INFLATION TABLE
EFFECTIVE 07/01/11

REPORT YEAR END (RYE)	MIDPOINT OF RYE	MIDPOINT OF RYE INDEX	MIDPOINT OF RATE PERIOD	MIDPOINT OF RATE PERIOD INDEX	HISTORICAL INFLATION FACTOR % *
12-08	06-08	1.153	12-11	1.244	7.892%
01-09	07-08	1.167	12-11	1.244	6.598%
02-09	08-08	1.167	12-11	1.244	6.598%
03-09	09-08	1.167	12-11	1.244	6.598%
04-09	10-08	1.171	12-11	1.244	6.234%
05-09	11-08	1.171	12-11	1.244	6.234%
06-09	12-08	1.171	12-11	1.244	6.234%
07-09	01-09	1.176	12-11	1.244	5.782%
08-09	02-09	1.176	12-11	1.244	5.782%
09-09	03-09	1.176	12-11	1.244	5.782%
10-09	04-09	1.180	12-11	1.244	5.424%
11-09	05-09	1.180	12-11	1.244	5.424%
12-09	06-09	1.180	12-11	1.244	5.424%
01-10	07-09	1.187	12-11	1.244	4.802%
02-10	08-09	1.187	12-11	1.244	4.802%
03-10	09-09	1.187	12-11	1.244	4.802%
04-10	10-09	1.189	12-11	1.244	4.626%
05-10	11-09	1.189	12-11	1.244	4.626%
06-10	12-09	1.189	12-11	1.244	4.626%
07-10	01-10	1.200	12-11	1.244	3.667%
08-10	02-10	1.200	12-11	1.244	3.667%
09-10	03-10	1.200	12-11	1.244	3.667%
10-10	04-10	1.203	12-11	1.244	3.408%
11-10	05-10	1.203	12-11	1.244	3.408%
12-10	06-10	1.203	12-11	1.244	3.408%
01-11	07-10	1.210	12-11	1.244	2.810%
02-11	08-10	1.210	12-11	1.244	2.810%
03-11	09-10	1.210	12-11	1.244	2.810%
04-11	10-10	1.215	12-11	1.244	2.387%
05-11	11-10	1.215	12-11	1.244	2.387%
06-11	12-10	1.215	12-11	1.244	2.387%
07-11	01-11	1.224	12-11	1.244	1.634%

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

COST CENTER LIMITATIONS EFFECTIVE 07/01/11

COST CENTER	UPPER LIMIT
Operating	$31.45
Indirect Health Care	$45.89
Direct Health Care	$99.24 *
Real and Personal Property Fee	$9.11

* = Base limit for a facility average case mix index of 1.0079

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/11
NF ONLY

	INCENTIVE OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 75th percentile (4.78), or	$2.50
	CMI adjusted staffing < 75th percentile but improved >= 10%	$0.25
2	Staff turnover rate <= 75th percentile, 40.6% or	$2.50
	Staff turnover rate > 75th percentile but reduced >= 10%	$0.25
3	Completion of the full Kansas Culture Change Instrument Survey	$0.38
4	Medicaid occupancy >= 60%	$1.13
	Total Incentive Points Available	$6.51

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/11
NF-MH ONLY

	QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 120% (3.66) of NF-MH median (3.05), or CMI adjusted staffing ratio between 110% (3.36) and 120%	2, or 1
2	Total occupancy <= 90%	1
3	Operating expenses < $19.14, 90% of NF-MH median, $21.27	1
4	Staff turnover rate <= 75th percentile, 24% Staff turnover rate <= 50th percentile, 34% Contracted labor < 10% of total direct health care labor costs	2, or 1
5	Staff retention >= 75th percentile, 81% Staff retention >= 50th percentile, 79%	2, or 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

