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State/Territory Name: Kentucky

State Plan Amendment (SPA) #: 13-025

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

FEB 12 2014

Mr. Lawrence Kissner
Commissioner
Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621

RE: State Plan Amendment (SPA) KY 13-025

Dear Mr. Kissner:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 13-025. Effective March 1, 2014 this amendment proposes to revise the payment methodology for Nursing Facilities. Specifically, the amendment proposes to implement a retrospective annual cost settlement method for Kentucky operated Veteran's Nursing Facilities.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of March 1, 2014. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely,

//s//

Cindy Mann
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:	2. STATE
13-025	Kentucky

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

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

4. PROPOSED EFFECTIVE DATE
January 1, 2014
March

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
Section 1919 of the Social Security Act 42 CFR 483 subpart B	a. FFY 2014 $12.2 million increase b. FFY 2015 $21.7 million increase
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 4.19-D, Page 1-6 Att. 4.19.D, Exhibit B, Page 22 and 23, page 40.	Same

10. SUBJECT OF AMENDMENT:
The purpose of this State Plan Amendment is to provide covered for Medicaid recipients in a Veteran's Affairs state operated and controlled nursing home

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
//s//	Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
13. TYPED NAME: Lawrence Kissner	
14. TITLE: Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: 11/26/13	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12-20-13	18. DATE APPROVED: 02-12-14
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:03-01-14	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Cindy Mann	22. TITLE: Director

The following pen and Ink changes be made to the CMS 179
Block 4 change effective date to 03/01/14
Block 8 add Attachment 4.19-D, Exhibit B page 40

SECTION 220. INTRODUCTION TO COST-BASED REIMBURSEMENT SYSTEM

A. The Department for Medicaid Services has established a prospective reimbursement system for costs-based facilities. Cost based facilities include the following:

1. Institutions for Mental Diseases (IMD's);
2. Pediatric Nursing Facilities; and
3. Intermediate Care facilities for individuals with an intellectual disability (ICF-IID).
4. Veteran's Affairs (VA) state operated and controlled nursing facility.

The reimbursement methodology for the facilities listed is outlined here. Also included in this section are the facilities that are reimbursed by all- inclusive rates. The payment method is designed to achieve two major objectives: *1).* To assure that needed facility care is available for all eligible recipients including those with higher care needs and, 2). To assure Department for Medicaid Services control and cost containment consistent with the public interest and the required level of care.

B. 1. This cost-based system is designed to provide a reasonable return in relation to cost but also contains factors to encourage cost containment. Under this system, payment shall be made to state owned or operated, non-state but government owned or operated, and non-governmental ICF-IIDs on a prospectively determined basis for routine cost of care with no year-end adjustment required other than adjustments which result from either desk reviews or field audits.

2. Effective with the eight month period ending June 30, 2006, and continuing annually thereafter on a state fiscal year basis, a year-end cost settlement will be required for state owned or operated ICF-IID. Total reimbursement to state owned or operated ICF-IID in aggregate shall be limited to the lesser of actual costs or the amount the state reasonably estimates would have been paid under Medicare Payment Principles. The determination will be in conformance with the standards and methods as expressed in 42 CFR 447.257 and 447.272. Cost associated with prescription drugs should be removed from the routine cost. Central Office Overhead costs for facilities that are state owned, but not state operated should be adjusted to remove costs that are determined in accordance with Medicare reimbursement principles to duplicate costs incurred by the operating entity.

3. Effective with the period ending June 30, 2014, and continuing annually thereafter on a state fiscal year basis, a year-end cost settlement will be required for state owned or operated VA facilities. Total reimbursement to VA's in aggregate shall be limited to the lesser of actual costs or the amount the state reasonably estimates would have been paid under Medicare Payment Principles. The determination will be in conformance with the standards and methods as expressed in 42 CFR 447.257 and 447.272. Cost associated with prescription drugs should be removed from the routine cost. Central Office Overhead costs for facilities that are state owned, but not state operated should be adjusted to remove costs that are determined in accordance with Medicare reimbursement principles to duplicate costs incurred by the operating entity. An interim per diem inclusive of routine, capital, and ancillary costs will be established based on the most recently submitted Medicare cost report for the July 1 rate-setting period. Costs, excluding capital, will be trended and indexed utilizing Global Insight inflation factors. A pro-forma cost report will be used for the initial rate-setting period if the Medicare cost report is not available. Once a desk review has been completed to review for allowable costs, and allow for Medicaid claims to process and paid through the MMIS for the period, a final cost settlement will be completed.

