DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: SPA #04-10

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 2005 $ 0
b. FFY 2006 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 30 & 31

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 30, 31& 32

10. SUBJECT OF AMENDMENT:
Disproportionate Share Payments

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Gary J. Daniels is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
Gary J. Daniels

14. TITLE:
Acting Secretary of Social & Rehabilitation Services

15. DATE SUBMITTED:
February 28, 2005

16. RETURN TO:
Gary J. Daniels, Acting Secretary
Secretary of Social & Rehabilitation Services
Docking State Office Building
915 SW Harrison, Room 651S
Topeka, KS 66612-1570

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: SEP 24 2004

18. DATE APPROVED: MAY 10 2005

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL: Jackie Garner

21. TYPED NAME: JACKIE GARNER

22. TITLE: DEPUTY DIRECTOR, CMSO

23. REMARKS:

# Disproportionate Share Low-Income Utilization

**All data on this schedule, except where specifically noted, should only include hospital inpatient data. Do not include SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory sugical center, hospice or non-reimbursable cost centers. Although specific line numbers from the Medicare Cost Reports are given, if blank lines on the Medicare Cost Report are used by the hospital, the blank lines should also be included or excluded, as appropriate, where there are similar references.**

**Hospital Name** _____

**Kansas Medicaid Number** _____ **Fiscal Year Ending** _____

**A1** **Medicaid/Medikan inpatient payments for the most recent available hospital fiscal year, excluding disproportionate share payemnts. Contact Health Care Policy (785-296-3981) for a log summary.** _____

**A1a** **Medicaid/MediKan outpatient payments for the most recent available hospital fiscal year. Outpatient payments only includes payments made to the hospital for outpatient services.** _____

**Other State and local government income. Provide source and description. Disproportionate share payments should not be included here. (Medicare Worksheet G-3, Governmental appropriations (Line 23))**

**A2** _____

**A3** **Total Medicaid/Medikan, State and local government funds. (A1 + A1a + A2)** _____

**A4** **Inpatient Revenues (Medicare Worksheet G-2 Column 1, Total Inpatient Routine Care Services (Line 16) + Ancillary (Line 17) + Outpatient (Line 18) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU (Line 8)-other appropriate lines)** _____

**A5** **Total patient revenues (Medicare Worksheet G-2, Line 25, Column 3)** _____

**A6** **Ratio of inpatient revenues to total patient revenues (A4 ) A5)** _____

**A7** **Contractual Allowances and discounts (Medicare Worksheet G-3, Line 2)** _____

**A8** **Inpatient share of contractual allowances and discounts (A6 H A7)** _____

**A9** **Net inpatient revenue (A4 - A8)** _____

**A10** **Ratio of Medicaid/Medikan, State and local government funds to net inpatient revenue (A3 ) A9)** _____

**B1** **Inpatient charity care charges. 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 spendown incurred by a Medicaid recipient 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 allowance) or third party or employee discounts. Information to support this number must be maintained by the hospital and is subject to review.** _____

**B1a** **Outpatient charity care charges. Outpatient services only includes services provided by the hospital and reported in the Medicare cost report as outpatient services. All other requirements in B1 apply here.** _____

**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 H 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) - Ambulance (Line 65) - DME (Line 66 & 67) - Medicare (Line 69) - Unapproved Teaching (Line 70) - HHA (Line 71 through 81) - CORF (Line 82) - HHA (Line 89 & 90) - ASC (Line 92) - Hospice (Line 93)) | _____ |
| B6 - | Hospital revenue (Medicare Worksheet G2, Column3, Total Patient Revenue (Line 25) - Swing Bed (Line 4 & 5) SNF (Line 6) - ICF (Line 7) - LTCU(Line 8) - HHA (Line 19) - Ambulance (Line 20) - CORF (Line 21) - ASC(Line 22) - Hospice (Line 23)) | _____ |
| 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 (B1 + B1a - B8 (if negative use 0)) | _____ |
| B10 | Ratio of unduplicated charity care to total inpatient revenue (B9 ) A4) | _____ |
| C1 | Low-Income utilization rate (A10 + B10) | _____ |

Section D only applies if C1 exceeds 0.25 and there is a minimum 1% Medicaid utilization.

| | | |
|---|---|---|
| D1 | Hospital Limitation. All hospital are limited to no more than 100% of their net Medicaid cost plus the cost of the uninsured. The uninsured are only those patients shown in charity care (B1) for which no other payment is received. Report the uninsured here. Do not report Medicaid here. This line must be completed or no disproportionate share payments will be made. | _____ |
| D2 | Cost of the uninsured (D1 x B7) | _____ |
| 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) | _____ |
| D6 | Kansas portion of the uninsured (D2 X D5) | _____ |
| D7 | Loss/Gain on Inpatient Kansas Medicaid payments (computed by Medicaid) | _____ |
| D7a | Loss/Gain on Outpatient Kansas Medicaid Payments (computed by Medicaid) | _____ |
| D8 | Estimated Disproportionate Share Payments prior to federal allotment (D6 + D7 + D7a) | _____ |

I declare that I have examined this statement, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the books maintained by the facility. I understand that the misrepresentation or falsification of any information set forth in this statement may be prosecuted under applicable Federal and/or State law.

_____
Signature of Officer/Administrator

_____ _____
Title Date