Table of Contents

State/Territory Name: KS

State Plan Amendment (SPA) #: 18-0010

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

April 15, 2019

Christiane Swartz
Deputy Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

RE: Kansas Medicaid State Plan Amendment TN: 18-0010

Dear Ms. Swartz:

We have reviewed the proposed amendment (SPA) to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 18-0010. This amendment rebases Nursing Facility and Nursing Facility for Mental Health payment rates for state fiscal year 2019. This SPA also updates charts and exhibits with the State plan that demonstrate the revised factors and limits applicable to the rate period beginning with SFY 2019. Changes are also made to the Nursing Facility Quality and Efficiency Incentive Factors.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 18-0010 is approved effective July 1, 2018. We are enclosing the CMS-179 and the amended plan page.

If you have any questions, please call Tim Weidler at (816) 426-6429.

Sincerely,

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: KS 18-0010

2. STATE: Kansas

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.201, 42 CFR 442.10

7. FEDERAL BUDGET IMPACT
a. FFY 2018 $ 4,288,849
b. FFY 2019 $ 12,530,063

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19D Part I Subpart C Exhibit C-1 Page 1, 2, 3, 4, 5, 7, 8, 9, 11, 12, 13, 13a (new), 13b (new), 14, 15, 17a, 18, 19
Attachment 4.19D Part I Subpart C Exhibit C-2 Page 1, 2, 3, 3a, 3b, 3c, 4, 5
Attachment 4.19D Part I Subpart C Exhibit C-3 Page 1, 2, 3, 3a
Attachment 4.19D Part I Subpart C Exhibit C-4 Page 1
Attachment 4.19D Part I Subpart C Exhibit C-5 Page 1, 2, 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19D Part I Subpart C Exhibit C-1 Page 1, 2, 3, 4, 5, 7, 8, 9, 11, 12, 13, 14, 15, 17a, 18, 19
Attachment 4.19D Part I Subpart C Exhibit C-2 Page 1, 2, 3, 3a, 3b, 3c, 4, 5
Attachment 4.19D Part I Subpart C Exhibit C-3 Page 1, 2, 3, 3a
Attachment 4.19D Part I Subpart C Exhibit C-4 Page 1, 2 (removal)
Attachment 4.19D Part I Subpart C Exhibit C-5 Page 1, 2, 3

10. SUBJECT OF AMENDMENT
Methods and Standard for Establishing Payment Rates: Nursing Facilities and Nursing Facilities for Mental Health

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
☒ OTHER, AS SPECIFIED: Christiane Swartz is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Christiane Swartz

14. TITLE
Deputy Medicaid Director, Division of Health Care Finance

15. DATE SUBMITTED
September 25, 2018

16. RETURN TO
Christiane Swartz, Deputy Medicaid Director
KDHE, Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED
APR 15 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
JUL 01 2018

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
Kristin Fan

22. TITLE
Director, FMG

23. REMARKS

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 eleven 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, and Retroactive Rate Adjustments.

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.) 129-10-17. 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. 129-10-17.

When a non-arm's 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. 129-10-17.

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 2015, 2016, and 2017.

If the current provider has not submitted a calendar year report during the base cost period, 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. 129-10-18.

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 July 31, 2018. 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 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. 129-10-17.

The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to July 31, 2018. This adjustment will be based on the IHS Global Insight, National Skilled Nursing Facility Market Basket Without Capital Index (IHS Index). The IHS 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 July 31, 2018. 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 2015 to 2017. 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 July 31, 2018. This adjustment will be based on the IHS Index. The IHS 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 July 31, 2018. 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 the base cost data period.

All cost data used to set rates for facilities reentering the program shall be adjusted to July 31, 2018. This adjustment will be based on the IHS Index. The IHS 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 July 31, 2018. 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

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

Narrative Explanation of Nursing Facility Reimbursement Formula

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 5.20, 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 5.20 (Set D01) case mix indices developed by the Centers for Medicare and Medicaid Services (CMS) 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.

Rates will be adjusted for case mix twice annually using case mix data from the two quarters preceding the rate effective date. The case mix averages used for the rate adjustments will be the simple average of the case mix averages for each quarter. 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.

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 July 31, 2018. The inflation will be based on the IHS Global Insight, CMS Nursing Home without Capital Market Basket index.

The IHS Global Insight, CMS Nursing Home without Capital Market Basket 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 IHS index.

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

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

Narrative Explanation of Nursing Facility Reimbursement Formula

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 2017 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.

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

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

Narrative Explanation of Nursing Facility Reimbursement Formula

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 April 1, 2018.

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.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted from the midpoint of the cost report period to July 31, 2018. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based

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

Narrative Explanation of Nursing Facility Reimbursement Formula

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 statewide average CMI for the cost report year by the facility's cost report period CMI, 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 eight 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 $80 and the upper payment limit is based on 130% of the median, then the upper payment limit for the statewide average CMI would be $104 (**D**=130% x $80).

