Table of Contents

State/Territory Name: Kentucky

State Plan Amendment (SPA) #: KY 24-0004

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 S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

January 8, 2025

Lisa Lee
275 E. Main St.
Frankfort, KY 40601

RE: TN 24-0004

Dear Commissioner Lee:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Kentucky state plan amendment (SPA) to Attachment 4.19-D KY-24-0004, which was submitted to CMS on June 5, 2024. This plan amendment is amending its state plan to transition from the RUG III methodology to the Patient Driven Payment Model (PDPM) to calculate each individual price-based long term care facility's average case-mix.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Tom Caughey at 517-487-8598 or via email at tom.caughey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

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: 24 — 0004

2. STATE: KY

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 413

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 273,981,772
b. FFY 2025 $ 273,981,772

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att. 4.19-C Pg. 1-2
Att. 4.19-D Exhb. A Pg.1-1(a) - 1(a) New
Att. 4.19-D Exhb. A Pg. 2-3
Att. 4.19-D Exhb. B Pg. 7-7(a) - 7(a) New
Att. 4.19-D Exhb. B Pg. 8-10, 12,14,16
Att. 4.19-D Exhb. A Pg. 3(a) New

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att. 4.19-C Pg. 1-2
Att. 4.19-D Exhb. A Pg. 1-3
Att. 4.19-D Exhb. B Pg. 7-10,12,14,16

9. SUBJECT OF AMENDMENT
Changes to the long term care reimbursement

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Lisa D. Lee

13. TITLE
Commissioner

14. DATE SUBMITTED
6/5/2024

15. RETURN TO
Lisa Lee
275 E. Main St.
Frankfort, KY 40601

FOR CMS USE ONLY

16. DATE RECEIVED
June 5, 2024

17. DATE APPROVED
January 8, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS
1/8/2025 - State authorized Block 6 update for budget impact and new page added to block 7

PAYMENTS FOR RESERVED BEDS

Payment is made for a reserved bed in Intermediate Care Facilities for Individuals with an Intellectual Disability in accordance with the following:

A. Payment for the bed reservation shall not exceed the following number of days:

A maximum of fifteen (15) days for a hospital stay for treatment of an acute condition(s), and a total of forty-five (45) days for leave(s) of absence in any given quarter (except that not more than thirty (30) days of such leave may be consecutive days).

B. Payment may ordinarily be made when the following conditions exist:

1. The individual is an eligible recipient and is authorized for Program benefits in the patient status in which he is currently residing.

2. The individual is expected to return to the same patient status, barring complications:

3. There is a likelihood that the bed would be occupied by some other patient if not reserved.

4. In the case of a leave of absence, the physician orders and the patient's plan of care provides for such an absence.

PAYMENTS FOR RESERVED BEDS

Payment is made for a reserved bed for price-based nursing facilities in accordance with the following:

The program will reimburse reserved bed days in accordance with the following specified upper limits and criteria.

(1) Reserved bed days will be reimbursed for a maximum of thirty (30) days per calendar year due to hospitalization.

(2) Reserved bed days will be reimbursed for a maximum of ten (10) days during the calendar year for leaves of absence other than for hospitalization.

(3) Reserved bed days will be reimbursed at seventy-five (75) percent of a facility's rate.

(4) Coverage during a recipient's absence for hospitalization or leave of absence is contingent on the following conditions being met:

(a) The person is in Title XIX payment status in the patient status he/she is authorized to receive and has been a resident of the facility at least overnight. Persons for whom Title XIX is making Title XVIII co-insurance payments are not considered to be in Title XIX payment status for purposes of this policy;

(b) The person can be reasonably expected to return to the same patient status;

(c) Due to demand at the facility for beds at that level, there is a likelihood that the bed would be occupied by some other patient where it not reserved;

(d) The hospitalization is for treatment of an acute condition, and not for testing, brace-fitting, etc.: and

(e) In the case of leaves of absence other than for hospitalization, the patient's physician orders and plan of care provide for such leaves. Leaves of absence include visits with relatives and friends, and leaves to participate in state-approved therapeutic or rehabilitative programs.

KENTUCKY CASE MIX ASSESSMENT AND REIMBURSEMENT SYSTEM

RESIDENT ASSESSMENT

INTRODUCTION

The Kentucky Department for Medicaid Services is implementing a new reimbursement system for price-based nursing facilities participating in the Medicaid program. These facilities include:

1. A free-standing nursing facility;
2. A hospital-based nursing facility;
3. A nursing facility with waiver;
4. A nursing facility with an intellectual disability specialty; and
5. A hospital providing swing bed nursing facility care.

