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 or related party 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 2005, 2006, and 2007.

If the current provider has not submitted a calendar year report between 2005 and 2007, 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 12/31/08. The resident days and inflation factors used in the rate determination will be explained in greater detail in the following sections.

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

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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 should be considered in determining 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, the real and personal property fee, and per diem pass-throughs to cover costs not included in the cost report data. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. Pass-throughs are explained in separate subparts of Attachment 4.19D of the State Plan. 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 12/31/08. 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 12/31/08. 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.

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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 2005 to 2007. 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 12/31/08. 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 12/31/08. 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 2005.

All cost data used to set rates for facilities reentering the program shall be adjusted to 12/31/08. 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 12/31/08. 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.

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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.

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 Indirect Health Care cost center less food and utilities. All licensed beds are required to be certified to participate in the Medicaid program.

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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 12/31/08. 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

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).

6) Upper Payment Limits

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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 2007 historic cost reports in the 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.

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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 property fees in effect July 1, 2008.

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.

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.

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Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted from the midpoint of the cost report period to 12/31/08. 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 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.

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The Medicaid Acuity Adjustment is calculated quarterly to account for changes in the Medicaid CMI. To illustrate this calculation take the following situation: The facility's direct health care per diem cost is $60.00, the Direct Health Care per diem limit is $72.00, and these are both tied to a statewide average CMI of 1.000, and the facility's 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, 2008 were inflated with 12 months of inflation effective July 1, 2008. The inflation factor was from the Data Resources, Inc.-WEFA, National Skilled Nursing Facility Total Market Basket Index (DRI Index). The providers receive 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 to 12/31/08

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 Incentive Factor is a per diem amount determined by six per diem add-ons providers can earn for various outcomes measures. Providers that maintain a case mix adjusted staffing ratio at or above the 75th percentile will earn a $1.00 per diem add-on. Providers that fall below the 75th percentile staffing ratio but improve their staffing ratio by 10% or more will earn a $0.10 per diem add-on. Providers that achieve a turnover rate at or below the 75th percentile will earn a $1.00 per diem add-on. Providers that have a turnover rate greater than the 75th percentile but that reduce their turnover rate by 10% or more will receive a per diem add-on of $0.10. Providers that have completed the full Kansas Culture Change Instrument Survey will receive a $0.15 per diem add-on. Finally, providers that have a Medicaid occupancy percentage of 60% or more will

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receive a $0.45 per diem add-on. The total of all the per diem add-ons a provider qualifies for will be their incentive factor.

The table below summarizes the incentive factor outcomes and per diem add-ons:

Incentive Outcome:	Incentive Points:
1) CMI adjusted staffing ratio $\geq 75^{th}$ percentile (4.72) or	$ 1.00
CMI adjusted staffing $< 75^{th}$ percentile but improved $\geq 10\%$	0.10
2) Staff turnover rate $\leq 75^{th}$ percentile (38%) or	1.00
Staff turnover rate $> 75^{th}$ percentile but reduced $\geq 10\%$	0.10
3) Completion of the full Kansas Culture Change Instrument Survey	0.15
4) Medicaid occupancy $\geq 60\%$	0.45
Total Incentive Per Diem Add-on Available	$ 2.60

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 three 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.

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 3.50, 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 3.21, which is 110% of the statewide NFMH median. Providers with staffing

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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 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 $21.97, or 90% of the statewide median of $24.41

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 38%, 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 greater than 38% but equal to or below 49%, 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 76%, the 75th percentile statewide will earn two points. Providers with staff retention rates at or above 71%, 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% (3.50) of state median (2.91), or CMI adjusted staffing ratio between 110% (3.21) and 120%	2, or 1
2) Total occupancy < 90%	1
3) Operating expenses < $21.97, 90% of NFMH median ($24.41)	1
4) Staff turnover rate at or better than the 75th percentile, 38% Staff turnover rate > 38% but at or better than the 50th percentile, 49% Contracted labor < 10% of total direct health care labor costs	2, or 1
5) Staff retention ≥ 75th percentile, 76% Staff retention ≥ 50th percentile, 71%	2, or 1
Total Incentive Points Available	8

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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: 6-8 points	$3.00
Tier 2: 5 points	$2.00
Tier 3: 4 points	$1.00
Tier 4: 0-3 points	$0.00

The survey and certification performance of each NF and NF-MH provider will be reviewed prior to any incentive factor payment. In order to qualify for the incentive factor a home must not have received any health care survey deficiency of scope and severity level "H" or higher during the survey review period. Homes that receive "G" level deficiencies, but no "H" level or higher deficiencies, and that correct the "G" level deficiencies within 30 days of the survey, will receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level "F" will receive 100% of the calculated incentive factor. The survey and certification review period will be the 15-month period ending one quarter prior to the rate effective date. The following table lists the rate effective dates and corresponding review period end dates.