C. Ancillary services as defined, shall be reimbursed on a cost basis with a year-end retroactive settlement. As with routine cost, ancillary services are subject to both desk reviews and field audits that may result in retroactive adjustments.

D. The basis of the prospective payment for routine care cost is the most recent annual cost report data (available as of May 16) trended to the beginning of the rate year and indexed for the prospective rate year. The routine cost is divided into two major categories: Nursing Services Cost and All Other Cost.

SECTION 230. PARTICIPATION REQUIREMENTS

PARTICIPATION REQUIREMENTS. Except for ICF-IID's and VA's, cost-based facilities participating in the Department for Medicaid program shall be required to have at least ten (10) of its Medicaid certified beds participating in the Medicare Program or twenty (20) percent of its beds if greater, but not less than ten (10) beds; for a facility with less than ten (10) beds, all beds participate in the Medicare Program.

SECTION 240. REIMBURSEMENT FOR REQUIRED SERVICES UNDER THE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR) FOR VENTILATOR UNITS, BRAIN INJURY UNITS, IMDS, AND PEDIATRIC FACILITIES.

A. Prior to admission of an individual, a nursing facility shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.

B. The department shall reimburse a nursing facility for services delivered to an individual if the facility complies with the requirements of 907 KAR 1:755

C. Failure to comply with 907 KAR 1:755 may be grounds for termination of nursing the facility participation in the Medicaid Program.

SECTION 250. LIMITATION ON CHARGES TO RESIDENTS.

F. Except for applicable deductible and coinsurance amounts, a NF that receives reimbursement for a Medicaid resident shall not charge a resident or his representative for the cost of routine or ancillary services.

G. A NF may charge a resident or his representative for an item if the resident requests the item, the NF informs the resident in writing that there will be a charge. A NF shall not charge a resident for an item or service if Medicare or Medicaid pays for the item pursuant to 42 CFR 483.1 0(c)(8)(ii).

H. A NF shall not require a resident or an interested party to request any item or services as a condition of admission or continued stay. A NF shall inform the resident or an interested party requesting an item or service that a charge will be made in writing that there will be a charge and the amount of the charge.

shall be given to out- of-state home offices to make the records available within the Commonwealth.

SECTION 430. APPORTIONMENT OF ALLOWABLE COST

A. Consistent with prevailing practices where third party organizations pay for health care on a cost basis, reimbursement under the Medicaid Program involves a determination of(l) each provider's allowable costs of producing services, and (2) an apportionment of these costs between the Medicaid Program and other payors.

Cost apportionment is the process of recasting the data derived from the accounts ordinarily kept by a provider to identify costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and pro-ration of indirect costs.

B. The objective of this apportionment is to ensure, to the extent reasonably possible, that the Medicaid Program's share of a provider's total allowable costs is equal to the Medicaid Program's share of the provider's total services, subject to Medicaid Program limitations on payments so as not to pay for inefficiencies and to provide a financial incentive for providers to achieve cost efficiencies.

SECTION 440. COST REPORTING

A. The Medicaid Program requires each Cost-Based Facility to submit an annual report of its operations. The report shall be filed for the fiscal year used by the provider unless otherwise approved by the Medicaid Program.

B. Amended cost reports (to revise cost report information that has been previously submitted by a provider) may be permitted or required as determined by the Medicaid Program.

C. The cost report shall be due within sixty (60) days after the provider's fiscal year ends for non-VA facilities. The VA cost report shall be due within 5 months after the provider's fiscal year end, unless an extension has been approved by the Department.

D. Providers may request in writing a thirty (30) day extension. The request shall explain in detail why the extension is necessary. There shall be no automatic extension of time for the filing of the cost report. After the extension period has elapsed, the Medicaid Program shall suspend all payments to the provider until an acceptable cost report is received.