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 facility's Medicaid CMI is determined by averaging the facility average Medicaid CMI from the two quarters preceding the rate effective data. The Medicaid CMI is then divided by the statewide average CMI for the cost data period. Finally, this result, 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 semi-annually to account for changes in the Medicaid CMI. To illustrate this calculation take the following situation:

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

Narrative Explanation of Nursing Facility Reimbursement Formula

The facility's direct health care per diem cost is $80.00, the Direct Health Care per diem limit is $104.00 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 $80.00, 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 $72.00 (0.9000/1.0000 x $80.00). 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 $88.00 (1.1000/1.0000 x $80.00). 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 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.

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

Narrative Explanation of Nursing Facility Reimbursement Formula

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. 129-10-25). 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 $3.00 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 $0.50 per diem add-on. Providers that achieve a staff retention rate at or above the 75th percentile will earn a $2.50 per diem add-on as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers that have a staff retention rate lower than the 75th percentile but that increase their staff retention rate by 10% or more will receive a per diem add-on of $0.50 as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers that have a Medicaid occupancy percentage of 65% or more will receive a $0.75 per diem add-on. Finally, providers that maintain quality measures at or above the 75th percentile will earn a $1.25 per diem add on. The total of all the per diem add-ons a provider qualifies for will be their incentive factor.

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

Narrative Explanation of Nursing Facility Reimbursement Formula

i. Case Mix Adjusted Nurse Staffing Ratio

The case mix adjusted nurse staffing ratio component of the incentive factor is determined by taking each nursing facility's total direct health care hours per resident day and is case mix adjusted to the period statewide average. The 75th percentile staff ratio based on the 2017 Medicaid cost reports is 5.14. Therefore, nursing facilities with a total staffing ratio of 5.14 or higher will receive the staff ratio per diem add-on of $3.00. Homes that are below 5.14, but that have improved the staff ratio 10 percent or more over the previous year, will receive a per diem add-on of $0.50.

ii. Staff Retention Rate

The staff retention rate component of the incentive factor is derived from each nursing facility's total retention percentage from Schedule J of the 2017 Medicaid cost report. The 75th percentile base on the 2017 cost reports is 72 percent. Therefore, nursing facilities with a total retention rate of 72 percent or higher and less than 10 percent contract labor, will receive the staff retention rate per diem add-on of $2.50. Nursing facilities with a total retention rate below 72 percent, but that have improved the staff retention ratio by 10 percent or more over the previous year, and have less than 10 percent contract labor will receive a per diem add-on of $0.50.

iii. Medicaid Occupancy Percentage

The Medicaid occupancy percentage component of the incentive factor is determined by calculating each nursing facility's Medicaid occupancy percentage using Medicaid days and resident days from the Medicaid cost report. The threshold is set at 65 percent, therefore, nursing facilities with a Medicaid occupancy rate of 65 percent or higher will receive the Medicaid occupancy percentage per diem add-on of $0.75.

iv. The Quality Measures based on the CMS Nursing Home Compare Program

The quality measures component of the incentive factor is determined by each nursing facility's performance on nine long-stay quality measures assessed by the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare program. The nine measures included in the scoring are:

- Decline in Late-Loss ADLs
- Decline in Mobility on Unit
- High-Risk Residents with Pressure Ulcers
- Moderate to Severe Pain
- Antipsychotic Medications
- Falls with Major Injury
- Physical Restraints

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

Narrative Explanation of Nursing Facility Reimbursement Formula

- Indwelling Catheter
- Urinary Tract Infection

The scoring for each quality measure is determined by the point values CMS assigns based on facility performance relative to the national distribution for the quality measure. CMS assigns a point value of 20, 40, 60, 80, or 100 to each measure. The total quality score for each facility is calculated by summing the points for each of the nine quality measures. The highest total quality measure score for the incentive factor is 900. Additional information about how CMS assigns point values for each measure can be found in the Nursing Home Compare Technical Users' Guide, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf

The FY 2019 quality measures scores were determined from the CMS Nursing Home Compare Dataset: 2016Q4 – 2017Q3 which includes all assessment data from October 1, 2016 through September 30, 2017. The 75th percentile quality measures score based on this dataset is 640. Homes with a total quality measures score of 640 or higher will receive the quality measures per diem add-on of $1.25.

