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State/Territory Name: Kansas

State Plan Amendment (SPA) #: 23-0023

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244-1850

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

Medicaid and CHIP Operations Group

December 5, 2023

Christine Osterlund, Acting State Medicaid Director
Kansas Department of Health and Environment
900 SW Jackson, Suite 900
Topeka, KS 66612-1220

Re: Kansas State Plan Amendment (SPA) 23-0023

Dear Christine Osterlund:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0023. This amendment updates Nursing Facility provider enrollment and proposes to increase Nursing Facility Rates for State Fiscal Year (SFY) 2024.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act. This letter is to inform you that Kansas Medicaid SPA 23-0023 was approved on December 4, 2023, with an effective date of July 1, 2023.

If you have any questions, please contact Helenita Augustus at 410-786-8902 or via email at Helenita.Augustus@cms.hhs.gov .

Sincerely,

[redacted]

Ruth A. Hughes, Acting Director
Division of Program Operations

Enclosures

cc: Bobbie Graff-Hendrixson
Bill Stelzner
Bill Thompson
Trescia Power
Sheri Jurad

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: 23 — 0023

2. STATE: KS

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.201, 42 CFR 442.10, 42 CFR 440

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 281,569
b. FFY 2024 $ 888,448

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att. 4.19-D Part 1 Exhibit A-19 Page 1-2; Att. 4.19-D Part 1 Subpart C Exhibit C-1 Page 2-4, 7-9, 14-17a, 17b (new), 18; Att. 4.19-D Part 1 Subpart C Exhibit C-2 Page 1-3, 3a, 4-5; Att. 4.19-D Part 1 Subpart C Exhibit C-3 Page 1-3, 3a; Att. 4.19-D Part 1 Subpart C Exhibit C-4 Page 1; Att. 4.19-D Part 1 Subpart C Exhibit C-5 Page 1-3; Att. 4.19-D Part 1 Subpart S Page 1; Att. 3.1-A, Page 8a; Section 2, Coverage and Eligibility, Page 11; Section 3, Service Provisions, Page 21b; Section 4, General Program Administration, Page 45

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
Att. 4.19-D Part 1 Exhibit A-19 Page 1-2; Att. 4.19-D Part 1 Subpart C Exhibit C-1 Page 2-4, 7-9, 14-17a, 18; Att. 4.19-D Part 1 Subpart C Exhibit C-2 Page 1-3, 3a, 4-5; Att. 4.19-D Part 1 Subpart C Exhibit C-3 Page 1-3, 3a; Att. 4.19-D Part 1 Subpart C Exhibit C-4 Page 1; Att. 4.19-D Part 1 Subpart C Exhibit C-5 Page 1-3; Att. 4.19-D Part 1 Subpart S Page 1; Att. 3.1-A, Page 8a; Section 2, Coverage and Eligibility, Page 11; Section 3, Service Provisions, Page 21b; Section 4, General Program Administration, Page 45

9. SUBJECT OF AMENDMENT

Methods and Standard for Establishing Payment Rates: Nursing Facilities and Nursing Facilities for Mental Health, with Technical Corrections to Other Sections of Kansas Medicaid State Plan.

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: Sarah Fertig is the Governor's Designee

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Sarah Fertig

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
September 12, 2023

15. RETURN TO
Sarah Fertig, State Medicaid Director
KDHE, Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

FOR CMS USE ONLY

16. DATE RECEIVED
September 12, 2023

17. DATE APPROVED
December 4, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2023

19. SIGNATURE
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Ruth A. Hughes

21. TITLE OF APPROVING OFFICIAL
Acting Director, Division of Program Operations

22. REMARKS

Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date for the prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
[redacted] and		_____(3)	[redacted]
42 CFR 438.6	(c)		The Medicaid agency elects to enter into a risk contract that complies with 42 CFR 438.6, and that is procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):
	_____		Qualified under title XIII 1310 of the Public Health Service Act
	__X__		A Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2
	____		A Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2
	____		A Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2
	_____		Not applicable