The new price-based reimbursement methodology will consist of a reasonable standard price set for a day of service for rural and urban facilities. This should provide an incentive to providers to manage costs efficiently and economically.

The standard price includes:

1. Standardized wage rates;
2. Staffing *ratios;*
3. Benefits and absenteeism factors; and
4. "Other cost" percentages.

The new price-based reimbursement methodology is dependent on the specific care needs of each Medicaid and dually eligible Medicare resident in a nursing facility. The new methodology will base the resident acuity using the Minimum Data Set (MDS) 3.0 as the assessment tool. The Resource Utilization Group (RUGs) will continue to be used in the phase in schedule listed below. Starting with rates effective July 1, 2024, the Patient Driven Payment Model (PDPM) is the classification tool to place residents into different case-mix groups necessary to calculate the "casemix score". MDS assessments will be classified using the Patient Driven Payment Model nursing group. A time-weighted methodology is used in calculating case mix by determining the number of days that a MD record is active over a calendar quarter rather than captured from a single day during the calendar quarter. The PDPM methodology will be phased in according to the table below:

Rate Effective Date	Percent of CMI from RUG-III	Percent of CMI from PDPM
7/1/2024	75%	25%
10/1/2024	50%	50%
1/1/2025	25%	75%
4/1/2025 and after	0%	100%

This methodology entails a re-determination of a facility's mix of residents each quarter in order to establish a new facility specific nursing rate on a quarterly basis.

One of the objectives of the new case-mix system is to mirror the resident assessment process used by Medicare and therefore not require the facilities to use two case-mix assessment tools to determine resident acuity. The second objective for using the MDS 3.0 and PDPM is to improve reimbursement for facilities providing services for residents with higher care needs in order to improve access to care for those recipients.

1. There will be two major categories for the standard price:

    a. Case-mix adjustable portion includes wages for personnel that provide or are associated with direct care and non- personnel operation costs (supplies, etc). The case-mix adjustable portion will be separated into urban and rural designations based on Core Based Statistical Area definitions, evaluated every year, using the most recent Federal Office of Management and Budget's Core Based Statistical Area definitions; and

b. Non case-mix adjustable portion of the standard price includes an allowance to offset provider assessment, food, non-capital facility related cost, professional supports and consultation, and administration. These costs are reflected on a per diem basis and will be based on Core Based Statistical Area definitions, evaluated every year, using the most recent Federal Office of Management and Budget's Core Based Statistical Area definitions.

For dates of service on or after July 1, 2024, rates are increased to $41.43 per day as an allowance to offset a provider assessment.

2. Each July 1 the rate will be
   a. Adjusted by an inflation allowance using the appropriate CMS Nursing Home without Capital Market Basket. The inflation allowance will not be applied to the capital cost component.
   b. Rebased at least once every four (4) years beginning July 1, 2024

3. Capital Cost Add-on:

Each nursing facility will be appraised by November 30, 1999 and the department shall appraise a price- based NF to determine the facility specific capital component again in 2009, thereafter every five (5) years. The appraisal contractor will use the CoreLogic Commercial Express valuation system or its successor for facility depreciated replacement cost. The capital cost component add-on will consist of the following limits:

   a. Forty thousand dollars per licensed bed, adjusted every July 1 thereafter by the same value as the NF's depreciated replacement cost;
   b. Two thousand dollars per bed for equipment;
   c. Ten percent of depreciated replacement cost for land value;
   d. A rate of return will be applied, equal to the 20 year Treasury bond plus a 2% risk factor, subject to a 9% floor and 12% ceiling; and
   e. In order to determine the facility-specific per diem capital reimbursement, the department shall use the greater of actual bed days or bed days at 90%.

4. Renovations to nursing facilities in non-appraisal years:

   a. For facilities that have 60 or fewer beds, re-appraisals shall be conducted if the total renovation cost is $75,000 or more.
   b. For facilities that have more than 60 beds, re-appraisal shall be conducted if the total renovation cost is $150,000.