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

Narrative Explanation of Nursing Facility Reimbursement Formula

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

INCENTIVE OUTCOME	INCENTIVE FACTOR PER DIEM
CMI adjusted staffing ratio >= 75th percentile (5.14), or	$3.00
CMI adjusted staffing < 75th percentile but improved >= 10%	$0.50
Staff retention rate >= 75th percentile, 72 %or	$2.50
Staff retention rate < 75th percentile but increased >= 10%	
Contracted labor < 10% of total direct health care labor costs	$0.50
Medicaid occupancy >= 65%	$0.75
Quality Measures >=75th percentile (640)	$1.25
Total Incentive Add-ons Available	$7.50

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 ($0.00) to seven dollars and fifty cents ($7.50). 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 outcomes 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 3.82, which is 120% of the statewide NFMH median of 3.18. They

will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.50 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 90% they will earn a point.

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

Narrative Explanation of Nursing Facility Reimbursement Formula

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 $20.53, or 90% of the statewide median of $22.81.

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 45%, 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 45% but equal to or below 55%, 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 84%, the 75th percentile statewide will earn two points. Providers with staff retention rates below 84%, but at or above 68%, the 50th percentile statewide will earn one point.

The table below summarizes the incentive factor outcomes and points:

QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
CMI adjusted staffing ratio >= 120% (3.82) of NF-MH median (3.18), or CMI adjusted staffing ratio between 110% (3.50) and 120%	2, or 1
Total occupancy <= 90%	1
Operating expenses < $20.53, 90% of NF-MH median, $22.81	1
Staff turnover rate <= 75th percentile, 45% Staff turnover rate <= 50th percentile, 55% Contracted labor < 10% of total direct health care labor costs	2, or 1
Staff retention >= 75th percentile, 84% Staff retention >= 50th percentile, 68%	2, or 1
Total Incentive Points Available	8

APR 15 2019

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

Narrative Explanation of Nursing Facility Reimbursement Formula

Level 2 Culture Change Achievement $1.00	This is a bridge level to acknowledge achievement in Level 1. Homes may receive this level at the same time they are working on other PEAK core areas at Level 1. Homes may receive this incentive for up to 3 years. If Level 3 is not achieved at the end of the third year, homes may start back at Level 0 or 1 depending on KDADS and KSU's recommendation.	Available beginning July 1 following confirmed completion of action plan goals. Incentive is granted for one full fiscal year.
Level 3 Person-Centered Care Home $2.00	Demonstrates minimum competency as a person-centered care home (see KDADS full criteria). This is confirmed through a combination of the following: High score on the KCCI evaluation tool. Demonstration of success in other levels of the program. Performing successfully on a Level 2 screening call with the KSU PEAK 2.0 team. Passing a full site visit.	Available beginning July 1 following confirmed minimum competency as a person-centered care home. Incentive is granted for one full fiscal year. Renewable bi-annually.
Level 4 Sustained Person-Centered Care Home $2.50	Homes earn person-centered care home award two consecutive years.	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies. Incentive is granted for two fiscal years. Renewable bi-annually.

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

Narrative Explanation of Nursing Facility Reimbursement Formula

Level 5 Person-Centered Care Mentor Home $3.00	Homes earn sustained person-centered care home award and successfully engage in mentoring activities suggested by KDADS (see KDADS mentoring activities). Mentoring activities should be documented.	Available beginning July 1 following confirmation of mentor home standards. Incentive is granted for two fiscal years. Renewable bi-annually.

Survey and Certification Performance Adjustment

The survey and certification performance of each NF and NF-MH provider will be reviewed quarterly to determine each provider's eligibility for incentive factor payments. In order to qualify for an incentive factor payment 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 be eligible to receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level "F" will be eligible to receive 100% of the calculated incentive factor. The survey and certification review period will be the 12-month period ending one quarter prior to the incentive eligibility review date. The following table lists the incentive eligibility review 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.

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.