State/Territory: Kansas

Citation			
1905(a)(9) of the Act	3.1	(a)(7)	Homeless Individuals Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act	☒	(a)(8)	Presumptively Eligible Pregnant Women Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), And 1905(r) of the Act		(a)(9)	EPSDT Services The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

State/Territory Kansas

Citation	4.13	Required Provider Agreement
		With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:
42 CFR 431.107		(a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are also met.
42 CFR Part 483, 1919 of the Act		(b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are met.
42 CFR Part 483, Subpart D		(c) For providers of ICF/IID services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.
1920 of the Act		(d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.
		☐ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

☒ Provided: ☒ No limitations ☐ With Limitations*

☐ Not provided.

22. Respiratory care services (in accordance with section 1902 (e) (9) (A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

23. Certified pediatric or family nurse practitioners' services.

☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

129-10-31. Responsibilities of, assessment of, and disbursements for the nursing facility quality care assessment program. (a) In addition to the terms defined K.S.A. 75-7435 and amendments thereto, each of the following terms shall have the meaning specified in this subsection, unless the context requires otherwise:

(1) "High medicaid volume skilled nursing care facility" means any facility that provided more than 25,000 days of nursing facility care to medicaid recipients during the most recent calendar year cost-reporting period.

(2) "Kansas homes and services for the aging," as used in K.S.A. 74-7435 and amendments thereto, means the leadingage Kansas.

(3) "Nursing facility quality care assessment program" means the determination, imposition, assessment, collection, and management of an annual assessment imposed on each licensed bed in a skilled nursing care facility required by K.S.A. 75-7435, and amendments thereto.

(4) "Skilled nursing care facility that is part of a continuing care retirement facility" means a provider who is certified as such by the Kansas insurance department before the start of the state's fiscal year in which the assessment process is occurring.

(5) "Small skilled nursing care facility" means any facility with fewer than 46 licensed nursing facility beds.

(b) The assessment shall be based on a state fiscal year. Each skilled nursing facility shall pay the annual assessment as follows:

(1) The assessment amount shall be $818 annually per licensed bed for the following:

(A) Each skilled nursing care facility that is part of a continuing care retirement facility;

(B) each small skilled nursing care facility; and

(C) each high medicaid volume skilled nursing care facility.

(2) The assessment amount for each skilled nursing care facility other than those identified in paragraphs (c)(1)(A) through (C) shall be $4,908 annually per licensed bed.

(3) The assessment amount shall be paid accordingly to the method of payment designated by the secretary of the Kansas department of health and environment. Any skilled nursing care facility may be allowed by the secretary of the Kansas department of health and environment to have an extension to complete the payment of the assessment, but no such extension shall exceed 90 days. (Authorized by and implementing 75-7435; effective Feb. 18, 2011; amended December 27, 2013; amended June 26, 2020.)

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 2020, 2021, and 2022.

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, 2023. 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, 2023. This adjustment will be based on the S&P Global Market Intelligence, National Skilled Nursing Facility Market Basket Without Capital Index (S&P Index). The S&P 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, 2023. 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.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

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 2020-2022. 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, 2023. This adjustment will be based on the S&P Index. The S&P 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, 2023. 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, 2023. This adjustment will be based on the S&P Index. The S&P 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, 2023. 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.

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, 2023. The inflation will be based on the S&P Global Market Intelligence, CMS Nursing Home without Capital Market Basket index.

The S&P Global Market Intelligence, 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 S&P 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

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 2022 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

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, 2023.

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, 2023. 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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Narrative Explanation of Nursing Facility Reimbursement Formula

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 (5.60), or	$3.00
CMI adjusted staffing < 75th percentile but improved >= 10%	$0.50
Staff retention rate >= 75th percentile, 71% or	$2.50
Staff retention rate < 75th percentile but increased >= 10%	
Contracted labor < 10% of total direct health care labor costs	$0.50
Medicaid occupancy >= 65%	$0.75
Quality Measures >=75th percentile (580)	$1.25
Total Incentive Add-ons-Available	$7.50

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 3.29, which is 120% of the statewide NFMH median of 2.74. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.01, which is 110% of the statewide NFMH median. Providers with staffing

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ratios below 110% of the NFMH median will receive no points for this incentive measure.

