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State/Territory Name: KS

State Plan Amendment (SPA) #: 15-0008

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

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

Financial Management Group

MAY 11 2016

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

RE: Kansas State Plan Amendment TN: 15-008

Dear Mr. Randol:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 15-008. This amendment updates components of the nursing facility rate setting methodology and updates numerous charts and exhibits within the State plan that demonstrate the revised factors and limits applicable to the new rate period beginning with SFY 2016. This SPA also clarifies provisions of the Quality and Incentive per diem add-on program and the Culture Change/Person-Centered Care Incentive Program (referred to as PEAK).

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 15-008 is approved effective July 1, 2015. We are enclosing the CMS-179 and the amended plan pages.

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 15-008

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, 2015

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 2015 $0
b. FFY 2016 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment, 4.19D, Part 1, Subpart C, Exhibit C-1 Pages 2, 3, 4, 7, 8, 9, 12, 14, 15 & 17a,
Attachment, 4.19D, Part 1, Subpart C, Exhibit C-2 Pages 1, 2, 3 & 3a
Attachment, 4.19-D, Part 1, Subpart C, Exhibit C-3, Pages 1, 2, 3 & 3a
Attachment, 4.19-D, Part 1, Subpart C, Exhibit C-4, Page 1
Attachment, 4.19-D, Part 1, Subpart C, Exhibit C-5, Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment, 4.19D, Part 1, Subpart C, Exhibit C-1 Pages 2, 3, 4, 7, 8, 9, 12, 14, 15 & 17a,
Attachment, 4.19D, Part 1, Subpart C, Exhibit C-2 Pages 1, 2, 3 & 3a
Attachment, 4.19-D, Part 1, Subpart C, Exhibit C-3, Pages 1, 2, 3 & 3a
Attachment, 4.19-D, Part 1, Subpart C, Exhibit C-4, Page 1
Attachment, 4.19-D, Part 1, Subpart C, Exhibit C-5, Page 1

10. SUBJECT OF AMENDMENT
Nursing facility annual rate increases

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:
Michal Randol is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
for Michael Randol

14. TITLE
Director, Division of Health Care Finance

15. DATE SUBMITTED
September 29, 2015

16. RETURN TO
Michael Randol, 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 MAY 11 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL JUL 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME Kristin FAN

22. TITLE Director, FMG

23. REMARKS

FORM CMS-179 (07/92

Instructions on Back

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 2010, 2011, and 2012.

If the current provider has not submitted a calendar year report between 2010 and 2012, 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 12/31/12. 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 12/31/12. 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 12/31/12. 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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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 2010 to 2012. 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 12/31/12. 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 12/31/12. 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 2010.

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

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 12/31/12. 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.

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

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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 2012 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

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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, 2012.

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 12/31/12. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based

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

INCENTIVE OUTCOME	INCENTIVE POINTS
CMI adjusted staffing ratio >= 75th percentile (4.93), or	$2.25
CMI adjusted staffing < 75th percentile but improved >= 10%	$0.20
Staff turnover rate <= 75th percentile, 46 % or	$2.25
Staff turnover rate > 75th percentile but reduced >= 10%	$0.20
Medicaid occupancy >= 60%	$1.00
Total Incentive Points Available	$5.90

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 or exceeds 3.78, which is 120% of the statewide NFMH median of 3.47. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.15 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.

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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 $19.35, or 90% of the statewide median of $21.50.

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 44%, 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 44% but equal to or below 52%, 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 73%, the 75th percentile statewide will earn two points. Providers with staff retention rates at or above 67%, 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% (3.78) of NF-MH median (3.47), or CMI adjusted staffing ratio between 110% (3.15) and 120%	2, or 1
Total occupancy <= 90%	1
Operating expenses < $19.35, 90% of NF-MH median, $21.50	1
Staff turnover rate <= 75th percentile, 44% Staff turnover rate <= 50th percentile, 52% Contracted labor < 10% of total direct health care labor costs	2, or 1
Staff retention >= 75th percentile, 73% Staff retention >= 50th percentile, 67%	2, or 1
Total Incentive Points Available	8

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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 $3.00	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.