5. Facilities Protection Period:

a. Rate Protection - Until July 1, 2002, no NF shall receive a rate under the new methodology that is less than their rate that was set in July 1, 1999 unless a facility's resident acuity changes. However, NFs may receive increases in rates as a result of the new methodology as the Medicaid budget allows.
b. Case Mix - Until July 1, 2000, no facility will receive an average case-mix weight lower than the casemix weight used for the January I, 1999 rate setting. After July I, 2000, the facility shall receive the casemix weight as calculated by RUGs III or PDPM from data extracted from MDS 3.0 information.
c. Effective January 1, 2003, county owned hospital-based nursing facilities shall not receive a rate that is less than the rate that was in effect on June 30, 2002.

7. Case-mix Rate Adjustments. Rates will be recomputed quarterly based on revisions in the case mix assessment classification that affects the Nursing Services components. Due to CMS ending support of RUGs starting 10/1/2023, the rates effective 4/1/2024 are equal to the rate effective 1/1/2024

PDPM CMIs will have a phase in period, in accordance with the following schedule:

Rate Effective Date	Percent of CMI from RUG-III	Percent of CMI from PDPM
7/1/2024	75%	25%
10/1/2024	50%	50%
1/1/2025	25%	75%
4/1/2025 and after	0%	100%

8. Case-mix rate adjustment will be recomputed should a provider or the department find an error.

9. Ancillary Add On. Effective July 1, 2024, ancillary services will be included in the per diem rate calculations and will not be paid outside the per diem rate. Ancillary services include the following:
   - Speech Therapy
   - Occupational Therapy
   - Physical Therapy
   - Oxygen Services
   - Laboratory; and
   - X-ray

The ancillary add on will be calculated every July 1. Effective July 1, 2024, the ancillary add on will be calculated as the Medicaid ancillary payments from the prior year divided by Medicaid days. Effective July 1, 2025 and after, the ancillary add on will be calculated as the prior year Medicaid ancillary charges divided by the total Medicaid days, limited to the posted ancillary fee schedule amounts per unit.

10. Medicare Upper Payment Limit. Upper payment limit demonstrations will be completed in accordance with guidance issued from CMS, specifically State Medicaid Director Letter #13-003 and 22-005. Only services covered by both the Medicare and Medicaid program will be included within the UPL test to ensure comparable services are included for both Medicaid and Medicare calculations for the demonstration. This includes Physical Therapy, Occupational Therapy, Speech Therapy, Nursing Component, Non-Therapy Ancillary, and non-case mix adjusted. Adjustments to specific Medicare components will be made if necessary to account for differences within the reimbursement programs. The UPL demonstration will use day one-hundred as a starting point for the Medicare rate component, for providers included within a PDPM UPL methodology. Providers receiving cost-based reimbursement may utilize a cost based UPL reimbursement methodology following Medicare and Medicaid cost principles.

F. The price-based model reimbursement methodology provides for a facility specific capital cost add-on calculated using the CoreLogic Commercial Express Valuation System, a commercial valuation system that estimates the depreciated and non-depreciated replacement cost of a facility.

G. The Office of Inspector General has required the sub- mission of the Minimum Data Set (MDS) since 1992 and DMS sought to use a tool familiar to the nursing facility industry in order to calculate case-mix. The case-mix portion of the rate will utilize the MDS 3.0 and the Resource Utilization Group (RUG) III to calculate the individual facility's average case-mix. Effective with July 1, 2024 rates, CMIs will be calculated using the Patient Driven Payment Model PDPM nursing component according to the phase in schedule below:

Rate Effective Date	Percent of CMI from RUG-III	Percent of CMI from PDPM
7/1/2024	75%	25%
10/1/2024	50%	50%
1/1/2025	25%	75%
4/1/2025 and after	0%	100%

H. The case-mix portion of the rate will be adjusted quarterly to reflect the facility's case-mix assessments from a previous quarter and to adjust the direct care and non-personnel operation costs (supplies, etc.) portion of the standard price for the current quarter. For example, the rate effective 7/1/2008 - 9/30/2008 will be based on assessments from l/1 /2008 - 3/31/2008 as of 6/30/2008.

SECTION 110. PARTICIPATION REQUIREMENTS

A. The facilities referenced in Section one hundred (100) shall be reimbursed using the methodology described in 907 KAR l:065. These facilities shall be licensed by the state survey agency (Office of Inspector General) for the Commonwealth of Kentucky and certified for Medicaid participation by the Department for Medicaid Services.