Rate Effective Date:	Review Period End Date:
July 1	March 31st
October 1	June 30th
January 1	September 30th
April 1	December 31st

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

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

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.

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.

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/09
NF ONLY

	QUALITY/EFFICIENCY OUTCOME	INCENTIVE PER DIEM
1	CMI adjusted staffing ratio ≥ 75th percentile (4.72) or	$1.00
	CMI adjusted staffing < 75th percentile but improved ≥ 10%	$0.10
2	Staff turnover rate ≤ 75th percentile (38%) or	$1.00
	Staff turnover rate > 75th percentile but reduced ≥ 10%	$0.10
3	Completion of the full Kansas Culture Change Instrument Survey	$0.15
4	Medicaid occupancy ≥ 60%	$0.45
	Total Incentive Per Diem Add-on Available	$2.60

JAN 11 2010

June 23, 2009

Administrator
«FAC_NAME»
«FAC_ADDRES»
«CITY», KS «ZIP»

Provider #: 104«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 2010 to our fiscal agent, Electronic Data Systems of Kansas. The rate will become effective July 1, 2009.

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 2008) 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 Chris Chase or call her at (785) 296-0703. She can also be reached via electronic mail at Chris.Chase@aging.ks.gov. For questions concerning desk review adjustments please contact Craig Kammen, Audit Manager, at (785) 296-6457 or by email at Craig.Kammen@aging.ks.gov.

Sincerely,

Amanda Barta, Reimbursement Manager
NF/CARE Programs
Program and Policy Commission

AB:ckc
Enclosures

June 23, 2009

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 2010 to our fiscal agent, Electronic Data Systems of Kansas. The rate will become effective July 1, 2009.

The Kansas Department on Aging (KDOA), administers the Medicaid nursing facility services payment program on behalf of KHPA. The rate was calculated by applying the appropriate Medicaid program policies and regulations to the cost report (Form MS 2008) 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 Craig.Kammen@aging.ks.gov.

Sincerely,

Lise Ullery
Fiscal Coordinator

Enclosures

JAN 15 2010

COMPILATION OF INCENTIVE POINTS AWARDED
EFF. 07/01/09

NURSING FACILITY

	INCENTIVE AMOUNT AWARDED	# OF PROVIDERS	PERCENTAGE
Staffing ≥ 75th	$1.00	63	19.5%
Staffing < 75th, improved 10%	$0.10	34	10.5%
Turnover ≤ 75th	$1.00	74	22.9%
Turnover > 75th, improved 10%	$0.10	122	37.8%
KCCI completion	$0.15	100	31.0%
Medicaid occupancy	$0.45	233	72.1%
No Incentive Received	$0.00	17	5.3%
Total Facilities		323	

NURSING FACILITY MENTAL HEALTH

INCENTIVE POINTS AWARDED	# OF PROVIDERS	PERCENTAGE
0	1	9.1%
1	2	18.2%
2	3	27.3%
3	1	9.1%
4	1	9.1%
5	2	18.2%
6	0	0.0%
7	1	9.1%
8	0	0.0%
TOTALS	11	100.0%

Kansas Medicaid / MediKan

Case Mix Schedule
1st QTR 2010

Current Provider Information

Provider Number:	EDS Provider Number:	Medicaid CMI:	0.9355 [a]
Facility Name:	Area/County:	Medicare CMI:	0.0000
Address:		Private Pay/Other CMI:	0.9011
City/State/Zip:			
Administrator:			