MAY 17 2012

OWNER/ADMINISTRATOR LIMITATION TABLE EFFECTIVE 07/01/11

Number of Beds	Total Bed Days	Maximum Owner/Admin Compensation	Limit PPD	F/Y	Amount	Cost of Living State Emp.
15	5,490	$22,327	$4.07	76	10,000	---
16	5,856	24,826	$4.24	77	10,280	2.800%
17	6,222	27,325	$4.39	78	10,537	2.500%
18	6,588	29,824	$4.53	79	11,301	7.250%
19	6,954	32,323	$4.65	80	11,781	4.250%
20	7,320	34,822	$4.76	81	12,617	7.100%
21	7,686	37,321	$4.86	82	13,248	5.000%
22	8,052	39,820	$4.95	83	14,109	6.500%
23	8,418	42,319	$5.03	84	14,426	2.250%
24	8,784	44,818	$5.10	85	15,147	5.000%
25	9,150	47,317	$5.17	86	15,933	5.190%
26	9,516	49,816	$5.23	87	16,411	3.000%
27	9,882	52,315	$5.29	88	16,575	1.000%
28	10,248	54,814	$5.35	89	17,238	4.000%
29	10,614	57,313	$5.40	90	17,755	3.000%
30	10,980	59,812	$5.45	91	18,021	1.500%
31	11,346	62,311	$5.49	92	18,021	0.000%
32	11,712	64,810	$5.53	93	18,111	0.500%
33	12,078	67,309	$5.57	94	18,202	0.500%
34	12,444	69,808	$5.61	95	18,407	1.125%
35	12,810	72,307	$5.64	96	18,591	1.000%
36	13,176	74,806	$5.68	97	18,591	0.000%
37	13,542	77,305	$5.71	98	18,777	1.000%
38	13,908	79,804	$5.74	99	19,059	1.500%
39	14,274	82,303	$5.77	00	19,250	1.000%
40	14,640	84,802	$5.79	01	19,250	0.000%
41	15,006	87,301	$5.82	02	19,683	2.250%
42	15,372	89,800	$5.84	03	19,683	0.000%
43	15,738	92,299	$5.86	04	19,978	1.500%
44	16,104	94,798	$5.89	05	20,577	3.000%
45	16,470	97,297	$5.91	06	20,834	1.250%
46	16,836	99,796	$5.93	07	21,355	2.500%
47	17,202	102,295	$5.95	08	21,782	2.000%
48	17,568	104,794	$5.97	09	22,327	2.500%
49	17,934	107,293	$5.98	10	22,327	0.000%
50	18,300	109,792	$6.00	11	22,327	0.000%
		90th Percentile PPD Administrator & Co-Administrator Salary.		12	22,327	0.000%

MAY 17 2012

June 17, 2011

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

Provider #: 104«PROV_NUM»01
HP Enterprise 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 2012 to our fiscal agent, HP Enterprise Services. The rate will become effective July 1, 2011.

The Kansas Department on Aging (KDOA), administers the Medicaid nursing facility services payment program on behalf of the Kansas Health Policy Authority. The rate was calculated by applying the appropriate Medicaid program policies and regulations to the cost report(s) (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 2010 calendar year end cost report. This information is intended to assist you with preparation of future cost reports.

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 about the adjustments, please contact John Oliver at (785) 296-6457 or via electronic mail at John.Oliver@aging.ks.gov. For questions on the Medicaid Rate, please contact Chris Chase at (785) 296-0703 or via electronic mail at Chris.Chase@aging.ks.gov.

Sincerely,

Dave Halferty, Chief Financial Officer
Financial and Information Services Commission

DH:ckc
Enclosure(s)

June 21, 2009

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

Provider #: 154«PROV_NUM»01
EDS Provider #: «EDS_PROV_N»

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We forwarded the per diem rate shown on the enclosed Case Mix Payment Schedule for the first quarter of state fiscal year 2012 to our fiscal agent, HP Enterprise Services. The rate will become effective July 1, 2011.

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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 John Oliver, Audit Manager, at (785) 296-6457 or by email at John.Oliver@aging.ks.gov.

