990.)

30-7-68

30-7-68. Request for fair hearing. (a) Unless preempted by federal law, a request for fair hearing shall be in writing and received by the agency within 30 days from the date of the order or notice of action. Pursuant to K.S.A. 77-531, an additional three days shall be allowed if the notice or order is mailed.

(b) A request for fair hearing involving food stamps shall be received by the agency within 90 days from the date of the notice of action. Pursuant to K.S.A. 77-531, an additional three days shall be allowed if the notice or order is mailed.

(c) The freedom to request a fair hearing shall not be limited or interfered with by the agency. The effective date of this regulation shall be January 2, 1991. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended Oct. 1, 1989; amended Jan. 2, 1990; amended Jan. 7, 1991.)

30-7-60. Pre-appeal administrative remedies. (a) A pre-appeal administrative remedy is any procedure or process, the purpose of which is to encourage settlement or otherwise resolve the dispute before appeal to the administrative hearings section.

(b) Pre-appeal administrative remedies are to be encouraged to promote the resolution of disputes between the parties involved. Pre-appeal administrative remedies may also be used by the parties to narrow and define the issues to be appealed to the administrative hearings section. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3306; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 303; effective July 1, 1989.)

30-7-70

30-7-70. Agency's review of decision. (a) Upon receipt of notice that a request for fair hearing has been made, the agency shall review its action or decision. Upon reconsideration, the agency may amend or change its action or decision before or during the hearing.

(b) If a satisfactory adjustment is reached prior to the hearing, the agency shall submit a report to the hearing officer, in writing, but the appeal shall remain pending until the appellant submits a signed, written statement withdrawing the appellant's request for fair hearing. If the appellant fails to timely submit a signed, written statement withdrawing the request for fair hearing, the hearing officer may dismiss the request for fair hearing. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

30-7-71

30-7-71. Venue. (a) Fair hearings for applicants or recipients shall be held in the social and rehabilitation services' administrative area in which the applicant or recipient resides unless another site has been designated by the hearing officer or the hearing is conducted pursuant to the provisions of K.A.R. 30-7-72.

(b) Fair hearings for other appellants shall be held in Topeka, Kansas unless another site has been designated by the hearing officer or the hearing is conducted pursuant to the provisions of K.A.R. 30-7-72. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

30-7-72

30-7-72. Telephone hearings. The hearing officer may conduct the fair hearing or any prehearing by telephone or other electronic means if each participant in the hearing or prehearing has an opportunity to participate in the entire proceeding while the proceeding is taking place. A party may be granted a face to face hearing or prehearing if good cause can be shown that a fair and impartial hearing or prehearing could not be conducted by telephone or other electronic means. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

30-7-73

30-7-73. Summary reversals. The hearing officer may, without notice or hearing, summarily reverse the agency's decision or action in the matter if it is clear from the agency's summary that the agency's decision or action was incorrect. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1988, Ch. 356, Sec. 302; effective July 1, 1989.)

30-7-74

30-7-74. Independent medical, psychiatric and psychological examinations. When the hearing involves medical, psychiatric or psychological issues, the hearing officer may order on the hearing officer's own motion that an independent medical, psychiatric or psychological assessment other than that of the person or persons involved in making the original decision shall be obtained at agency expense and made part of the record if the hearing officer considers it necessary. If a party requests the independent assessment, that party shall pay the costs incurred in obtaining the assessment. If the party requesting the assessment signs a poverty affidavit, the independent medical, psychiatric or psychological assessment shall be performed at agency expense. The effective date of this regulation shall be July 1, 1989. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306, as amended by L. 1983, Ch. 356, Sec. 302; effective July 1, 1989.)

30-7-75. Agency's summary. Within 15 days after notification of the request for fair hearing the agency shall furnish the appellant and the administrative hearings section with a summary setting forth the following information:

(a) Name and address of the appellant;

(b) a summary statement concerning why the appellant is filing a request for a fair hearing;

(c) a brief chronological summary of the agency's action in relationship to the appellant's request for a fair hearing;

(d) a statement of the basis of the agency's decision;

(e) a citation of the applicable policies relied upon by the agency;

(f) a copy of the notice which notified appellant of the decision in question;

(g) applicable correspondence; and

(h) the name and title of the person or persons who will represent the agency at the hearing. The effective date of this regulation shall be July 1, 1991. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended July 1, 1991.)

30-7-76. Transcripts. (a) A transcript of the hearing may be prepared if requested by an appellant, the agency, the hearing officer, the state appeals committee or the secretary. The party requesting the transcript or review of the hearing officer's decision shall pay any costs associated in obtaining a transcript.

(b) If an appellant requests a transcript, the agency shall pay the costs of transcribing the recording if the appellant signs a poverty affidavit.

(c) If a transcript is prepared, the reporter shall sign the following certification on all copies: "This is to certify that

_____ conducted a
Name of Hearing Officer

hearing on the application of _____
Name of Appellant

in _____ county, state of Kansas, on _____
Date

at _____ and that the foregoing is a true and correct transcript of the record of the hearing."

_____
Signature of Reporter

The effective date of this regulation shall be January 2, 1992. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended Jan. 2, 1992.)

30-7-77. Rehearing. (a) Any party, within 15 days after service of the hearing officer's decision, may file a petition for rehearing with the administrative hearings section, stating the specific grounds upon which the rehearing of the hearing officer's decision is requested.

(b) A rehearing may be granted to either party on all or part of the issues when it appears that the rights of the party are substantially affected because:

(1) Of an erroneous ruling of the hearing officer;

(2) the decision in whole or in part is contrary to the evidence; or

(3) of newly discovered evidence which the moving party could not with reasonable diligence have discovered or produced at the hearing.

(c) The filing of a petition for rehearing is not a prerequisite for review at any stage of the proceedings. The filing of a petition for rehearing does not stay any time limits or further proceedings that may be conducted under the Kansas administrative procedures act, K.S.A. 77-501 et seq. and amendments thereto, or any other provision of law. The effective date of this regulation shall be January 2, 1992. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended Jan. 2, 1992.)

30-7-78. State appeals committee. (a) The secretary may appoint one or more state appeals committees to review the decisions or orders of hearing officers.

(b) The committees shall consist of three impartial persons.

(c) Decisions of the committee shall be by majority vote.

(d) The record, as defined in K.S.A. 77-532, shall be the basis for the state appeals committee review. The effective date of this regulation shall be January 2, 1992. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective July 1, 1989; amended Jan. 2, 1992.)

30-7-79

30-7-79. Motions. (a) Motions, unless made during a hearing, shall:

(1) Be in writing; and

(2) state with particularity their bases.

(b) The opposing party shall have 15 days from the date of mailing or personal delivery within which to file a response. The hearing officer may waive the deadline for good cause.

(c) The hearing officer on his or her own motion or at the request of either party may conduct a hearing on the motion. A party requesting a hearing shall include the request in the motion or response. The effective date of this regulation shall be August 1, 1990. (Authorized by K.S.A. 75-3304; implementing K.S.A. 75-3306; effective Aug. 1, 1990.)

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Reserve for future use.

DEC 13 2002

Public process for proposed changes in NF and NF/MH payment rates or payment methodologies. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.