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State/Territory Name: KS

State Plan Amendment (SPA) #: 17-0010

This file contains the following documents in the order listed:

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

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

Financial Management Group

DEC 12 2017

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

RE: Kansas State Plan Amendment TN: 17-010

Dear Mr. Hamdorf:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 17-010. This amendment rebases Nursing Facility and Nursing Facility for Mental Health payment rates for State fiscal year 2018. Payment rates will increase on average by 4.76 percent. This SPA also updates charts and exhibits within the State plan that demonstrate the revised factors and limits applicable to the rate period beginning with SFY 2018.

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 17-010 is approved effective July 1, 2017. We are enclosing the CMS-179 and the amended plan page.

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

Sincerely,

Kristin Fan
Director

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

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

1. TRANSMITTAL NUMBER: KS 17-010

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, 2017

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 2017 $4,006,772
b. FFY 2018 $11,705,963

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19D, Part I, Subpart C, Exhibit C-1 pages 2,3,4,7,8,9, 11, 14,15, 17, 17a, 19
Attachment 4.19D, Part I, Subpart C, Exhibit C-2 pages 1, 2, 3, 3a, 3b, 3c, 5
Attachment 4.19D, Part I, Subpart C, Exhibit C-3 pages 1, 2, 3, 3a
Attachment 4.19D, Part I, Subpart C, Exhibit C-5 pages 1, 2, 3

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

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

11. GOVERNOR'S REVIEW *(Check One)*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Michael 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 27, 2017

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 DEC 12 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL JUL 01 2017

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME Kristin Fan

22. TITLE Director, FMG

23. REMARKS

Pen + ink change to blocks #8 and #9 per State's request. (TW)

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 2014, 2015, and 2016.

If the current provider has not submitted a calendar year report during the base cost period, the cost data submitted by the previous provider for that same period will be used as the base cost data. Once the provider completes their first 24 months in the program, their first calendar year cost report will become the provider's base cost data.

The allowable expenses are divided into three cost centers. The cost centers are Operating, Indirect Health Care and Direct Health Care. They are defined in K.A.R. 129-10-18.

The allowable historic per diem cost is determined by dividing the allowable resident related expenses in each cost center by resident days. Before determining the per diem cost, each year's cost data is adjusted from the midpoint of that year to December 31, 2017. The resident days and inflation factors used in the rate determination will be explained in greater detail in the following sections.

The inflated allowable historic per diem cost for each cost center is then compared to the cost center upper payment limit. The allowable per diem rate is the lesser of the inflated allowable historic per diem cost in each cost center or the cost center upper payment limit. Each cost center has a separate upper payment limit. If each cost center

upper payment limit is exceeded, the allowable per diem rate is the sum of the three cost center upper payment limits. There is also a separate upper payment limit for owner, related party, administrator, and co-administrator compensation. The upper payment limits will be explained in more detail in a separate section.

The case mix of the residents adjusts the Direct Health Care cost center. The reasoning behind a case mix payment system is that the characteristics of the residents in a facility should be considered in determining the payment rate. The idea is that certain resident characteristics can be used to predict future costs to care for residents with those same characteristics. For these reasons, it is desirable to use the case mix classification for each facility in adjusting provider rates.

There are add-ons to the allowable per diem rate. The add-ons consist of the incentive factor, the real and personal property fee, and per diem pass-throughs to cover costs not included in the cost report data. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. Pass-throughs are explained in separate subparts of Attachment 4.19D of the State Plan. The add-ons plus the allowable per diem rate equal the total per diem rate.

Rates for New Construction and New Facilities (New Enrollment Status)

The per diem rate for newly constructed nursing facilities, or new facilities to the Kansas Medical Assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 129-10-17.