Cost Report Statistics

Calendar Year Cost Reports Used For Base Data:	12/31/05	12/31/06	12/31/07	
Inflation Factor:	13.443%	8.874%	5.488%	
Facility Cost Report Period CMI:	0.9406	0.8933	0.9389	
Statewide Average CMI:	0.9638	0.9772	0.9878	0.9763 [b]
NF Or NF/MH Beds:	49	49	49	
Bed Days Available:	18,971	17,885	17,885	
Inpatient Days:	15,908	16,070	16,189	
Occupancy Rate:	83.9%	89.9%	90.5%	
Medicaid Days:	7,319	7,561	8,059	
Calc Days If Appl:	0	0	0	

Calculation of Combined Base Year Reimbursement Rate

Operating

Total Reported Costs:	$403,230	$376,820	$459,768		
Cost Report Adjustments:	$0	$0	$0		
O/A Limit Adjustment:	$0	$0	$0		
Total Adjusted Costs:	$403,230	$376,820	$459,768		
Total Inflated Adjusted Costs:	$456,995	$410,259	$485,000		
Total Combined Base Cost:				$1,352,255	
Days Used In Division Oper:	15,908	16,070	16,189	48,167	
				28.07	Oper Per Diem
				28.82	Oper Per Diem Cost Limitation
				28.07	Oper Per Diem Rate (1)

Indirect Health Care

Total Reported Costs:	$710,635	$708,934	$728,157		
Cost Report Adjustments:	$0	$0	$0		
Total Adjusted Costs:	$710,635	$708,934	$728,157		
Total Inflated Adjusted Costs:	$806,165	$771,844	$768,118		
Total Combined Base Cost:				$2,346,129	
Days Used In Division IDHC:	15908	16,070	16,189	48,167	
				48.71	IDHC Per Diem
				41.64	IDHC Per Diem Cost Limitation
				41.64	IDHC Per Diem Rate (2)

Direct Health Care

Total Reported Costs:	$1,293,394	$1,185,499	$1,473,481		
Cost Report Adjustments:	$0	$0	$0		
Total Adjusted Costs:	$1,293,394	$1,185,499	$1,473,481		
Total Inflated Adjusted Costs:	$1,467,265	$1,290,700	$1,554,346		
Total CMI Adjusted Costs:	$1,503,455	$1,411,925	$1,635,299		
Total Combined Base Cost:				$4,550,679	
Days Used In Division DHC:	15,908	16,070	16,189	48,167	
				94.48	Case Mix Adjusted DHC Per Diem
				82.18	DHC Per Diem Cost Limitation
				82.18	Allowable DHC Per Diem Cost [c]
			[c]*([a]/[b])	78.75	Medicaid Acuity Adjustment (3)

Real and Personal Property Fee

6.60	Real and Personal Property Fee
0.00	Inflation (0.000%)
0.00	RPPF Rebase Add On
6.60	RPPF Before Limit
8.62	RPPF Limitation
6.82	Allowable RPPF (4)

Calculation of Medicaid Rate

Operating, IDHC, And DHC Rates and RPPF (1) +(2) + (3) +(4):		155.28
Incentive Factor		2.00
DME Pass Through		0.00
Minimum Wage Pass Through		0.00
Total Reimbursement Rate Calculated	07/01/2009	157.28
Private Pay Rate (Register)	02/01/2009	139.19
Private Pay Rate (Medicaid Adjustment)	02/01/2009	144.50
Total Medicaid Rate Effective	**07/01/2009**	**144.50**

Prepared by Myers and Stauffer on 07/01/2009

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

Provider Number:
EDS Provider Number:

Facility Name:

Rate Effective Date: 07/01/09

	Incentive Possible	Facility Stats	Incentive Awarded
1. Case Mix Adjusted Nurse Staff Ratio			
Tier 1: At or Above the NF 75th Percentile (4.72)	$ 1.00		$ 1.00
Tier 2: Below the NF 75th Percentile but Improved At or Above 10%	$ 0.10		$ 0.00
Cost Report Year Data:		5.95 12/31/2008	
2. Staff Turnover			
Tier 1: At or Below the NF 75th Percentile (38%)	$ 1.00		$ 1.00
Tier 2: Above the NF 75th Percentile but Reduced At or Above 10%	$ 0.10		$ 0.00
And Contract Nursing Labor Less than 10% of total DHC Labor Costs			
Cost Report Year Data:		27% 12/31/2008	
3. Completion of the full Kansas Culture Change Instrument Survey	$ 0.15		$ 0.15
4. Occupancy Rate			
Medicaid Occupancy At or Above 60%	$ 0.45		$ 0.45
Cost Report Year Data:		85% 12/31/2008	
Total Incentive before Survey Adjustment			$ 2.60
Survey Adjustment and Reduction 0%			$ 0.00
Final Incentive Awarded			**$ 2.60**