NFMH providers may earn one point for low occupancy outcomes measures. If they have total occupancy less than 90% they will earn a point.

NFMH providers may earn one point for low operating expense outcomes measures. They will earn a point if their per diem operating expenses are below $34.40, or 90% of the statewide median of $38.22.

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 60%, 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 84%, the 75th percentile statewide will earn two points. Providers with staff retention rates below 84%, but at or above 69%, 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% (3.29) of NF-MH median (2.74), or CMI adjusted staffing ratio between 110% (3.01) and 120%	2, or 1
Total occupancy <= 90%	1
Operating expenses < $34.40, 90% of NF-MH median, $38.22	1
Staff turnover rate <= 75th percentile, 44% Staff turnover rate <= 50th percentile, 60% Contracted labor < 10% of total direct health care labor costs	2, or 1
Staff retention >= 75th percentile, 84% Staff retention >= 50th percentile, 69%	2, or 1
Total Incentive Points Available	8

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Narrative Explanation of Nursing Facility Reimbursement Formula

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

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-8 points	$7.50
Tier 2: 5 points	$5.00
Tier 3: 4 points	$2.50
Tier 4: 0-3 points	$0.00

The Culture Change/Person-Centered Care Incentive Program

The Culture Change/Person-Centered Care Incentive Program (PEAK 2.0) includes nine different incentive levels to recognize homes that are either pursuing culture change, have made major achievements in the pursuit of culture change, have met minimum competencies in person-centered care, have sustained person-centered care, or are mentoring others in person-centered care.

Each incentive level has a specific pay-for-performance incentive per diem attached to it that homes can earn by meeting defined outcomes. The first six levels (Level 0 – Level 5) are intended to encourage quality improvement for homes that have not yet met the minimum competency requirements for a person-centered care home.

Level 6 recognizes those homes that have attained a minimum level of core competency in person-centered care. Level 7 and Level 8 are reserved for those homes that have demonstrated sustained person-centered care for multiple years and have gone on to mentor other homes in their pursuit of person-centered care. The table below provides a brief overview of each of the levels.

Methods and Standards for Establishing Payment Rates
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Narrative Explanation of Nursing Facility Reimbursement Formula

LEVEL & PER DIEM INCENTIVE	SUMMARY OF REQUIRED NURSING HOME ACTION	INCENTIVE DURATION
LEVEL 0: The Foundation $0.50 Per Medicaid Resident Per Day (PMRPD)	Home completes a self-evaluation tool according to the enrollment 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 for the remainder of the program year. At successful completion of the Foundation level, homes move to Level 1.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year, provided the home participates in program activities. Homes' incentive may be dropped mid-year for non-participation. Receipt of incentive also based on survey eligibility.
LEVEL 1: 0-2 Cores $0.75 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 1 incentive by passing the Foundation level and/or sustaining practices in 1-2 cores. Level 1 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 2: 3-4 Cores $1.00 PMRPD	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 2 incentive by passing and/or sustaining 3-4 cores. Level 2 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.