Sincerely,

Rita Barnard
SRS NF/MH Programs

RB:ckc
Enclosures

COMPILATION OF COST CENTER LIMITATIONS
EFFECTIVE 07/01/11

	BEFORE INFLATION					***AFTER INFLATION***				
	OPER	IDHC	DHC	RPPF	TOTAL	OPER	IDHC	DHC	RPPF	TOTAL
MEDIAN	27.72	37.58	73.74	8.68	147.72	28.59	39.90	76.34	8.68	153.51
MEAN	28.90	39.11	75.24	8.23	151.48	29.86	41.40	78.23	8.23	157.72
WTMN	28.48	38.55	72.26	8.79	148.08	29.55	40.85	78.96	8.79	158.15
# OF PROV	322					322				

COMPILATION OF ADMINISTRATOR, CO-ADMIN OWNER EXPENSE - O/A LIMIT
EFFECTIVE 07/01/11

	ADMINISTRATOR		CO-ADMINISTRATOR		TOTAL ADMN & CO-ADMN		OWNER	
	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD
HIGH	211,849	9.95	86,456	4.30	211,849	9.95	337,366	14.30
99th	184,812	8.15	83,779	4.19	185,998	8.24	300,508	11.60
95th	115,565	6.88	73,072	3.74	119,796	6.94	206,888	8.02
90th	99,427	5.85	64,065	3.18	107,136	6.00	167,236	6.77
85th	91,294	5.17	63,808	2.61	94,577	5.28	124,169	6.42
80th	85,632	4.89	62,020	2.41	89,541	4.93	112,630	5.50
75th	81,306	4.51	59,466	2.38	83,150	4.59	91,513	4.91
70th	78,476	4.34	59,276	2.21	79,372	4.38	81,545	4.26
65th	75,247	4.18	57,189	2.08	76,438	4.23	70,929	3.79
60th	72,531	3.85	51,305	2.04	74,408	3.96	64,339	2.88
55th	70,470	3.58	46,757	1.94	71,382	3.73	55,053	2.59
50th	68,285	3.39	42,877	1.81	68,844	3.46	50,855	2.48
40th	62,758	3.05	40,891	1.38	63,176	3.17	40,765	2.10
30th	58,430	2.72	34,330	0.95	59,050	2.79	28,169	1.60
20th	51,114	2.28	26,879	0.85	52,177	2.39	20,026	0.74
10th	34,394	1.94	22,173	0.63	35,969	1.95	5,396	0.11
1st	12,342	1.02	16,057	0.45	12,342	1.02	1,604	0.08
LOW	3,047	0.71	15,291	0.43	3,047	0.71	1,139	0.07
MEAN	69,643	3.69	45,831	1.82	71,584	3.77	71,407	3.26
WTMN	78,628	3.24	44,809	1.54	81,261	3.33	77,616	2.84
# of Prov	307		13		307		53	

COMPILATION OF INCENTIVE POINTS AWARDED
EFF. 07/01/11

NURSING FACILITY

INCENTIVE AWARDED			# OF PROVIDERS	PERCENTAGE
$0.00			21	6.6%
$0.13	to	$0.25	7	2.2%
$0.31	to	$0.50	53	16.6%
$0.56	to	$1.00	27	8.5%
$1.13	to	$2.00	90	28.2%
$2.50	to	$3.25	74	23.2%
$3.63	to	$5.00	26	8.2%
$5.38	to	$6.50	21	6.6%
TOTALS			319	100%

NURSING FACILITY MENTAL HEALTH

INCENTIVE POINTS AWARDED	INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
0	$0.00	3	27.3%
1	$0.00	2	18.2%
2	$0.00	2	18.2%
3	$0.00	1	9.1%
4	$2.50	2	18.2%
5	$5.00	0	0.0%
6	$7.50	0	0.0%
7	$7.50	1	9.1%
8	$7.50	0	0.0%
TOTALS		11	100.0%

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

Minimum Wage Pass-Through

To compensate providers for increased expenses incurred to raise employees' 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.

1) 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.

2) 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 most recent cost report resident day total.

As an example, consider an employer that has ten employees receiving a wage of $6.75 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 $0.50. If each employee is expected to work 2,000 hours during fiscal year 2010, the total impact per employee will be $1,000 ($0.50 x 2,000 hrs). The total estimated impact for the provider

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

Minimum Wage Pass-Through

will be $10,000 ($1,000 x 10). If the employer provided 10,000 resident days during the most recent cost report, the pass-through per diem will be $10,000/10,000 days, or $1.00.

3) Per Diem Limits

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

4) 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.