COMPILATION OF NF
INCENTIVE POINTS AWARDED
EFF. 07/01/15

NURSING FACILITY

INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	81	25.3%
$0.20	26	8.1%
$0.40	1	0.3%
$1.00	65	20.3%
$1.20	29	9.1%
$1.40	4	1.3%
$2.25	61	19.1%
$2.45	4	1.3%
$3.25	20	6.3%
$3.45	1	0.3%
$4.50	21	6.6%
$5.50	7	2.2%
TOTALS	320	100%

PEAK INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	96	30.0%
$0.50	160	50.0%
$1.00	1	0.3%
$1.50	54	16.9%
$2.00	2	0.6%
$3.00	1	0.3%
$4.00	6	1.9%
TOTALS	320	100.0%

COMPILATION OF NF-MH INCENTIVE POINTS AWARDED EFF. 07/01/15

INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	6	54.5%
$2.50	3	27.3%
$5.00	2	18.2%
$7.50	0	0.0%
TOTALS	11	100.0%

PEAK INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	5	45.5%
$0.50	3	27.3%
$1.00	0	0.0%
$2.00	3	27.3%
$3.00	0	0.0%
$4.00	0	0.0%
TOTALS	11	100.0%

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 real and personal property fee is calculated by adding the facility's applicable Mortgage Interest, Lease/Improvements, and Depreciation, and dividing the total by the number of Census days per MS-2004 (or calculated by 85% rule, if applicable). The property fee will be the lower of the facility-specific inflated property fee or the upper payment limit.

INFLATION TABLE
EFFECTIVE 07/01/15

REPORT YEAR END (RYE)	MIDPOINT OF RYE	MIDPOINT OF RYE INDEX	MIDPOINT OF RATE PERIOD	MIDPOINT OF RATE PERIOD INDEX	HISTORICAL INFLATION FACTOR % *
12-09	06-09	1.180	12-12	1.267	7.373%
01-10	07-09	1.187	12-12	1.267	6.740%
02-10	08-09	1.187	12-12	1.267	6.740%
03-10	09-09	1.187	12-12	1.267	6.740%
04-10	10-09	1.189	12-12	1.267	6.560%
05-10	11-09	1.189	12-12	1.267	6.560%
06-10	12-09	1.189	12-12	1.267	6.560%
07-10	01-10	1.200	12-12	1.267	5.583%
08-10	02-10	1.200	12-12	1.267	5.583%
09-10	03-10	1.200	12-12	1.267	5.583%
10-10	04-10	1.203	12-12	1.267	5.320%
11-10	05-10	1.203	12-12	1.267	5.320%
12-10	06-10	1.203	12-12	1.267	5.320%
01-11	07-10	1.210	12-12	1.267	4.711%
02-11	08-10	1.210	12-12	1.267	4.711%
03-11	09-10	1.210	12-12	1.267	4.711%
04-11	10-10	1.212	12-12	1.267	4.538%
05-11	11-10	1.212	12-12	1.267	4.538%
06-11	12-10	1.212	12-12	1.267	4.538%
07-11	01-11	1.224	12-12	1.267	3.513%
08-11	02-11	1.224	12-12	1.267	3.513%
09-11	03-11	1.224	12-12	1.267	3.513%
10-11	04-11	1.231	12-12	1.267	2.924%
11-11	05-11	1.231	12-12	1.267	2.924%
12-11	06-11	1.231	12-12	1.267	2.924%
01-12	07-11	1.239	12-12	1.267	2.260%
02-12	08-11	1.239	12-12	1.267	2.260%
03-12	09-11	1.239	12-12	1.267	2.260%
04-12	10-11	1.239	12-12	1.267	2.260%
05-12	11-11	1.239	12-12	1.267	2.260%
06-12	12-11	1.239	12-12	1.267	2.260%
07-12	01-12	1.252	12-12	1.267	1.198%
08-12	02-12	1.252	12-12	1.267	1.198%
09-12	03-12	1.252	12-12	1.267	1.198%
10-12	04-12	1.255	12-12	1.267	0.956%
11-12	05-12	1.255	12-12	1.267	0.956%
12-12	06-12	1.255	12-12	1.267	0.956%
01-13	07-12	1.263	12-12	1.267	0.317%
02-13	08-12	1.263	12-12	1.267	0.317%
03-13	09-12	1.263	12-12	1.267	0.317%
04-13	10-12	1.267	12-12	1.267	0.000%
05-13	11-12	1.267	12-12	1.267	0.000%
06-13	12-12	1.267	12-12	1.267	0.000%

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

COST CENTER LIMITATIONS EFFECTIVE 07/01/15

COST CENTER	UPPER LIMIT
Operating	$32.25
Indirect Health Care	$47.78
Direct Health Care	103.69*
Real and Personal Property Fee	$9.38