INFLATION TABLE
EFFECTIVE 07/01/18

REPORT YEAR END (RYE)	MIDPOINT OF RYE	MIDPOINT OF RYE INDEX	MIDPOINT OF RATE PERIOD	MIDPOINT OF RATE PERIOD INDEX	HISTORICAL INFLATION FACTOR % *
12-14	06-14	1.003	07-18	1.104	10.070%
01-15	07-14	1.009	07-18	1.104	9.415%
02-15	08-14	1.009	07-18	1.104	9.415%
03-15	09-14	1.009	07-18	1.104	9.415%
04-15	10-14	1.011	07-18	1.104	9.199%
05-15	11-14	1.011	07-18	1.104	9.199%
06-15	12-14	1.011	07-18	1.104	9.199%
07-15	01-15	1.015	07-18	1.104	8.768%
08-15	02-15	1.015	07-18	1.104	8.768%
09-15	03-15	1.015	07-18	1.104	8.768%
10-15	04-15	1.022	07-18	1.104	8.023%
11-15	05-15	1.022	07-18	1.104	8.023%
12-15	06-15	1.022	07-18	1.104	8.023%
01-16	07-15	1.030	07-18	1.104	7.184%
02-16	08-15	1.030	07-18	1.104	7.184%
03-16	09-15	1.030	07-18	1.104	7.184%
04-16	10-15	1.030	07-18	1.104	7.184%
05-16	11-15	1.030	07-18	1.104	7.184%
06-16	12-15	1.030	07-18	1.104	7.184%
07-16	01-16	1.037	07-18	1.104	6.461%
08-16	02-16	1.037	07-18	1.104	6.461%
09-16	03-16	1.037	07-18	1.104	6.461%
10-16	04-16	1.044	07-18	1.104	5.747%
11-16	05-16	1.044	07-18	1.104	5.747%
12-16	06-16	1.044	07-18	1.104	5.747%
01-17	07-16	1.052	07-18	1.104	4.943%
02-17	08-16	1.052	07-18	1.104	4.943%
03-17	09-16	1.052	07-18	1.104	4.943%
04-17	10-16	1.057	07-18	1.104	4.447%
05-17	11-16	1.057	07-18	1.104	4.447%
06-17	12-16	1.057	07-18	1.104	4.447%
07-17	01-17	1.066	07-18	1.104	3.565%
08-17	02-17	1.066	07-18	1.104	3.565%
09-17	03-17	1.066	07-18	1.104	3.565%
10-17	04-17	1.074	07-18	1.104	2.793%
11-17	05-17	1.074	07-18	1.104	2.793%
12-17	06-17	1.074	07-18	1.104	2.793%
01-18	07-17	1.082	07-18	1.104	2.033%
02-18	08-17	1.082	07-18	1.104	2.033%
03-18	09-17	1.082	07-18	1.104	2.033%
04-18	10-17	1.086	07-18	1.104	1.657%
05-18	11-17	1.086	07-18	1.104	1.657%
06-18	12-17	1.086	07-18	1.104	1.657%

* = (Midpoint of rate period index / Midpoint of rye index) -1

COST CENTER LIMITATIONS EFFECTIVE 07/01/18

COST CENTER	UPPER LIMIT
Operating	$38.57
Indirect Health Care	$54.50
Direct Health Care	129.23*
Real and Personal Property Fee	$9.80

* = Base limit for a facility average case mix index of 1.253

APR 15 2019

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/18

NF ONLY

	INCENITVE OUTCOME	INCENTIVE AMOUNTS
1)	CMI adjusted staffing ratio >= 75th percentile (5.14), or	$3.00
	CMI adjusted staffing < 75th percentile but improved >= 10%	$0.50
2)	Staff retention rate >= 75th percentile, 72% or	$2.50
	Staff retention rate < 75th percentile but increased >= 10%	$0.50
	Contracted labor < 10% of total direct health care labor costs	
3)	Medicaid occupancy >= 65%	$0.75
4)	Quality Measures >= 75th percentile (640)	$1.25
	Total Incentive Available	$7.50

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/18

NF-MH ONLY

	QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 120% (3.82) of NF-MH median (3.18), or	2, or
	CMI adjusted staffing ratio between 110% (3.50) and 120%	1
2	Total occupancy <= 90%	1
3	Operating expenses < $20.53, 90% of NF-MH median, $22.81	1
4	Staff turnover rate <= 75th percentile, 45%	2, or
	Staff turnover rate <= 50th percentile, 55%	1
	Contracted labor < 10% of total direct health care labor costs	
5	Staff retention >= 75th percentile, 84%	2, or
	Staff retention >= 50th percentile, 68%	1
	Total Incentive Points Available	8

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-8 points	$7.50
Tier 2: 5 points	$5.00
Tier 3: 4 points	$2.50
Tier 4: 0-3 points	$0.00

APR 15 2019

PEAK INCENTIVE FACTOR EFFECTIVE 07/01/18

Level & Per Diem Incentive	Summary of Required Nursing Home Action	Incentive Duration
Level 0 The Foundation $0.50	Home completes the KCCI evaluation tool according to the application instructions. Home participates in all required activities noted in "The Foundation" timeline and workbook. Homes that do not complete the requirements at this level must sit out of the program for one year before they are eligible for reapplication.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level 1 Pursuit of Culture Change $0.50	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing 4 PEAK 2.0 cores in Domains 1-4. The home self-reports progress on the action planned cores via phone conference with the PEAK team. The home may be selected for a random site visit. The home must participate in the random site visit, if selected, to continue incentive payment. Homes should demonstrate successful completion of 75% of core competencies selected. A home can apply for Levels 1 & 2 in the same year. Homes that do not achieve Level 2 with three consecutive years of participation at Level 1 must return to a Level 0 or sit out for two years depending on KDADS and KSU's recommendation.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level 2 Culture Change Achievement $1.00	This is a bridge level to acknowledge achievement in Level 1. Homes may receive this level at the same time they are working on other PEAK core areas at Level 1. Homes may receive this incentive for up to 3 years. If Level 3 is not achieved at the end of the third year, homes must start back at Level 0 or 1 depending on KDADS and KSU's recommendation.	Available beginning July 1 following confirmed completion of action plan goals. Incentive is granted for one full fiscal year.