5) Phasing Out the Pass-Through

The per diem pass-through will be phased out as the effects of the minimum wage increase are reflected in the cost reports.

The pass-through per diems will also be adjusted on a facility-specific basis to reflect the ratio of cost data that includes the new minimum wage costs. Since the base cost period for fiscal year 2012 is the cost report data from 2008-2010, minimum wage increases for July 1, 2008 and July 1, 2009 may not be reflected in the base cost data. Minimum wage pass-through per diems calculated during fiscal year 2009 and fiscal year 2010 will be reduced to reflect the ratio of the cost data that includes the new minimum wage costs.

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.

6) Auditing and Adjustments

Each qualifying providers' application and supporting documentation for the minimum wage pass-through will be subject to desk review and field audit and may by revised based on those findings. Corrections that result in a $0.10 or greater per diem change to the pass-through will be implemented. Retroactive rate adjustments will be made when necessary.

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

Durable Medical Equipment (DME) Pass-Through

To compensate providers for increased expenses incurred due to the transfer of responsibility for all durable medical equipment to the nursing home program, a per diem pass-through will be determined and added on to each 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 DME pass-through.

1) Qualifying Providers

All providers with costs reported on line 507 of the Medicaid cost report will be eligible to receive the DME pass-through.

2) Per Diem Pass-Through Calculation

The per diem pass-through will be determined by dividing the inflated unadjusted costs reported on line 507 for the base cost data period effective July 1, 2008, by the non-Medicaid days reported for the same period. Non-Medicaid resident days will be determined by subtracting Medicaid resident days from total resident days.

As an example, consider a provider that reported $1,000 on line 507 for each year in the base cost data period from 2005 through 2007. The cost will first be inflated for each year based on the IHS factors applied to cost data used to determine the base reimbursement rates. For 2005 the inflated cost would be $1,134, for 2006 the inflated costs would be $1,089, and for 2007 the inflated costs would be $1,055. The total inflated costs would be $3,278. If the provider reported 30,000 resident days during the base cost data period and 20,000 Medicaid days, the non-Medicaid resident day total would be 10,000 (30,000 – 20,000). The DME pass-through per diem would then be $0.33 ($3,278 / 10,000 rounded to the nearest hundredth).

3) Per Diem Limits

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

4) Effective Dates

The durable medical equipment pass-through will be effective July 1, 2008.

5) Phasing Out the Pass-Through

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

Durable Medical Equipment (DME) Pass-Through

The per diem pass-through will be phased out as the effects of transferring responsibility for all DME to the nursing home program are reflected in the cost reports.

The pass-through per diems will be adjusted on a facility-specific basis to reflect the ratio of cost data that includes the new DME expenses.

During the phasing out of the DME pass-through, if the per diem add-on falls below $0.10, it will be removed from the rate calculation. Since the base cost period for fiscal year 2012 is the cost report data from 2008-2010, DME expenses for July 1, 2008 may not be reflected in the base cost data. DME per diems calculated during fiscal year 2009 will be reduced to reflect the ratio of the cost data that reflects the new DME expenses.

6) Auditing and Adjustments

Each qualifying providers' cost report and supporting documentation used to determine the DME pass-through will be subject to desk review and field audit and may by revised based on those findings. Corrections that result in a $0.10 or greater per diem change to the pass-through will be implemented. Retroactive rate adjustments will be made when necessary.

Kansas Medicaid / MediKan

Case Mix Schedule
1st QTR 2012

Current Provider Information

Provider Number:	HP Enterprises Provider Number:	Medicaid CMI:	0.9588
Facility Name:	Area/County:	Medicare CMI:	0.0000
Address:		Private Pay/Other CMI:	0.9895
City/State/Zip:			
Administrator:			

Cost Report Statistics

Calendar Year Cost Reports Used For Base Data:	12/31/08	12/31/09	12/31/10	
Inflation Factor:	7.892%	5.424%	3.408%	
Facility Cost Report Period CMI:	0.9445	0.9199	0.8936	
Statewide Average CMI:	1.0026	1.0087	1.0124	1.0079 [b]
NF Or NF/MH Beds:	49	49	49	
Bed Days Available:	17,934	17,885	17,885	
Inpatient Days:	15,987	16,786	17,419	
Occupancy Rate:	89.1%	93.9%	97.4%	
Medicaid Days:	7,773	8,020	9,251	
Calc Days If Appl:	0	0	0	