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Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

LEVEL 3: **5-6 Cores** **$1.25** **PMRPD**	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 3 incentive by passing and/or sustaining 5-6 cores. Level 3 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 4: **7-8 Cores** **$1.50** **PMRPD**	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 4 incentive by passing and/or sustaining 7-8 cores. Level 4 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 5: **9-11 Cores** **$1.75** **PMRPD**	Home completes a self- evaluation tool (annually). Home submits an action plan addressing at least 2 of the total 12 PEAK cores. A home can turn in additional action plans mid-year at their discretion. Homes are eligible for level 5 incentive by passing and/or sustaining 9-11 cores. Level 5 homes undergo an in-person or Zoom evaluation with the PEAK team. 20-25 homes are selected for a random site visit. Homes must participate in the random site visit, if selected, to continue incentive payment. Action planned cores are evaluated within the same fiscal year. Previously passed cores will be re-evaluated every 2 years for sustainability. Level is adjusted based on the evaluation results and KDADS' guidance.	Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year. Receipt of incentive also based on survey eligibility.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

LEVEL 6: 12 Cores Person-Centered Care Home $2.00 PMRPD	Home completes a self- evaluation tool (annually). Homes are eligible for level 6 by demonstrating minimum competency as a person-centered care home (passes all 12 core areas or 90% of the PEAK practices). The home does this by passing a full on-site visit to evaluate all 12 PEAK core areas. KDADS and KSU will facilitate a full on-site visit to evaluate PEAK practices. KDADS will make final determination of movement to level 6.	Available beginning July 1 following confirmed minimum competency of person-centered practice. Incentive is granted for one full fiscal year. Receipt of incentive also based on survey eligibility.
LEVEL 7: 12 Cores Sustained Person-Centered Care Home $2.50 PMRPD	Home completes a self- evaluation tool (annually). Homes are eligible for level 7 by demonstrating minimum competency as a person-centered care home (passes all 12 core areas or 90% of the PEAK practices) two consecutive years. The home does this by passing a full on-site visit to evaluate all 12 PEAK core areas. KDADS and KSU will facilitate a full on-site visit to evaluate PEAK practices. KDADS will make final determination of movement to level 7.	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies in all 12 PEAK cores for the second consecutive year. Incentive is granted for two fiscal years. Renewable biannually. Receipt of incentive also based on survey eligibility.
LEVEL 8: 12 Cores Mentor Home $3.00 PMRPD	Home completes a self- evaluation tool (annually). Homes are eligible for level 8 by demonstrating minimum competency as a person-centered care home (passes all 12 core areas or 90% of the PEAK practices) two consecutive years and meeting the minimum mentoring activities, as directed in the mentoring log. The home does this by passing a full on-site visit to evaluate all 12 PEAK core areas. KDADS and KSU will facilitate a full on-site visit to evaluate PEAK practices bi-annually and turning in a mentor log. KDADS will make final determination of movement to level 8.	Available beginning July 1 following confirmation of mentor home standards (upkeep of minimum person-centered care competencies in all 12 PEAK cores and mentoring points). Incentive is granted for two fiscal years. Renewable bi-annually. Receipt of incentive also based on survey eligibility.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Survey and Certification Performance Adjustment

The survey and certification performance of each NF and NF-MH provider will be reviewed quarterly to determine each provider's eligibility for incentive factor payments. In order to qualify for an incentive factor payment a home must not have received any health care survey deficiency of scope and severity level "H" or higher during the survey review period. Homes that receive "G" level deficiencies, but no "H" level or higher deficiencies, and that correct the "G" level deficiencies within 30 days of the survey, will be eligible to receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level "F" will be eligible to receive 100% of the calculated incentive factor. The survey and certification review period will be the 12-month period ending one quarter prior to the incentive eligibility review date. The following table lists the incentive eligibility review dates and corresponding review period end dates.

Incentive Eligibility Effective Date:	Review Period End Date:
July 1	March 31st
October 1	June 30th
January 1	September 30th
April 1	December 31st

10) Rate Effective Date

Rate effective dates are determined in accordance with K.A.R. 129-10-19. The rate may be revised for an add-on reimbursement factor (i.e., rebased property fee), desk review adjustment or field audit adjustment.