Level 3 Person-Centered Care Home $2.00	Demonstrates minimum competency as a person-centered care home (see KDADS full criteria). This is confirmed through a combination of the following: High score on the KCCI evaluation tool. Demonstration of success in other levels of the program. Performing successfully on a Level 2 screening call with the KSU PEAK 2.0 team. Passing a full site visit.	Available beginning July 1 following confirmed minimum competency as a person-centered care home. Incentive is granted for one full fiscal year. Renewable bi-annually.
Level 4 Sustained Person-Centered Care Home $2.50	Homes earn person-centered care home award two consecutive years.	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies. Incentive is granted for two fiscal years. Renewable bi-annually.
Level 5 Person-Centered Care Mentor Home $3.00	Homes earn sustained person-centered care home award and successfully engage in mentoring activities suggested by KDADS (see KDADS mentoring activities). Mentoring activities should be documented.	Available beginning July 1 following confirmation of mentor home standards. Incentive is granted for two fiscal years. Renewable bi-annually.

Owner/Related Party Salary Limitations
Effective 7/01/18

Job Classification		Salary Range**	Bed Capacity 0-59	60-120	121+	0-99	100	Any Size
Administrator	*	23	37,003					
	*	28		47,258				
	*	31			54,683			
Co-Administrator	*	19	30,493					
	*	22		35,235				
	*	24			38,896			
Accountant II		25						40,872
Attorney II		33						60,382
Bookkeeper		15						25,043
Secretary II		15						25,043
Gen. Maint. & Repair Tech Senior		18						29,016
Physical Plant Supervisor		24						38,896
Physical Plant Supervisor Senior		26						42,806
Cook Senior		14						23,878
Food Service Supervisor Senior		19						30,493
Housekeeping/Laundry Worker		10						19,635
Director of Nursing (RN III)	*	30						52,104
Registered Nurse	*	29						49,650
Licensed Practical Nurse (LPN)	*	19						30,493
LPN Supervisor	*	20						31,990
Health Care Assistant (Nurse Aides)	*	13						22,714
Mental Health Aide		14						23,878
Physical Therapist II	*	27						45,032
Physical Therapist Aide		13						22,714
Occupational Therapist II	*	26						42,806
Speech Pathologist/Audiologist I	*	26						42,806
Activity Therapy Tech.		14						23,878
Activity Therapist I	*	23						37,003
Social Worker Specialist	*	25						40,872
Medical Records Administrator		24						38,896
Medical Records Technician		19						30,493
Central Office Staff (3+ Facilities)								
Chief Executive Officer		36						69,784
Chief Operating Officer		34						63,357
All Other Chief Officers		31						54,683

* License/Registration/Certificate Requirement
** Step 7 of the salary range has been used to set the limits.

OWNER/ADMINISTRATOR LIMITATION TABLE EFFECTIVE 07/01/18

Number of Beds	Total Bed Days	Maximum Owner/Admin Compensation	Limit PPD	F/Y	Amount	Cost of Living State Emp.
15	5,475	$22,941	$4.19	76	10,000	=====
16	5,840	$26,076	$4.47	77	10,280	2.800%
17	6,205	$29,211	$4.71	78	10,537	2.500%
18	6,570	$32,346	$4.92	79	11,301	7.250%
19	6,935	$35,481	$5.12	80	11,781	4.250%
20	7,300	$38,616	$5.29	81	12,617	7.100%
21	7,665	$41,751	$5.45	82	13,248	5.000%
22	8,030	$44,886	$5.59	83	14,109	6.500%
23	8,395	$48,021	$5.72	84	14,426	2.250%
24	8,760	$51,156	$5.84	85	15,147	5.000%
25	9,125	$54,291	$5.95	86	15,933	5.190%
26	9,490	$57,426	$6.05	87	16,411	3.000%
27	9,855	$60,561	$6.15	88	16,575	1.000%
28	10,220	$63,696	$6.23	89	17,238	4.000%
29	10,585	$66,831	$6.31	90	17,755	3.000%
30	10,950	$69,966	$6.39	91	18,021	1.500%
31	11,315	$73,101	$6.46	92	18,021	0.000%
32	11,680	$76,236	$6.53	93	18,111	0.500%
33	12,045	$79,371	$6.59	94	18,202	0.500%
34	12,410	$82,506	$6.65	95	18,407	1.125%
35	12,775	$85,641	$6.70	96	18,591	1.000%
36	13,140	$88,776	$6.76	97	18,591	0.000%
37	13,505	$91,911	$6.81	98	18,777	1.000%
38	13,870	$95,046	$6.85	99	19,059	1.500%
39	14,235	$98,181	$6.90	00	19,250	1.000%
40	14,600	$101,316	$6.94	01	19,250	0.000%
41	14,965	$104,451	$6.98	02	19,683	2.250%
42	15,330	$107,586	$7.02	03	19,683	0.000%
43	15,695	$110,721	$7.05	04	19,978	1.500%
44	16,060	$113,856	$7.09	05	20,557	3.000%
45	16,425	$116,991	$7.12	06	20,834	1.250%
46	16,790	$120,126	$7.15	07	21,355	2.500%
47	17,155	$123,261	$7.19	08	21,782	2.000%
48	17,520	$126,396	$7.21	09	22,237	2.500%
49	17,885	$129,531	$7.24	10-18	22,327	0.000%
50	18,250	$132,666	$7.27	19	22,941	2.750%