The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to December 31, 2017. This adjustment will be based on the IHS Global Insight, National Skilled Nursing Facility Market Basket Without Capital Index (IHS Index). The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to December 31, 2017. The provider shall remain in new enrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

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

The payment rate for the first 24 months of operation shall be based on the base cost data of the previous owner or provider. This base cost data shall include data from each calendar year cost report that was filed by the previous provider from 2014 to 2016. 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 December 31, 2017. This adjustment will be based on the IHS Index. The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to December 31, 2017. The provider shall remain in change-of-provider status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change of provider status.

Rates for Facilities Re-entering the Program (Reenrollment Status)

The per diem rate for each provider reentering the Medicaid program shall be determined from a projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more. The per diem rate for all other providers reentering the program shall be determined from the base cost data filed with the agency or the most recent cost report filed preceding the base cost data period.

All cost data used to set rates for facilities reentering the program shall be adjusted to December 31, 2017. This adjustment will be based on the IHS Index. The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to December 31, 2017. 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 December 31, 2017. The inflation will be based on the IHS Global Insight, CMS Nursing Home without Capital Market Basket index.

The IHS Global Insight, CMS Nursing Home without Capital Market Basket Indices listed in the latest available quarterly publication will be used to determine the inflation tables for the payment schedules processed during the payment rate period. This may require the use of forecasted factors in the inflation table. The inflation tables will not be revised until the next payment rate period.

The inflation factor will not be applied to the following costs:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

The inflation factor for the real and personal property fees will be based on the IHS index.

6) Upper Payment Limits

There are three types of upper payment limits that will be described. One is the owner/related party/administrator/co-administrator limit. The second is the real and personal property fee limit. The last type of limit is an upper payment limit for each cost

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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 2016 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, 2017.

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 December 31, 2017. 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 first step is to normalize each facility's inflated Direct Health Care costs to the statewide average CMI. This is done by dividing the statewide average CMI for the cost report year by the facility's cost report period CMI, then multiplying this answer by the facility's inflated costs. This step is repeated for each cost report year for which data is included in the base cost data.

The second step is to determine per diem costs and array them to determine the median. The per diem cost is determined by dividing the total of each provider's base direct health care costs by the total days provided during the base cost data period. The median is located using a day-weighted methodology. That is, the median cost is the per diem cost for the facility in the array at which point the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all providers. The facility with the median resident day in the array sets the median inflated direct health care cost. For example, if there are eight million resident days, the facility in the array with the 4 millionth day would set the median.

The final step in calculating the base Direct Health Care upper payment limit is to apply the percentage factor to the median cost. For example, if the median cost is $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.

The next step is to determine the Medicaid acuity adjusted allowable Direct Health Care cost. The facility's Medicaid CMI is determined by averaging the facility average Medicaid CMI from the two quarters preceding the rate effective data. The Medicaid CMI is then divided by the statewide average CMI for the cost data period. Finally, this result, is then multiplied by the Allowable Direct Health Care per diem cost. The result is referred to as the Medicaid Acuity Adjustment.

The Medicaid Acuity Adjustment is calculated semi-annually to account for changes in the Medicaid CMI. To illustrate this calculation take the following situation: The

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

INCENTIVE OUTCOME	INCENTIVE FACTOR PER DIEM
CMI adjusted staffing ratio >= 75th percentile (5.26), or	$2.25
CMI adjusted staffing < 75th percentile but improved >= 10%	$0.20
Staff turnover rate <= 75th percentile, 49 % or Staff turnover rate > 75th percentile but reduced >= 10% Contracted labor < 10% of total direct health care labor costs	$2.25 $0.20
Medicaid occupancy >= 60%	$1.00
Total Incentive Add-ons-Available	$5.50

Nursing Facility for Mental Health Quality and Efficiency Incentive Factor:

The Quality and Efficiency Incentive plan for Nursing Facilities for Mental Health (NFMH) will be established separately from NF. NFMH serve people who often do not need the NF level of care on a long term basis. There is a desire to provide incentive for NFMH to work cooperatively and in coordination with Community Mental Health Centers to facilitate the return of persons to the community.