Calculation of Combined Base Year Reimbursement Rate

Operating

Total Reported Costs:	$553,671	$607,206	$616,439		
Cost Report Adjustments:	$0	$0	$0		
O/A Limit Adjustment:	$0	$0	$0		
Total Adjusted Costs:	$553,671	$607,206	$616,439		
Total Inflated Adjusted Costs:	$597,367	$640,141	$637,447		
Total Combined Base Cost:				$1,874,955	
Days Used In Division Oper:	15,987	16,786	17,419	50,192	
				37.36	Oper Per Diem
				31.45	Oper Per Diem Cost Limitation
				31.45	Oper Per Diem Rate (1)

Indirect Health Care

Total Reported Costs:	$866,858	$954,305	$940,483		
Cost Report Adjustments:	$0	$0	$0		
Total Adjusted Costs:	$866,858	$954,305	$940,483		
Total Inflated Adjusted Costs:	$935,270	$1,006,067	$972,535		
Total Combined Base Cost:				$2,913,872	
Days Used In Division IDHC:	15,987	16,786	17,419	50,192	
				58.05	IDHC Per Diem
				45.89	IDHC Per Diem Cost Limitation
				45.89	IDHC Per Diem Rate (2)

Direct Health Care

Total Reported Costs:	$1,569,321	$1,683,346	$1,748,759		
Cost Report Adjustments:	$21,348	$17,590	($16,650)		
Total Adjusted Costs:	$1,590,669	$1,700,936	$1,732,109		
Total Inflated Adjusted Costs:	$1,716,205	$1,793,195	$1,791,139		
Total CMI Adjusted Costs:	$1,821,776	$1,966,296	$2,029,263		
Total Combined Base Cost:				$5,817,335	
Days Used In Division DHC:	15,987	16,786	17,419	50,192	
				115.90	Case Mix Adjusted DHC Per Diem
				99.24	DHC Per Diem Cost Limitation
				99.24	Allowable DHC Per Diem Cost [c]
			[c]*([a]/[b])	94.41	Medicaid Acuity Adjustment (3)

Real and Personal Property Fee

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

Calculation of Medicaid Rate

Operating, IDHC, And DHC Rates and RPPF (1) +(2) + (3) +(4):		178.57
Incentive Factor		2.50
DME Pass Through		0.00
Minimum Wage Pass Through		0.00
Total Medicaid Rate Effective	**07/01/2011**	**181.07**

MAY 17 2012

Prepared by Myers and Stauffer on 06/30/2010

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

Provider Number:
HP Enterprise Services Provider Number:

Facility Name:

Rate Effective Date: 07/01/11

	Incentive Possible	Facility Stats	Incentive Awarded
1. Case Mix Adjusted Nurse Staff Ratio			
Tier 1: At or Above the NF 75th Percentile (4.78)	$ 2.50		$ 0.00
Tier 2: Below the NF 75th Percentile but Improved At or Above 10%	$ 0.25		$ 0.00
Cost Report Year Data:		3.38 12/31/2010	
2. Staff Turnover			
Tier 1: At or Below the NF 75th Percentile (40.6%)	$ 2.50		$ 2.50
Tier 2: Above the NF 75th Percentile but Reduced At or Above 10% And Contract Nursing Labor Less than 10% of total DHC Labor Costs	$ 0.25		$ 0.00
Cost Report Year Data:		40.4% 12/31/2010	
3. Completion of the full Kansas Culture Change Instrument Survey	$ 0.38		$ 0.00
4. Occupancy Rate			
Medicaid Occupancy At or Above 60%	$ 1.13		$ 1.13
Cost Report Year Data:		62% 12/31/2010	
Total Incentive before Survey Adjustment			$ 3.63
Survey Adjustment and Reduction 0%			$ 0.00
Final Incentive Awarded			**$ 3.63**

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KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

Provider Number:
HP Enterprise Services Provider Number:

Facility Name:

Rate Effective Date: 07/01/11

	Incentive Possible	Facility Stats	Incentive Awarded
1. Case Mix Adjusted Nurse Staff Ratio			
Tier 1: At or Above 120% of NF-MH Median (3.66)	2		0
Tier 2: At or Above 110% of NF-MH Median of (3.36)	1		0
(NF-MH Median is 3.05 for an Average Statewide CMI of 1.0124)			
		2.19	
Cost Report Year Data:		12/31/2010	
2. Operating Expense			
At or Below the NF 75th Percentile (40.6%)	1		0
		$19.94	
Cost Report Year Data:		12/31/2010	
3. Staff Turnover			
Tier 1: At or Below the NF 75th Percentile (24%)	2		0
Tier 2: At or Below the NF 75th Percentile (34%)	1		1
And Contract Nursing Labor Less than 10%			
of total DHC Labor Costs			
		26%	
Cost Report Year Data:		12/31/2010	
4. Staff Retention			
Tier 1: At or Below the NF 75th Percentile (81%)	2		0
Tier 2: At or Below the NF 75th Percentile (79%)	1		1
		79%	
Cost Report Year Data:		12/31/2010	
5. Occupancy Rate			
Total Occupancy At or Below 90%	1		0
		99%	
Cost Report Year Data:		12/31/2010	
Total Points Awarded			**2**
Incentive Before Survey Adjustment			$0
Survey Adjustment and Reduction	0%		$0
Final Incentive			**$0**

Scoring:

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

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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-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. 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 2008, 2009, and 2010.

If the current provider has not submitted a calendar year report between 2008 and 2010, 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 12/31/11. 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

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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 12/31/11. This adjustment will be based on the IHS Global Insight, National Skilled Nursing Facility Market Basket Without Capital 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 12/31/11. 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.

Rates for Facilities Recognized as a Change of Provider (Change of Provider Status)

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Narrative Explanation of Nursing Facility Reimbursement Formula

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 2008 to 2010. 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 12/31/11. This adjustment will be based on the IHS GLOBAL INSIGHT, NATIONAL SKILLED NURSING FACILITY MARKET BASKET WITHOUT CAPITAL 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 12/31/11. 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 2008.

All cost data used to set rates for facilities reentering the program shall be adjusted to 12/31/11. This adjustment will be based on the IHS GLOBAL INSIGHT, NATIONAL SKILLED NURSING FACILITY MARKET BASKET WITHOUT CAPITAL 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 12/31/11. 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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Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

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 12/31/11. The inflation will be based on the IHS GLOBAL INSIGHT, NATIONAL SKILLED NURSING FACILITY MARKET BASKET WITHOUT CAPITAL INDEX.

The IHS 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 GLOBAL INSIGHT, NATIONAL SKILLED NURSING FACILITY TOTAL MARKET BASKET.

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6) Upper Payment Limits

There are three types of upper payment limits that will be described. One is the owner/related party/administrator/co-administrator limit. The second is the real and personal property fee limit. The last type of limit is an upper payment limit for each cost center. The upper payment limits are in effect during the payment rate period unless otherwise specified by a State Plan amendment.

Owner/Related Party/Administrator/Co-Administrator Limits:

Since salaries and other compensation of owners are not subject to the usual market constraints, specific limits are placed on the amounts reported. First, amounts paid to non-working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have their compensation limited by the percent of their total work time to a standard work week. A standard work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled, "Statement of Owners and Related Parties." This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in excess of the Kansas Civil Service based salary chart are transferred to the Operating cost center where the excess is subject to the Owner/Related Party/Administrator/Co-Administrator per diem compensation limit.

The Schedule C is an array of non-owner administrator and co-administrator salaries. The schedule includes the calendar year 2009 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 April 1, 2011.

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

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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 12/31/11. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based on the IHS GLOBAL INSIGHT, NATIONAL SKILLED NURSING FACILITY MARKET BASKET WITHOUT CAPITAL 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	130% 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.

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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 130% of the median, then the upper payment limit for the statewide average CMI would be $78 (**D**=130% 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.