APR 15 2019

COMPILATION OF COST CENTER LIMITATIONS
EFFECTIVE 07/01/18

	BEFORE INFLATION					***AFTER INFLATION***				
	OPER	IDHC	DHC	RPPF	TOTAL	OPER	IDHC	DHC	RPPF	TOTAL
MEDIAN	34.85	45.65	92.34	9.33	182.18	35.06	47.39	99.41	9.33	191.19
MEAN	37.12	48.32	96.52	13.40	195.35	37.94	49.94	102.08	13.40	203.36
WTMN	36.36	47.50	96.26	12.54	192.66	36.91	48.86	101.34	12.54	199.65
# OF PROV	322					322				

COMPILATION OF ADMINISTRATOR, CO-ADMIN OWNER EXPENSE - O/A LIMIT
EFFECTIVE 07/01/18

	ADMINISTRATOR		CO-ADMINISTRATOR		TOTAL ADMN & C0-ADMN		OWNER	
	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD
HIGH	308,839	13.56	92,480	7.62	308,839	13.56	209,520	12.19
99th	190,762	9.37	92,480	7.62	190,762	10.56	209,520	12.19
95th	144,961	8.44	92,480	7.62	144,961	8.54	186,922	11.03
90th	124,302	7.20	92,480	2.20	124,302	7.27	146,605	10.21
85th	110,631	6.64	50,985	2.20	110,631	6.83	139,867	10.10
80th	105,044	6.13	44,296	2.13	105,044	6.25	124,499	6.91
75th	99,134	5.92	42,308	1.70	99,134	5.97	117,121	6.65
70th	95,299	5.46	42,308	1.70	95,299	5.53	93,509	5.63
65th	92,839	5.19	36,482	1.25	92,839	5.21	88,325	4.47
60th	89,054	4.92	36,482	1.25	89,054	4.96	75,853	3.18
55th	86,188	4.66	23,818	1.21	86,188	4.67	74,464	2.38
50th	82,499	4.46	22,730	0.96	82,499	4.47	67,329	2.15
40th	76,643	4.02	20,394	0.71	76,643	4.06	45,132	2.07
30th	70,961	3.52	13,603	0.68	70,961	3.55	42,410	2.07
20th	62,546	2.99	10,000	0.49	62,546	3.02	27,848	1.80
10th	44,663	2.49	7,500	0.41	44,663	2.55	22,519	1.53
1st	16,808	1.24	727	0.03	16,808	1.23	8,170	0.49
LOW	2,667	0.42	727	0.03	2,667	0.42	8,170	0.49
MEAN	85,276	4.68	30,444	1.62	85,276	4.74	77,373	4.20
WTMN	76,260	4.14	24,873	1.24	76,471	4.20	63,787	3.37
# of Prov	314		12		314		31	

COMPILATION OF NF
INCENTIVE POINTS AWARDED
EFF. 07/01/18

NURSING FACILITY

INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	72	23.0%
$0.50	21	6.7%
$0.75	40	12.8%
$1.00	1	0.3%
$1.25	42	13.4%
$1.75	5	1.6%
$2.00	6	1.9%
$2.50	19	6.1%
$3.00	39	12.5%
$3.25	8	2.6%
$3.50	4	1.3%
$3.75	19	6.1%
$4.25	3	1.0%
$4.50	7	2.2%
$4.75	1	0.3%
$5.00	1	0.3%
$5.50	15	5%
$6.25	5	1.6%
$6.75	4	1.3%
$7.50	1	0.3%
TOTALS	313	100.0%

PEAK INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	153	48.9%
$0.50	76	24.3%
$1.00	1	0.3%
$1.50	66	21.1%
$2.00	4	1.3%
$2.50	7	2.2%
$3.00	6	1.9%
TOTALS	313	100.0%

COMPILATION OF NF-MH
INCENTIVE POINTS AWARDED
EFF. 07/01/18

NURSING FACILITY MENTAL HEALTH

INCENTIVE POINTS AWARDED	# OF PROVIDERS	PERCENTAGE
0	1	16.7%
1	2	33.3%
2	0	0.0%
3	3	50.0%
4	3	50.0%
5	1	16.7%
6	0	0.0%
7	0	0.0%
8	0	0.0%
TOTALS	10	100.0%