The Quality and Efficiency Incentive Factor is a per diem add-on ranging from zero ($0.00) to seven dollars and fifty cents ($7.50). It is designed to encourage quality care, efficiency and cooperation with discharge planning. The incentive factor is determined by five outcome measures: case-mix adjusted nurse staffing ratio; operating expense; staff turnover rate; staff retention rate; and occupancy rate. Each provider is awarded points based on their outcomes measures and the total points for each provider determine the per diem incentive factor included in the provider's rate calculation.

Providers may earn up to two incentive points for their case mix adjusted nurse staffing ratio. They will receive two points if their case-mix adjusted staffing ratio equals or exceeds 3.92, which is 120% of the statewide NFMH median of 3.27. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.60 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 $20.51, or 90% of the statewide median of $22.79.

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 ~~39~~50%, 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 50% but equal to or below 68%, 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 below 73%, but at or above 59%, 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% (3.92) of NF-MH median (3.27), or CMI adjusted staffing ratio between 110% (3.60) and 120%	2, or 1
Total occupancy <= 90%	1
Operating expenses < $20.51, 90% of NF-MH median, $22.79	1
Staff turnover rate <= 75th percentile, 50% Staff turnover rate <= 50th percentile, 68% Contracted labor < 10% of total direct health care labor costs	2, or 1
Staff retention >= 75th percentile, 73% Staff retention >= 50th percentile, 59%	2, or 1
Total Incentive Points Available	8

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

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

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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.

Budget Adjustments

Effective for dates of service on or after July 1, 2017, the calculated per diem reimbursement for all nursing facilities shall be reduced by an amount equal to 3.65%. The per diem reduction will be calculated for each nursing facility by multiplying the total calculated per diem rate for each provider by 3.65%. The per diem reduction amount will be subtracted from each nursing facility's total calculated per diem to determine the facility's final rate.

COMPILATION OF COST CENTER LIMITATIONS
EFFECTIVE 07/01/17

	BEFORE INFLATION					***AFTER INFLATION***				
	OPER	IDHC	DHC	RPPF	TOTAL	OPER	IDHC	DHC	RPPF	TOTAL
MEDIAN	32.95	43.95	88.02	9.29	174.21	34.94	47.22	93.95	9.29	185.40
MEAN	35.57	46.38	92.38	12.39	186.72	37.51	49.87	98.49	12.39	198.26
WTMN	34.44	45.27	92.08	12.56	184.35	36.44	48.78	97.71	12.56	195.49
# OF PROV	322					322				

REPORT YEAR END (RYE)	MIDPOINT OF RYE	MIDPOINT OF RYE INDEX	MIDPOINT OF RATE PERIOD	MIDPOINT OF RATE PERIOD INDEX	HISTORICAL INFLATION FACTOR % *
12-13	06-13	1.283	06-16	1.430	11.458%
01-14	07-13	1.287	06-16	1.430	11.111%
02-14	08-13	1.287	06-16	1.430	11.111%
03-14	09-13	1.287	06-16	1.430	11.111%
04-14	10-13	1.286	06-16	1.430	11.198%
05-14	11-13	1.286	06-16	1.430	11.198%
06-14	12-13	1.286	06-16	1.430	11.198%
07-14	01-14	1.300	06-16	1.430	10.000%
08-14	02-14	1.300	06-16	1.430	10.000%
09-14	03-14	1.300	06-16	1.430	10.000%
10-14	04-14	1.305	06-16	1.430	9.579%
11-14	05-14	1.305	06-16	1.430	9.579%
12-14	06-14	1.305	06-16	1.430	9.579%
01-15	07-14	1.313	06-16	1.430	8.911%
02-15	08-14	1.313	06-16	1.430	8.911%
03-15	09-14	1.313	06-16	1.430	8.911%
04-15	10-14	1.320	06-16	1.430	8.333%
05-15	11-14	1.320	06-16	1.430	8.333%
06-15	12-14	1.320	06-16	1.430	8.333%
07-15	01-15	1.329	06-16	1.430	7.600%
08-15	02-15	1.329	06-16	1.430	7.600%
09-15	03-15	1.329	06-16	1.430	7.600%
10-15	04-15	1.336	06-16	1.430	7.036%
11-15	05-15	1.336	06-16	1.430	7.036%
12-15	06-15	1.336	06-16	1.430	7.036%
01-16	07-15	1.347	06-16	1.430	6.162%
02-16	08-15	1.347	06-16	1.430	6.162%
03-16	09-15	1.347	06-16	1.430	6.162%
04-16	10-15	1.347	06-16	1.430	6.162%
05-16	11-15	1.347	06-16	1.430	6.162%
06-16	12-15	1.347	06-16	1.430	6.162%
07-16	01-16	1.362	06-16	1.430	4.993%
08-16	02-16	1.362	06-16	1.430	4.993%
09-16	03-16	1.362	06-16	1.430	4.993%
10-16	04-16	1.370	06-16	1.430	4.380%
11-16	05-16	1.370	06-16	1.430	4.380%
12-16	06-16	1.370	06-16	1.430	4.380%
01-17	07-16	1.380	06-16	1.430	3.623%
02-17	08-16	1.380	06-16	1.430	3.623%
03-17	09-16	1.380	06-16	1.430	3.623%
04-17	10-16	1.389	06-16	1.430	2.952%
05-17	11-16	1.389	06-16	1.430	2.952%
06-17	12-16	1.389	06-16	1.430	2.952%