REPORT YEAR END (RYE)	MIDPOINT OF RYE	MIDPOINT OF RYE INDEX	MIDPOINT OF RATE PERIOD	MIDPOINT OF RATE PERIOD INDEX	HISTORICAL INFLATION FACTOR % *
12-19	06-19	1.028	12-23	1.239	20.525%
01-20	07-19	1.032	12-23	1.239	20.058%
02-20	08-19	1.032	12-23	1.239	20.058%
03-20	09-19	1.032	12-23	1.239	20.058%
04-20	10-19	1.036	12-23	1.239	19.595%
05-20	11-19	1.036	12-23	1.239	19.595%
06-20	12-19	1.036	12-23	1.239	19.595%
07-20	01-20	1.045	12-23	1.239	18.565%
08-20	02-20	1.045	12-23	1.239	18.565%
09-20	03-20	1.045	12-23	1.239	18.565%
10-20	04-20	1.051	12-23	1.239	17.888%
11-20	05-20	1.051	12-23	1.239	17.888%
12-20	06-20	1.051	12-23	1.239	17.888%
01-21	07-20	1.058	12-23	1.239	17.108%
02-21	08-20	1.058	12-23	1.239	17.108%
03-21	09-20	1.058	12-23	1.239	17.108%
04-21	10-20	1.065	12-23	1.239	16.338%
05-21	11-20	1.065	12-23	1.239	16.338%
06-21	12-20	1.065	12-23	1.239	16.338%
07-21	01-21	1.079	12-23	1.239	14.829%
08-21	02-21	1.079	12-23	1.239	14.829%
09-21	03-21	1.079	12-23	1.239	14.829%
10-21	04-21	1.093	12-23	1.239	13.358%
11-21	05-21	1.093	12-23	1.239	13.358%
12-21	06-21	1.093	12-23	1.239	13.358%
01-22	07-21	1.112	12-23	1.239	11.421%
02-22	08-21	1.112	12-23	1.239	11.421%
03-22	09-21	1.112	12-23	1.239	11.421%
04-22	10-21	1.128	12-23	1.239	9.840%
05-22	11-21	1.128	12-23	1.239	9.840%
06-22	12-21	1.128	12-23	1.239	9.840%
07-22	01-22	1.149	12-23	1.239	7.833%
08-22	02-22	1.149	12-23	1.239	7.833%
09-22	03-22	1.149	12-23	1.239	7.833%
10-22	04-22	1.171	12-23	1.239	5.807%
11-22	05-22	1.171	12-23	1.239	5.807%
12-22	06-22	1.171	12-23	1.239	5.807%
01-23	07-22	1.192	12-23	1.239	3.943%
02-23	08-22	1.192	12-23	1.239	3.943%
03-23	09-22	1.192	12-23	1.239	3.943%
04-23	10-22	1.202	12-23	1.239	3.078%
05-23	11-22	1.202	12-23	1.239	3.078%
06-23	12-22	1.202	12-23	1.239	3.078%

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

COST CENTER LIMITATIONS EFFECTIVE 07/01/23

COST CENTER	UPPER LIMIT
Operating	$55.15
Indirect Health Care	$68.78
Direct Health Care	$186.15
Real and Personal Property Fee	$10.47

* = Base limit for a facility average case mix index of 1.0813

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/23

NF ONLY

	INCENITVE OUTCOME	INCENTIVE AMOUNTS
1)	CMI adjusted staffing ratio >= 75th percentile (5.60), or	$3.00
	CMI adjusted staffing < 75th percentile but improved >= 10%	$0.50
2)	Staff retention rate >= 75th percentile, 71% or	$2.50
	Staff retention rate < 75th percentile but increased >= 10%	$0.50
	Contracted labor < 10% of total direct health care labor costs	
3)	Medicaid occupancy >= 65%	$0.75
4)	Quality Measures >= 75th percentile (580)	$1.25
	Total Incentive Available	$7.50

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/23

NF-MH ONLY

	QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 120% (3.29) of NF-MH median (2.74), or CMI adjusted staffing ratio between 110% (3.01) and 120%	2, or 1
2	Total occupancy <= 90%	1
3	Operating expenses < $34.40, 90% of NF-MH median, $38.22	1
4	Staff turnover rate <= 75th percentile, 44% Staff turnover rate <= 50th percentile, 60% Contracted labor < 10% of total direct health care labor costs	2, or 1
5	Staff retention >= 75th percentile, 84% Staff retention >= 50th percentile, 69%	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