B. A nursing facility, except a nursing facility with waiver, choosing to participate in the Medicaid Program will be required to have twenty (20) percent of its Medicaid certified beds participate in the Medicare program or ten (10) of its Medicaid beds participating in the Medicare program whichever is greater. If the NF has less than ten (10) beds all of its beds shall participate in the Medicare Program.

C. The Medicaid Program shall reimburse all Medicaid beds in a nursing facility at the same rate. The Medicaid rate established for a facility is the weighted average rate for all Medicaid participating beds in that individual facility.

SECTION 120. PAYMENTS FOR SERVICES TO MEDICARE/MEDICAID RESIDENTS

A. Dually eligible residents and residents eligible for both Medicare and Medicaid (non-QMB) shall be required to Exhaust any applicable benefits under Title XVIII (Part A and Part B) prior to coverage under the Medicaid Program.

B. APPLICATION. Services received by a resident that are reimbursable by Medicare shall be billed first to the Medicare Program. Any appropriate co-insurance or deductible payment due from the Medicaid Program shall be paid outside the Cost-based facility Cost-Related Payment System in a manner prescribed by the Department for Medicaid Services. Coinsurance and deductible payments shall be based on rates set by the Medicaid Program. A day of service covered in this manner shall be considered a Medicare resident day and shall not be included as a Medicaid resident day in the facility cost report.

SECTION 130. PRICE-BASED NF REIMBURSEMENT METHODOLOGY

A. The price-based nursing facility reimbursement methodology reflects the differential in wages, property values and cost of doing business in rural and urban designated areas This results in two standard rates, a standard rate reflecting the lower wages for the rural facilities and a slightly higher rate for the urban facilities.

B. The rural and urban designated areas are based on the "Core Based Statistical Area (CBSA) definitions designating the urban population centers based on the national census and updated on a yearly basis, as published by the Federal Office of Management and Budget.

C. In order to determine the standard rates for urban and rural facilities, the department utilized an analysis of fair-market pricing and historical cost for staffing ratios, wage rates, cost of administration, food, professional support, consultation, and non-personnel operating expenses as a percentage of total cost.

D. The standard price is comprised of the following components and percentages of the total rate:

I. Personnel 65%

2. Non-personnel operating 6%;
3. Administration 13%;
4. Food 4%;
5. Professional support & consultation 2%;
6. Non-capital facility related cost 3%; and
7. Capital rate 7%.

E. The standard price shall be re-based in 2024 and every four years thereafter and adjusted for inflation every July -1, using the version of the CMS Nursing Home without Capital Market Basket that was effective on July 1.

F. A portion of the standard price for both urban and rural facilities will be adjusted each calendar quarter for "case-mix". The "case-mix" adjusted portion shall include the following:

I. The personnel cost of a:

(a) DON-Director of Nursing;
(b) RN-Registered Nurse;
(c) LPN-Licensed Practical Nurse;
(d) Nurse Aide;
(e) Activities worker; and
(f) Medical records director.

2. The non-personnel operating cost including:

(a) Medical supplies; and
(b) Activity supplies.

G. The "non-case-mix" portion of the standard price shall not be adjusted for case mix and includes:

1. Administration;
2. Non-direct care personnel;
3. Food;
4. Non-capital related costs;
5. Professional support;
6. Consultation;
7. Capital cost component; and
8. An allowance to offset a provider assessment.

H. The capital cost component shall be an "add-on" to the non case-mix" adjusted portion of the rate.

I. Ancillaries include the following services:

1. Speech Therapy;
2. Occupational Therapy;
3. Physical Therapy;
4. Oxygen Services;
5. Laboratory; and
6. X-ray.

J. Ancillary therapy services are reimbursed as part of the per diem rate, updated every July 1. Effective July 1, 2024, the ancillary add on will be calculated as the Medicaid ancillary payments from the prior year divided by Medicaid days. Effective July 1, 2025 and after, the ancillary add on will be calculated as the prior year Medicaid ancillary charges divided by the total Medicaid days, limited to the posted ancillary fee schedule amounts per unit.