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The next step is to determine the Medicaid acuity adjusted allowable Direct Health Care cost. The Medicaid CMI is divided by the statewide average CMI for the cost data period. This answer, is then multiplied by the Allowable Direct Health Care per diem cost. The result is referred to as the Medicaid Acuity Adjustment.

The Medicaid Acuity Adjustment is calculated quarterly to account for changes in the Medicaid CMI. To illustrate this calculation take the following situation: The facility's direct health care per diem cost is $60.00, the Direct Health Care per diem limit is $78.00, 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 IHS GLOBAL INSIGHT, NATIONAL SKILLED NURSING FACILITY TOTAL MARKET BASKET. The providers receive the lower of the inflated property fee or the upper payment limit.

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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. 129-10-25).

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 $2.50 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 $0.25 per diem add-on. Providers that achieve a turnover rate at or below the 75th percentile will earn a $2.50 per diem add-on. Providers that have a turnover rate greater than the 75th percentile but that reduce their turnover rate

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by 10% or more will receive a per diem add-on of $0.25. Providers that have completed the full Kansas Culture Change Instrument Survey will receive a $0.38 per diem add-on. Finally, providers that have a Medicaid occupancy percentage of 60% or more will receive a $1.13 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
CMI adjusted staffing ratio >= 75th percentile (4.78), or CMI adjusted staffing < 75th percentile but improved >= 10%	$2.50 $0.25
Staff turnover rate <= 75th percentile, 40.6% or Staff turnover rate > 75th percentile but reduced >= 10%	$2.50 $0.25
Completion of the full Kansas Culture Change Instrument Survey Medicaid occupancy >= 60%	$0.38 $1.13
Total Incentive Points Available	$6.51

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 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

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or exceeds 3.66, which is 120% of the statewide NFMH median of 3.05. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.36, 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.

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 $19.14, or 90% of the statewide median of $21.27.

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 24%, 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 24% but equal to or below 34%, 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 81%, the 75th percentile statewide will earn two points. Providers with staff retention rates at or above 79%, 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% (3.66) of NF-MH median (3.05), or CMI adjusted staffing ratio between 110% (3.36) and 120%	2, or 1
Total occupancy <= 90%	1
Operating expenses < $19.14, 90% of NF-MH median, $21.27	1
Staff turnover rate <= 75th percentile, 24% Staff turnover rate <= 50th percentile, 34% Contracted labor < 10% of total direct health care labor costs	2, or 1

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Staff retention >= 75th percentile, 81% Staff retention >= 50th percentile, 79%	2, or 1
Total Incentive Points Available	8

The Schedule E is an array containing the incentive points awarded to each NFMH provider for each quality and efficiency incentive outcome. The total of these points will be used to determine each provider's incentive factor based on the following table.

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

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Rate effective dates are determined in accordance with K.A.R. 30-10-19. The rate may be revised for an add-on reimbursement factor (i.e., rebased property fee), desk review adjustment or field audit adjustment.

11) Retroactive Rate Adjustments

Retroactive adjustments, as in a retrospective system, are made for the following three conditions:

A retroactive rate adjustment and direct cash settlement is made if the agency determines that the base year cost report data used to determine the prospective payment rate was in error. The prospective payment rate period is adjusted for the corrections.

If a projected cost report is approved to determine an interim rate, a settlement is also made after a historic cost report is filed for the same period.

All settlements are subject to upper payment limits. A provider is considered to be in projection status if they are operating on a projected rate and they are subject to the retroactive rate adjustment.

OS Notification

State/Title/Plan Number: Kansas 11-010

Type of Action: SPA Approval

Required Date for State Notification: 6/13/2012

Fiscal Impact: FFY 11 $2,750,000 FFY 11 $8,250,000

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: Yes **or Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:
This is a recurring annual amendment from the State. Effective July 1, 2011, this amendment modifies the rate setting methodology for Nursing Facility payments. Specifically, this amendment updates the base cost period and all components of the rate setting methodology by one year and updates numerous charts and exhibits within the State plan that demonstrate the revised factors and limits applicable to the new rate period. Funding for NF services comes from State general revenue and a previously approved nursing facility provider tax. Public process / public notice requirements were met. Tribal consultation requirements were met by the State.

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

CMS Contact:
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