Owner/Related Party Salary Limitations Effective 07/01/2023

Job Classification		Salary Range **	Bed Capacity 0-59	60-120	121+	0-99	100	Any Size
Administrator	*	23	37,003					
	*	28		47,258				
	*	31			54,683			
Co-Administrator	*	19	30,493					
	*	22		35,235				
	*	24			38,896			
Accountant II		25						40,872
Attorney II		33						60,382
Bookkeeper (Accounting Specialist)		20						31,990
Secretary II (Administrative Specialist)		20						31,990
Gen. Maint. & Repair Tech Senior		18						29,016
Physical Plant Supervisor		24						38,896
Physical Plant Supervisor Senior		26						42,806
Cook Senior		18						29,016
Food Service Supervisor Senior		19						30,493
Housekeeping/Laundry Worker		18						29,016
Director of Nursing (RN Administrator)	*	35						66,518
Registered Nurse	*	29						49,650
Licensed Practical Nurse (LPN)	*	20						31,990
LPN Senior	*	21						33,613
Health Care Assistant (CNA II)	*	18						29,016
Licensed Mental Health Technician		18						29,016
Physical Therapist II	*	27						45,032
Physical Therapist Aide		18						29,016
Occupational Therapist II	*	26						42,806
Speech Pathologist/Audiologist I	*	26						42,806
Activity Therapy Tech.		18						29,016
Activity Therapist I	*	23						37,003
Social Worker Specialist	*	25						40,872
Medical Records Administrator		24						38,896
Medical Records Technician		19						30,493
Central Office Staff (3+ Facilities)								
Chief Executive Officer		36						69,784
Chief Operating Officer		34						63,357
All Other Chief Officers		31						54,683

* License/Registration/Certificate Requirement

** Step 7 of the salary range has been used to set the limits.

OWNER/ADMINISTRATOR LIMITATION TABLE EFFECTIVE 07/01/2023

Number of Beds	Total Bed Days	Maximum Owner/Admin Compensation	Limit PPD	FY	Amount	Cost of Living State Emp.
15	5,490	$36,155	$6.59	79	11,301	7.250%
16	5,856	39,755	$6.79	80	11,781	4.250%
17	6,222	43,355	$6.97	81	12,617	7.100%
18	6,588	46,955	$7.13	82	13,248	5.000%
19	6,954	50,555	$7.27	83	14,109	6.500%
20	7,320	54,155	$7.40	84	14,426	2.250%
21	7,686	57,755	$7.51	85	15,147	5.000%
22	8,052	61,355	$7.62	86	15,933	5.190%
23	8,418	64,955	$7.72	87	16,411	3.000%
24	8,784	68,555	$7.80	88	16,575	1.000%
25	9,150	72,155	$7.89	89	17,238	4.000%
26	9,516	75,755	$7.96	90	17,755	3.000%
27	9,882	79,355	$8.03	91	18,021	1.500%
28	10,248	82,955	$8.09	92	18,021	0.000%
29	10,614	86,555	$8.15	93	18,111	0.500%
30	10,980	90,155	$8.21	94	18,202	0.500%
31	11,346	93,755	$8.26	95	18,407	1.125%
32	11,712	97,355	$8.31	96	18,591	1.000%
33	12,078	100,955	$8.36	97	18,591	0.000%
34	12,444	104,555	$8.40	98	18,777	1.000%
35	12,810	108,155	$8.44	99	19,059	1.500%
36	13,176	111,755	$8.48	00	19,250	1.000%
37	13,542	115,355	$8.52	01	19,250	0.000%
38	13,908	118,955	$8.55	02	19,683	2.250%
39	14,274	122,555	$8.59	03	19,683	0.000%
40	14,640	126,155	$8.62	04	19,978	1.500%
41	15,006	129,755	$8.65	05	20,577	3.000%
42	15,372	133,355	$8.68	06	20,834	1.250%
43	15,738	136,955	$8.70	07	21,355	2.500%
44	16,104	140,555	$8.73	08	21,782	2.000%
45	16,470	144,155	$8.75	09	22,327	2.500%
46	16,836	147,755	$8.78	10-18	22,327	0.000%
47	17,202	151,355	$8.80	19	22,941	2.750%
48	17,568	154,955	$8.82	20	23,515	2.500%
49	17,934	158,555	$8.84	21-23	24,103	2.500%
50	18,300	162,155	$8.86	24	25,308	5.000%