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

COST CENTER LIMITATIONS EFFECTIVE 07/01/17

COST CENTER	UPPER LIMIT
Operating	$38.43
Indirect Health Care	$54.30
Direct Health Care	$122.14*
Real and Personal Property Fee	$9.75

* = Base limit for a facility average case mix index of 1.200

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/17

NF ONLY

	INCENTIVE OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 75th percentile (5.26), or	$2.25
	CMI adjusted staffing < 75th percentile but improved >= 10%	$0.20
2	Staff turnover rate <= 75th percentile, 49% 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

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/17

NF-MH ONLY

	QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 120% (3.92) of NF-MH median (3.27), or CMI adjusted staffing ratio between 110% (3.60) and 120%	2, or 1
2	Total occupancy <= 90%	1
3	Operating expenses < $20.51, 90% of NF-MH median, $2.79	1
4	Staff turnover rate <= 75th percentile, 50% Staff turnover rate <= 50th percentile, 68% Contracted labor < 10% of total direct health care labor costs	2, or 1
5	Staff retention >= 75th percentile, 73% Staff retention >= 50th percentile, 59%	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

PEAK INCENTIVE FACTOR EFFECTIVE 07/01/17

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

OWNER/ADMINISTRATOR LIMITATION TABLE EFFECTIVE 07/01/17

Number of Beds	Total Bed Days	Maximum Owner/Admin Compensation	Limit PPD	F/Y	Amount	Cost of Living State Emp.
15	5,475	$22,327	$4.08	90	17,755	3.000%
16	5,840	$25,261	$4.33	91	18,021	1.500%
17	6,205	$28,195	$4.54	92	18,021	0.000%
18	6,570	$31,129	$4.74	93	18,111	0.500%
19	6,935	$34,063	$4.91	94	18,202	0.500%
20	7,300	$36,997	$5.07	95	18,407	1.125%
21	7,665	$39,931	$5.21	96	18,591	1.000%
22	8,030	$42,865	$5.34	97	18,591	0.000%
23	8,395	$45,799	$5.46	98	18,777	1.000%
24	8,760	$48,733	$5.56	99	19,059	1.500%
25	9,125	$51,667	$5.66	00	19,250	1.000%
26	9,490	$54,601	$5.75	01	19,250	0.000%
27	9,855	$57,535	$5.84	02	19,683	2.250%
28	10,220	$60,469	$5.92	03	19,683	0.000%
29	10,585	$63,403	$5.99	04	19,978	1.500%
30	10,950	$66,337	$6.06	05	20,577	3.000%
31	11,315	$69,271	$6.12	06	20,834	1.250%
32	11,680	$72,205	$6.18	07	21,355	2.500%
33	12,045	$75,139	$6.24	08	21,782	2.000%
34	12,410	$78,073	$6.29	09	22,327	2.500%
35	12,775	$81,007	$6.34	10	22,327	0.000%
36	13,140	$83,941	$6.39	11	22,327	0.000%
37	13,505	$86,875	$6.43	12	22,327	0.000%
38	13,870	$89,809	$6.48	13	22,327	0.000%
39	14,235	$92,743	$6.52	14	22,327	0.000%
40	14,600	$95,677	$6.55	15	22,327	0.000%
41	14,965	$98,611	$6.59	16	22,327	0.000%
42	15,330	$101,545	$6.62	17	22,327	0.000%
43	15,695	$104,479	$6.66	18	22,327	0.000%
44	16,060	$107,413	$6.69			
45	16,425	$110,347	$6.72			
46	16,790	$113,281	$6.75			
47	17,155	$116,215	$6.77			
48	17,520	$119,149	$6.80			
49	17,885	$122,083	$6.83			
50	18,250	$125,017	$6.85			