PEAK INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	4	40.0%
$0.50	2	20.0%
$1.50	4	40.0%
TOTALS	10	100.0%

June 20, 2018

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

Provider #: 104«PROV_NUM»01
HP Enterprise Services Provider #: «EDS_PROV_N»

Dear «ADMIN NAME»:

The per diem rate shown on the enclosed Case Mix Payment Schedule for state fiscal year 2019 has been forwarded to the Managed Care Organizations (MCOs) for processing of future reimbursement payments. The rate will become effective July 1, 2018.

The Kansas Department for Aging and Disability Services (KDADS), administers the Medicaid nursing facility services payment program on behalf of Kansas Department of Health and Environment. The rate was calculated by applying the published methodology, including applicable Medicaid program policies and regulations, to the cost reports (Form MS 2004) data shown on the enclosed payment schedule.

Also enclosed may be an audit adjustment sheet showing adjustments made during the desk review of the 2017 calendar year end cost report. This information is intended to assist you with preparation of future cost reports. The calendar years of 2015, 2016 and 2017 will be used as the base years for the purpose of setting rates. However, should you disagree with any adjustment, please email or mail me any information you have that supports your position. We will file the information with the cost report and will use that information to reevaluate the adjustments based on the documentation supplied.

If you do not agree with this action, you have the right to request a fair hearing appeal in accordance with K.A.R. 30-7-64 et seq. Your request for fair hearing shall be in writing and delivered to or mailed to the agency so that it is received by the **Office of Administrative Hearings, 1020 S. Kansas Ave., Topeka, KS 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 you received this letter by mail). Failure to timely request or pursue such an appeal may adversely affect your rights.

If you have questions about the adjustments, please contact John Oliver at (785) 296-6457 or email at John.Oliver@ks.gov. For questions on the Medicaid Rate, please contact Trescia Power at (785) 368-6685 or email at Trescia.Power@KS.gov or Tyler Russell at (785) 296-0703 or email at Tyler.A.Russell@KS.gov

Regards,

Trescia L. Power
Program Finance Oversight Manager
Kansas Department for Aging and Disability Services

Trescia.Power@ks.gov
Visit our website at: www.KDADS.ks.gov

Enclosures

Kansas Medicaid / MediKan

Case Mix Schedule
1st - 2nd QTR 2019 ANNUAL

Current Provider Information

Provider Number:	HP Enterprises Provider Number:	1st QTR Medicaid CMI:	1.0425
Facility Name:	Area/County:	2nd QTR Medicaid CMI:	1.0262
Address:		Average Medicaid CMI:	1.0344 [a]
City/State/Zip:			
Administrator:			

Cost Report Statistics

Calendar Year Cost Reports Used For Base Data:	12/31/2015	12/31/2016	12/31/2017	
Inflation Factor:	8.023%	5.747%	2.793%	
Facility Cost Report Period CMI:	1.0819	1.0599	1.0478	
Statewide Average CMI:	1.0231	1.0225	1.0302	1.0253 [b]
NF Or NF/MH Beds:	110	110	110	
Bed Days Available:	40,150	40,260	40,150	
Inpatient Days:	34,930	33,531	34,173	
Occupancy Rate:	87.0%	83.3%	85.1%	
Medicaid Days:	20,084	18,612	16,544	
Calc Days If Appl:	34128	34,221	34,128	

Calculation of Combined Base Year Reimbursement Rate

Operating

Total Reported Costs:	$1,390,682	$1,709,058	$1,641,808		
Cost Report Adjustments:	($11,131)	($188,689)	($206,994)		
O/A Limit Adjustment:	($77,276)	($52,772)	$0		
Total Adjusted Costs:	$1,302,275	$1,467,597	$1,434,814		
Total Inflated Adjusted Costs:	$1,390,500	$1,541,343	$1,472,864		
Total Combined Base Cost:				$4,404,707	
Days Used In Division Oper:	34,930	34,221	34,173	103,324	
				42.63	Oper Per Diem
				38.57	Oper Per Diem Cost Limitation
				38.57	Oper Per Diem Rate (1)

Indirect Health Care

Total Reported Costs:	$1,596,830	$1,567,174	$1,556,036		
Cost Report Adjustments:	$0	$0	$0		
Total Adjusted Costs:	$1,596,830	$1,567,174	$1,556,036		
Total Inflated Adjusted Costs:	$1,724,944	$1,657,239	$1,599,496		
Total Combined Base Cost:				$4,981,679	
Days Used In Division IDHC:	34,930	34,221	34,173	103,324	
				48.31	IDHC Per Diem
				54.50	IDHC Per Diem Cost Limitation
				48.31	IDHC Per Diem Rate (2)