COMPILATION OF COST CENTER LIMITATIONS
EFFECTIVE 07/01/2023

	BEFORE INFLATION					***AFTER INFLATION***				
	OPER	IDHC	DHC	RPPF	TOTAL	OPER	IDHC	DHC	RPPF	TOTAL
MEDIAN	46.07	47.91	127.33	9.97	231.27	50.14	59.81	143.19	9.97	263.11
MEAN	50.04	59.41	137.27	14.47	261.18	53.58	64.81	154.16	14.47	287.01
WTMN	49.38	58.09	134.71	15.89	258.07	52.23	62.79	150.71	15.89	281.63
# OF PROV	302					302				

COMPILATION OF ADMINISTRATOR, CO-ADMIN OWNER EXPENSE - O/A LIMIT
EFFECTIVE 07/01/23

	ADMINISTRATOR		CO-ADMINISTRATOR		TOTAL ADMN & C0-ADMN		OWNER	
	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD
HIGH	359,342	19.18	56,618	4.80	359,342	19.18	267,693	15.04
99th	256,853	13.32	56,618	4.80	256,853	13.32	267,693	15.04
95th	156,016	10.49	56,618	4.80	156,016	10.49	175,056	11.03
90th	129,124	8.84	56,618	4.80	129,593	8.86	97,206	3.71
85th	122,729	8.27	56,618	4.80	123,215	8.37	74,400	2.89
80th	116,269	7.79	50,803	2.87	118,006	7.79	52,966	2.43
75th	111,039	7.44	50,803	2.87	111,281	7.51	49,884	2.39
70th	106,817	7.00	50,803	2.87	107,184	7.02	45,203	1.97
65th	102,445	6.55	50,803	2.87	102,940	6.55	39,394	1.97
60th	98,344	6.24	41,277	2.33	98,904	6.24	35,165	1.97
55th	95,626	5.80	41,277	2.33	95,811	5.94	34,819	1.97
50th	92,077	5.56	41,277	2.33	92,349	5.57	31,729	1.97
40th	87,334	4.86	18,147	2.22	87,562	4.93	28,319	1.48
30th	80,715	4.24	18,147	2.22	81,331	4.27	26,407	1.16
20th	70,883	3.44	4,095	0.08	71,529	3.45	19,700	0.77
10th	53,188	2.87	4,095	0.08	53,188	2.90	12,312	0.68
1st	10,243	0.72	4,095	0.08	15,897	0.72	9,850	0.58
LOW	4,453	0.18	4,095	0.08	4,453	0.18	9,850	0.58
MEAN	94,749	5.79	34,188	2.46	95,320	5.83	49,552	2.44
WTMN	83,962	5.00	21,825	1.57	84,295	5.03	44,216	2.17
# of Prov	299		5		299		35	

COMPILATION OF NF
INCENTIVE POINTS AWARDED
EFF. 07/01/2023

NURSING FACILITY

INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	79	27.1%
$0.50	14	4.8%
$0.75	43	14.7%
$1.00	1	0.3%
$1.25	44	15.1%
$1.75	7	2.4%
$2.00	8	2.7%
$2.50	17	5.8%
$3.00	33	11.3%
$3.25	5	1.7%
$3.50	0	0.0%
$3.75	15	5.1%
$4.25	8	2.7%
$4.50	4	1.4%
$5.00	6	2.1%
$5.50	6	2.1%
$6.50	0	0.0%
$7.00	0	0.0%
$7.50	2	0.7%
TOTALS	292	100.0%