Kansas Medicaid / MediKan

Case Mix Schedule
1st - 2nd QTR 2018 ANNUAL

Current Provider Information

Provider Number:	HP Enterprises Provider Number:	1st QTR Medicaid CMI:	1.0444
Facility Name:	Area/County:	2nd QTR Medicaid CMI:	1.0241
Address:		Average Medicaid CMI:	1.0343 [a]
City/State/Zip:			
Administrator:			

Cost Report Statistics

Calendar Year Cost Reports Used For Base Data:	12/31/14	12/31/15	12/31/16	
Inflation Factor:	9.579%	7.036%	4.380%	
Facility Cost Report Period CMI:	1.0510	1.0429	1.0886	
Statewide Average CMI:	1.0145	1.0231	1.0225	1.0200 [b]
NF Or NF/MH Beds:	95	85	85	
Bed Days Available:	32,865	32,225	31,110	
Inpatient Days:	27,968	27,002	23,095	
Occupancy Rate:	85.1%	83.8%	74.2%	
Medicaid Days:	16,802	17,585	14,220	
Calc Days if Appl:	27935	27,391	26,444	

Calculation of Combined Base Year Reimbursement Rate

Operating

Total Reported Costs:	$693,546	$810,329	$827,212		
Cost Report Adjustments:	$0	$20,449	$0		
O/A Limit Adjustment:	($7,556)	($90,563)	$0		
Total Adjustad Costs:	$685,990	$740,215	$827,212		
Total Inflated Adjusted Costs:	$726,160	$775,955	$856,629		
Total Combined Base Cost:				$2,358,744	
Days Used In Division Oper:	27,968	27,391	26,444	81,803	
				28.83	Oper Per Diem
				38.43	Oper Per Diem Cost Limitation
				28.83	Oper Per Diem Rate (1)

Indirect Health Care

Total Reported Costs:	$1,258,374	$1,064,913	$967,021		
Cost Report Adjustments:	$0	$0	$0		
Total Adjusted Costs:	$1,258,374	$1,064,913	$967,021		
Total Inflated Adjusted Costs:	$1,378,914	$1,139,840	$1,009,377		
Total Combined Base Cost:				$3,528,131	
Days Used In Division IDHC:	27,968	27,391	26,444	81,803	
				43.79	IDHC Per Diem
				54.30	IDHC Per Diem Cost Limitation
				43.79	IDHC Per Diem Rate (2)

Direct Health Care

Total Reported Costs:	$1,875,091	$1,939,570	$1,830,983		
Cost Report Adjustments:	$0	($23,413)	$0		
Total Adjusted Costs:	$1,875,091	$1,916,157	$1,830,983		
Total Inflated Adjusted Costs:	$2,050,445	$2,047,184	$1,911,180		
Total CMI Adjusted Costs:	$1,979,235	$2,008,611	$1,795,133		
Total Combined Base Cost:				$5,782,979	
Days Used In Division DHC:	27,968	27,002	23,095	78,065	
				74.08	Case Mix Adjusted DHC Per Diem
				122.14	DHC Per Diem Cost Limitation
				74.08	Allowable DHC Per Diem Cost [c]
			[c]*([a]/[b])	75.12	Medicaid Acuity Adjustment (3)