JAN 15 2010

Methods and Standards for Establishing Payment Rates
Skilled Nursing and Intermediate Care Facility Rates
(NFs and NFs-MH)

Minimum Wage Pass-Through
for New Minimum Wage Effective July 1, 2010

To compensate providers for increased expenses incurred to raise employee's wages to the new minimum wage effective July 1, 2009 ($7.25), a per diem pass-through will be determined and added on to each qualifying provider's per diem rate. The pass-through per diem will not be subject to cost center limits, and the 85% occupancy rule will not be applied to the calculation of the minimum wage pass-through.

Qualifying Providers

In order to qualify for the minimum wage pass-through, a provider must submit a pass-through application on the forms provided by the Kansas Department on Aging. The application will document the hourly wages of all affected employees prior to the implementation of the new minimum wage. Wage increases made prior to June 1, 2009 will not be eligible for the minimum wage pass-through. Providers will also estimate and report the number of hours each affected employee is expected to work during state fiscal year 2010 (the twelve months beginning July 1, 2009 and ending June 30, 2010). Completed applications must be returned to the Kansas Department prior to September 30, 2009.

Per Diem Pass-Through Calculation

The per diem pass-through will be determined by first estimating the total impact of increasing wages to the new minimum wage, and then dividing by resident days to get a per diem add-on. The total impact of increasing wages to the new minimum wage will be determined for each provider through three steps. First the incremental wage increase to the new minimum wage will be calculated for each affected employee. Second the individual impact for each affected employee will be determined by multiplying the incremental wage increase by the estimated hours each affected employee is expected to work during fiscal year 2010. Finally the total impact of the minimum wage increase for each provider will be the sum of the individual impacts determined for each employee. A per diem pass-through add-on will then be calculated by dividing each provider's estimated total impact by the provider's 2008 resident day total.

As an example, consider an employer that has ten employees receiving a wage of $6.55 prior to July 1, 2009. If the employer raises their wages effective July 1, 2009, the incremental wage increase due to the new minimum wage will be $0.70. If each employee is expected to work 2,000 hours during fiscal year 2010, the total impact per employee will be $1,400 ($0.70 x 2,000 hrs). The total estimated impact for the provider will be $14,000 ($1,400 x 10). If the employer provided 10,000 resident days during 2007, the pass-through per diem will be $14,000/10,000 days, or $1.40.

Methods and Standards for Establishing Payment Rates
Skilled Nursing and Intermediate Care Facility Rates
(NFs and NFs-MH)

Minimum Wage Pass-Through
for New Minimum Wage Effective July 1, 2010

Per Diem Limits

No per diem add-on will be implemented that is not equal to or greater than $0.10.

Effective Dates

Pass-through applications received prior to June 30, 2009 will be effective July 1, 2009. After that date, each provider's per diem pass-through will be effective on the first day of the month following the receipt of a completed application. No pass-through per diems will be implemented after October 1, 2009.

Phasing Out the Pass-Through

The per diem pass-through is intended to be phased out as the effects of the minimum wage increase are reflected in the cost reports. This will be determined on a facility-specific basis reflecting the ratio of cost data that includes the new minimum wage costs.

For example, a provider that incurs a new expense for raising wages to the minimum wage on July 1, 2009, will have six months of that new cost reflected in their 2009 cost report. All cost reports prior to 2009 would not reflect any impact for the July 1, 2009 wage increases. Therefore if rates were determined using the 2007, 2008, and 2009 cost reports, only 6 months of the cost report data would reflect the new costs associated with the minimum wage increase. Thus the ratio of cost data that includes the new minimum wage costs would be 6 months out of 36 months, or 1/6. In this case the pass-through per diem would be reduced by 1/6 of its original amount.

All cost reports after 2009 should reflect a full 12 months of the impact of the new costs. Therefore if rates were set using the 2008, 2009, and 2010 cost reports, 18 months of the cost report data would reflect the new costs associated with the minimum wage increase. Thus the ratio of cost data that includes the new minimum wage costs would be 18 months out of 36 months, or 1/2. In this case the pass-through per diem would be reduced by 1/2 of its original amount.