Direct Health Care

Total Reported Costs:	$2,511,519	$2,557,200	$2,412,625		
Cost Report Adjustments:	$0	$0	$0		
Total Adjusted Costs:	$2,511,519	$2,557,200	$2,412,625		
Total Inflated Adjusted Costs:	$2,713,016	$2,704,162	$2,460,010		
Total CMI Adjusted Costs:	$2,613,889	$2,608,742	$2,438,353		
Total Combined Base Cost:				$7,660,984	
Days Used In Division DHC:	34,930	33,531	34,173	102,634	
				74.64	Case Mix Adjusted DHC Per Diem
				129.23	DHC Per Diem Cost Limitation
				74.64	Allowable DHC Per Diem Cost [c]
			[c]*([a]/[b])	75.30	Medicaid Acuity Adjustment (3)

Real and Personal Property Fee

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

Calculation of Medicaid Rate

Operating, IDHC, And DHC Rates and RPPF (1) +(2) + (3) +(4):		171.28
Incentive Factor		1.25
PEAK 2.0		0.50
Bed Tax Adjustment		2.60
DME Adjustment		0.00
Minimum Wage Adjustment		0.00
Total Medicaid Rate Effective	**07/01/2018**	**175.66**

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

Provider Number:
HP Enterprise Services Provider Number:

Facility Name:

Rate Effective Date: 07/01/18

		Incentive Possible	Facility Stats	Incentive Awarded
1.	Case Mix Adjusted Nurse Staff Ratio			
	Tier 1: At or Above the NF 75th Percentile (5.14)	$ 3.00		$ 3.00
	Tier 2: Below the NF 75th Percentile but Improved At or Above 10%	$ 0.50		$ 0.00
	Cost Report Year Data:		5.43 12/31/2017	
2	Staff Retention			
	Tier 1: At or Above the NF 75th Percentile (72%)	$ 2.50		$ 2.50
	Tier 2: Below the NF 75th Percentile but Improved At or Above 10% And Contract Nursing Labor Less than 10% of Total DHC Labor Costs (Contract Labor 8%)	$ 0.50		$ 0.00
	Cost Report Year Data:		88% 12/31/2017	
3.	Occupancy Rate			
	Medicaid Occupancy At or Above 65%	$ 0.75		$ 0.00
	Cost Report Year Data:		36% 12/31/2017	
4	Quality Measures			
	Score At or Above 75th Percentile (640)	$ 1.25		$ 1.25
			700	
	Total Incentive before Survey Adjustment			$ 6.75
	Survey Adjustment and Reduction 0%			$ 0.00
	Final Incentive Awarded			$ 6.75
Peak 2.0 Incentive		$ 3.00		$ 0.00
Peak 2.0 Survey Adjustment and Reduction 0%				$ 0.00
Final PEAK 2.0 Incentive Awarded				$ 0.00

APR 15 2019

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

Provider Number:
HP Enterprise Services Provider Number:

Facility Name:

Rate Effective Date: 07/01/18

	Incentive Possible	Facility Stats	Incentive Awarded
1. Case Mix Adjusted Nurse Staff Ratio			
Tier 1: At or Above 120% of NF-MH Median (3.82)	2		2
Tier 2: At or Above 110% of NF-MH Median of (3.50)	1		0
(NF-MH Median is 3.18 for an Average Statewide CMI of 1.0302)			
		5.72	
Cost Report Year Data:		12/31/2017	
2. Operating Expense			
At or below 90% of NF-MH Median ($20.53)	1		0
		$35.76	
Cost Report Year Data:		12/31/2017	
3. Staff Turnover			
Tier 1: At or Below the NF-MH 75th Percentile (45%)	2		0
Tier 2: At or Below the NF-MH 50th Percentile (55%)	1		0
And Contract Nursing Labor Less than 10% of Total DHC Labor Costs (0.0%)			
		60%	
Cost Report Year Data:		12/31/2017	
4. Staff Retention			
Tier 1: At or Above the NF-MH 75th Percentile (84%)	2		0
Tier 2: At or Above the NF-MH 50th Percentile (68%)	1		0
		63%	
Cost Report Year Data:		12/31/2017	
5. Occupancy Rate			
Total Occupancy At or Below 90%	1		1
		82%	
Cost Report Year Data:		12/31/2017	
Total Points Awarded			3
Incentive Before Survey Adjustment			$0.00
Survey Adjustment and Reduction	0%		$0.00
Final Incentive			$0.00

Scoring:

Points	Per Diem
6 - 8	$7.50
5	$5.00
4	$2.50
0 - 3	$0.00

PEAK 2.0 Incentive		$ 1.50
Survey Adjustment and Reduction	0%	$0.00
Total PEAK 2.0 Incentive		$ 1.50