Real and Personal Property Fee

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

Calculation of Medicaid Rate

Operating, IDHC, And DHC Rates and RPPF (1) +(2) + (3) +(4):		176.56
Incentive Factor		1.20
PEAK 2.0		0.50
Bed Tax Pass Through		3.01
DME Pass Through		0.00
Minimum Wage Pass Through		0.00
Medicaid Rate Subtotal		162.20
Budget Adjustment Using (3.650%)		(5.92)
Total Medicaid Rate Effective	**7/1/2017**	**156.28**

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

Provider Number:
HP Enterprise Services Provider Number:

Facility Name:

Rate Effective Date: 07/01/17

	Incentive Possible	Facility Stats	Incentive Awarded
1. Case Mix Adjusted Nurse Staff Ratio			
Tier 1: At or Above the NF 75th Percentile (5.26)	$ 2.25		$ 2.25
Tier 2: Below the NF 75th Percentile but Improved At or Above 10%	$ 0.20		$ 0.00
Cost Report Year Data:		6.22 12/31/2016	
2. Staff Turnover			
Tier 1: At or Below the NF 75th Percentile (49%)	$ 2.25		$ 2.25
Tier 2: Above the NF 75th Percentile but Reduced At or Above 10%	$ 0.20		$ 0.00
And Contract Nursing Labor Less than 10% of total DHC Labor Costs (Contract Labor 41%)		37%	
Cost Report Year Data:		12/31/2016	
3. Occupancy Rate			
Medicaid Occupancy At or Above 60%	$ 1.00		$0.00
Cost Report Year Data:		38% 12/31/2016	
Total Incentive before Survey Adjustment			$ 4.50
Survey Adjustment and Reduction 0%			$ 0.00
Final Incentive Awarded			$ 4.50
Peak 2.0 Incentive	$ 4.00		$ 0.50
Peak 2.0 Survey Adjustment and Reduction 0%			$ 0.00
Final PEAK 2.0 Incentive Awarded			$ 0.50

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

Provider Number:
HP Enterprise Services Provider Number:

Facility Name:

Rate Effective Date: 07/01/17

	Incentive Possible	Facility Stats	Incentive Awarded
1. Case Mix Adjusted Nurse Staff Ratio			
Tier 1: At or Above 120% of NF-MH Median (3.92)	2		2
Tier 2: At or Above 110% of NF-MH Median of (3.60)	1		0
(NF-MH Median is 3.27 for an Average Statewide CMI of 1.0225)			
		4.77	
Cost Report Year Data:		12/31/2016	
2. Operating Expense			
At or below 90% of NF-MH Median ($20.51)	1		0
		$31.06	
Cost Report Year Data:		12/31/2016	
3. Staff Turnover			
Tier 1: At or Below the NF-MH 75th Percentile (50%)	2		2
Tier 2: At or Below the NF-MH 50th Percentile (68%)	1		0
And Contract Nursing Labor Less than 10% of Total DHC Labor Costs (0.0%)			
		50%	
Cost Report Year Data:		12/31/2016	
4. Staff Retention			
Tier 1: At or Above the NF-MH 75th Percentile (73%)	2		0
Tier 2: At or Above the NF-MH 50th Percentile (59%)	1		1
		59%	
Cost Report Year Data:		12/31/2016	
5. Occupancy Rate			
Total Occupancy At or Below 90%	1		1
		97%	
Cost Report Year Data:		12/31/2016	
Total Points Awarded			6

Incentive Before Survey Adjustment		$ 7.50
Survey Adjustment and Reduction	0%	$0.00
Final Incentive		$ 7.50

Scoring:

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

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