During the phasing out of the minimum wage pass-through, if the per diem add-on falls below $0.10, it will be removed from the rate calculation.

This same methodology will be used to phase-out all prior minimum wage pass-throughs. Pass-through amounts for different years will be phased out separately.

State of Kansas Department of Aging

Minimum Wage Pass-Through Application
For Wage Enhancements Effective July 1, 2009

Provider Information

Provider Name:	Provider Number:
Street Address or Post Office Box:	Phone Number:
City:	Zip Code:

(1) Employee Name	(2) Social Security #	(3) POS.	(4) Enhanced Hrly Rate	(5) Prior Hrly Rate	(6) Enhance-ment	(7) Estimated Hrs Worked	(8) Est. Cost
			7.25				
			7.25				
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			7.25				

Subtotal of Minimum Wage Enhancements	(9)	
Added Benefits Costs of Minimum Wage Enhancements	(10)	
Total Costs for Minimum Wage Enhancements	(11)	
Resident Days (2008 or most recent cost report)	(12)	
Per Diem Amount	(13)	

JAN 1 [illegible] 2010

Instructions for Completing Minimum Wage Pass-Through Application

(1) Employee Name — The employee's name as it appears on the payroll register.

(2) Social Security # — The employee's social securtiy number.

(3) Position — The employee's position classification. Please select one of the following codes using the drop-down menu.

- AS Activity Staff
- DT Dietary Personnel
- HK Housekeeping Personnel
- LP Laundry Personnel
- LM Licensed Mental Health Technician
- MA Medication Aide
- NA Nurse Aide
- PO Plant Operating Personnel
- RA Restorative/Rehabilitative Aide
- UW Universal Worker
- O Other

(4) Enhanced Hrly Rt — Emplyee's enhanced hourly rate of pay.

(5) Prior Hrly Rt — Employee's hourly rate of pay before enhancement.

(6) Enhancement — Hourly rate enhancement. Column 5 - Column 6.

(7) Estimated Hrs Worked — Hours worked at enhanced rate of pay for this quarter.

(8) Total Enhancement — Total enhancement amount paid to this employee for this quarter. Column 8 multiplied by column 7.

(9) Subtotal of Enhancements — Total of all enhancement amounts listed in column 9.

(10) Added Benefits Cost of Enhancements — Added costs of Social Security, unemployment insurance contributions, retirement benefits etc., caused by increasing the employees' wages. Use the Benefits Costs Schedule below to calculate this cost.

Benefits Costs Schedule

Subtotal of Enhancements (Amount on line 9 of report) _____

Employer Percentage of Benefits x _____
Enter the emplyer's percentage of benefits and payroll taxes in decimal form(15% = 0.15). This includes the Social Security Tax(FICA), the unemployment insurance contributions, retirement benefits etc. It is acceptable to divide the total benefit lines by the total salary lines in the last cost report (MS2004) submitted, to determine the employer's benefits percentage.

(10) Added Benefits Costs of Wage Enhancements _____
Product of Subtotal of Enhancements and Employer Percentage of Benefits

(11) Total Costs for Minimum Wage Enhancements — Sum of Line 9 and 10. The total costs of wage enhancements and added benefits costs caused by these enhancements.

(12) Resident Days — Total resident days reported on line 48 of the 2008 cost report (or the most recent cost report filed).

(13) Per Diem Amount — Line (11) divided by Line (12)

OS Notification

State/Title/Plan Number: Kansas 09-003

Type of Action: SPA Approval

Required Date for State Notification: 2/03/2010

Fiscal Impact: FFY 09 ($930,000) FFY 10 ($2,790,000)

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

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

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

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:
Effective July 1, 2009, this amendment modifies the methodology for Nursing Facility payments. Specifically, under this amendment: Inflation of base period costs is being limited to 12/31/08 when previously costs would have been inflated to the midpoint of the rate year (12/31/09); the components of the Quality and Efficiency Incentive plan are being modified; and a minimum wage pass through is being implemented for the minimum wage increase that was effective 7/1/09.

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

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

CMS Contact:
Tim Weidler (816) 426-6429
National Institutional Reimbursement Team