K. Oxygen concentrator limitations. Effective October 1, 1991, the allowable cost of oxygen concentrator rentals shall be limited as follows:

1. A facility may assign a separate concentrator to any resident who has needed oxygen during the prior or current month and for whom there is a doctor's standing order for oxygen. For the charge by an outside supplier to be considered as an allowable cost, the charge shall be based upon actual usage. A minimum charge by an outside supplier is allowable if this charge does not exceed twenty- five (25) percent of the Medicare Part B maximum. The minimum charge is allowable if the concentrator is used less than an average of two (2) hours per day during the entire month (for example, less than 60 hours during a thirty (30) day month). The maximum allowable charge by the outside supplier shall not exceed one hundred (100) percent of the Medicare Part B maximum. For the maximum charge to a facility to be considered as the allowable cost, the concentrator shall have been used on average for a period of at least eight (8) hours per day for the entire month (for example, 240 hours during a thirty (30) day month). In those cases where the usage exceeds that necessary for the minimum charge and is less than the usage required for the maximum charge, the reimbursement shall be computed by dividing the hours of usage by

that a cost increase occurred as a result of licensure requirement or policy interpretation.

3. The provider- shall submit any documentation required by the department.

SECTION 140. PRICE- BASED NF REIMBURSEMENT CALCULATION

A. For each calendar quarter, based on the classification of urban and rural, the department shall calculate an individual NF's price-based rate to be the sum of:

1. The case-mix adjustable portion of a NF Standard Price, adjusted by the individual NF's current average case-mix index. Except that until June 30, 2000, the average case-mix index shall be the greater of the current average case-mix index or the case-mix average calculated as a ratio of the facility's case-mix index to the statewide average case-mix index that would have been used for January 1, 2000, rate setting. After July 1, 2000, the individual NF's actual average case-mix shall be used in the rate calculation; and

2. The non-case-mix adjustable portion of the assigned total Standard Price and the capital cost component.

B. A capital cost component shall be calculated on an individual facility basis based on the facility appraisal completed in November 1999. Reappraisal shall be conducted and utilized to determine the facility specific capital component. The department shall appraise a price-based NF to determine the facility specific capital component again in 2009, thereafter, every five (5) years. The Department shall contract with a certified appraisal company to perform the appraisal using the CoreLogic Commercial Express Valuation System. The appraisal is based on the depreciated replacement value of the individual facility. The same Appraisal Company shall perform any re-appraisal that may be requested by a facility within that five-year period.

C. A facility may request a re-appraisal within five years should renovations or additions have a minimum total cost of $150,000 for facilities with more than sixty (60) licensed beds. For facilities having sixty (60) or less licensed beds, the total renovation or addition must be a

cost rate of the previous owner unless the NF is eligible for re-appraisal pursuant to section IV B of this manual.

SECTION 150. ON-SITE REVIEWS AND VALIDATION

A. On a quarterly basis, beginning April 1, 2024, the department shall perform a review of NFs. The review will consist of a minimum of 30 percent of the Medicaid residents, reviewing one MDS assessment completed by the NF from each resident. The department shall validate the MDS assessments by using the Long-Term Care Facility Resident Assessment Instrument User's Manual.

B. Should the department invalidate a NF's MDS, resulting in the NF not meeting the minimum accuracy threshold, the NF may request a reconsideration of the findings of the department within ten (10) business days. The department shall receive a written request by the NF that the department reconsider the invalidation. The department shall conduct the second validation within ten (10) business days of receipt of the request and notify the provider in writing of the decision. A provider may appeal the second validation per 907 KAR 1:671, Sections 8 and 9.

SECTION 160. LIMITATION ON CHARGES TO RESIDENTS.

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

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

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

D. A NF may charge a resident for the cost of reserving a bed if requested by resident or interested party after the thirtieth (30^{th}) day of a temporary absence from the facility pursuant to 907 KAR 1:022.

SECTION 190. ANCILLARY SERVICES

A. Respiratory therapy and respiratory therapy supplies shall be considered in the routine services per diem rate.

B. The department shall calculate an add-on amount in accordance with 907 KAR 1:065, Section 12, to a nursing facility's routine services per diem rate updated every July 1. Effective July 1, 2024, the ancillary add on will be calculated as the Medicaid ancillary payments from the prior year divided by the Medicaid days. Effective July 1, 2025, and after, the ancillary add on will be calculated as the prior year Medicaid ancillary charges divided by the total Medicaid days, limited to the posted ancillary fee schedule amounts per unit.

C. A nursing facility shall submit documentation requested by the department in order to apply for a routine services per diem add-on in accordance with 907 KAR 1:065, Section I2.

SECTION 200. REIMBURSEMENT REVIEW AND APPEAL

A NF may appeal department decisions as to the application of this regulation as it impacts the NF's price- based reimbursement rate in accordance with 907 KAR 1:671, Section 8 and 9.