* = Base limit for a facility average case mix index of 1.0124

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/15

NF-MH ONLY

	QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 120% (4.20) of NF-MH median (3.05), or CMI adjusted staffing ratio between 110% (3.85) and 120%	2, or 1
2	Total occupancy <= 90%	1
3	Operating expenses < $19.11, 90% of NF-MH median, $21.23	1
4	Staff turnover rate <= 75th percentile, 24% Staff turnover rate <= 50th percentile, 36% Contracted labor < 10% of total direct health care labor costs	2, or 1
5	Staff retention >= 75th percentile, 84% Staff retention >= 50th percentile, 75%	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

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/15

NF ONLY

	INCENTIVE OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 75th percentile (4.93), or	$2.25
	CMI adjusted staffing < 75th percentile but improved >= 10%	$0.20
2	Staff turnover rate <= 75th percentile, 40.66% or	$2.25
	Staff turnover rate > 75th percentile but reduced >= 10%	$0.20
3	Medicaid occupancy >= 60%	$1.00
	Total Incentive Points Available	$5.50

COMPILATION OF COST CENTER LIMITATIONS
EFFECTIVE 07/01/15

	BEFORE INFLATION					***AFTER INFLATION***				
	OPER	IDHC	DHC	RPPF	TOTAL	OPER	IDHC	DHC	RPPF	TOTAL
MEDIAN	28.93	40.14	78.81	8.93	156.81	29.32	41.55	79.76	8.93	159.56
MEAN	30.22	41.54	80.42	9.44	161.62	30.76	42.91	83.55	9.44	166.66
WTMN	29.78	41.06	80.99	9.52	161.35	30.38	42.45	83.31	9.52	165.66
# OF PROV	308					308				

COMPILATION OF ADMINISTRATOR, CO-ADMIN OWNER EXPENSE - O/A LIMIT
EFFECTIVE 07/01/15

	ADMINISTRATOR		CO-ADMINISTRATOR		TOTAL ADMN & CO-ADMN		OWNER	
	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD
HIGH	246,357	10.53	87,847	3.12	246,357	10.53	250,618	10.83
99th	182,183	8.30	74,061	2.58	190,621	8.61	228,955	8.00
95th	123,262	6.95	74,061	2.58	123,520	7.07	226,620	6.66
90th	99,990	6.02	74,061	2.58	100,834	6.07	172,213	6.43
85th	93,928	5.40	69,915	2.23	94,683	5.44	97,199	5.30
80th	89,004	5.00	69,915	2.23	89,004	5.00	91,802	5.11
75th	84,277	4.73	69,915	2.23	84,277	4.73	89,040	4.42
70th	81,843	4.50	69,708	1.66	81,843	4.50	79,604	3.27
65th	77,406	4.22	69,708	1.66	77,482	4.23	75,662	3.04
60th	73,535	4.02	25,158	1.64	73,690	4.04	67,332	2.82
55th	71,518	3.76	25,158	1.64	71,518	3.76	60,106	2.77
50th	69,967	3.59	25,158	1.64	69,967	3.59	57,369	2.57
40th	65,734	3.26	20,354	0.50	65,734	3.26	50,036	2.27
30th	60,236	2.81	1,672	0.09	60,236	2.81	25,757	1.09
20th	52,890	2.51	1,672	0.09	52,890	2.51	12,362	0.46
10th	35,330	2.04	242	0.01	35,330	2.04	7,449	0.22
1st	11,826	1.09	242	0.01	11,826	1.09	4,321	0.19
LOW	3,137	0.87	242	0.01	3,137	0.87	3,644	0.18
MEAN	72,480	3.84	87,847	3.12	72,480	3.84	97,633	4.18
WTMN	82,861	3.41	87,847	3.12	82,861	3.41	99,971	4.13
# of Prov	297		8		297		40	

June 11, 2015

«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 2016 has been forwarded to the Managed Care Organizations (MCOs) for processing of future reimbursement payments. The rate will become effective July 1, 2015.

The Kansas Department on 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 2014 calendar year end cost report. This information is intended to assist you with preparation of future cost reports. The calendar years of 2010, 2011 and 2012 will be used as the base years for the purpose of setting, rates. These adjustments do not have any effect upon reimbursement. 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@kdads.ks.gov . For questions on the Medicaid Rate, please contact Chris Chase at (785) 296-0703 or email at Chris.Chase@kdads.ks.gov.

Sincerely,

[redacted]

Rhonda Boose, Reimbursement Manager
NF Reimbursement Program
Financial and Information Services

RB:ckc
Enclosures