$0.00	184	63.0%
$0.50	54	18.6%
$1.00	0	0.0%
$1.50	31	10.5%
$2.00	8	2.7%
$2.50	10	3.4%
$3.00	5	1.7%
TOTALS	292	100.0%

COMPILATION OF NF-MH
INCENTIVE POINTS AWARDED
EFF. 07/01/2023

NURSING FACILITY MENTAL HEALTH

INCENTIVE POINTS AWARDED	# OF PROVIDERS	PERCENTAGE
0	1	10.0%
1	1	10.0%
2	1	10.0%
3	2	20.0%
4	2	20.0%
5	2	20.0%
6	1	10.0%
7	0	0.0%
8	0	0.0%
TOTALS	10	100.0%

PEAK INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	6	60.0%
$0.50	3	30.0%
$1.50	1	10.0%
TOTALS	10	100.0%

June 15, 2023

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

Provider #: 104«PROV_NUM»01
KMAP ID #: «EDS_PROV_N»

Dear « NAME»:

The per diem rate shown on the enclosed Case Mix Payment Schedule for state fiscal year 2024 (FY24) has been forwarded to the Managed Care Organizations (MCOs) for processing of future reimbursement payments. The rate will become effective July 1, 2023.

The Kansas Department for 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 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 2020 calendar year end cost report. This information is intended to assist you with preparation of future cost reports.

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. The 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 Shirley Chung at (785) 296-6457 or email at Shirley.Chung@ks.gov. For questions on the Medicaid Rate, please contact Trescia Power at (785) 368-6685 or email at Trescia.Power@ks.gov or Steven Hime at (785) 296-2535 or email at Steven.Hime@ks.gov.

Sincerely,

Sheri Jurad
Director of NF/ACH Programs
Kansas Department for Aging and Disability Services

Kansas Medicaid / MediKan

Case Mix Schedule
1st - 2nd QTR 2024 ANNUAL

Current Provider Information

KDADS Provider Number:	KMAP Provider Number:	1st QTR Medicaid CMI:	0.8993
Facility Name:	Area/County:	2nd QTR Medicaid CMI:	0.9029
Address:		Average Medicaid CMI:	0.9011 (a)
City/State/Zip:			
Administrator:			

Cost Report Statistics

Calendar Year Cost Reports Used For Base Data:	12/31/2020	12/31/2021	12/31/2021	
Inflation Factor:	17.888%	13.358%	5 807%	
Facility Cost Report Period CMI:	0.8986	0.8400	0 9154	
Statewide Average CMI:	1.0706	1.0868	1 0865	1 0813 [b]
NF Or NF/MH Beds:	30	30	30	
Bed Days Available:	10,980	10,950	10,950	
Inpatient Days:	9,378	7,592	7,436	
Occupancy Rate:	85.4%	69 3%	67.9%	
Medicaid Days:	5,156	4,210	4,878	
Calc Days If Appl:	9,333	9,308	9,308	

Calculation of Combined Base Year Reimbursement Rate

Operating

Total Reported Costs:	$837,393	$920,328	$1,006,188		
Cost Report Adjustments:	$0	$0	($7,038)		
O/A Limit Adjustment:	($62,216)	$0	$0		
Total Adjusted Costs:	$775,177	$920,328	$999,150		
Total Inflated Adjusted Costs:	$924,970	$1,043,265	$1,057,171		
Total Combined Base Cost:				$3,025,406	
Days Used In Division Oper:	9,378	7,592	7,436	24,406	
				123.96	Oper Per Diem
				55.15	Oper Per Diem Cost Limitation
				55.15	Oper Per Diem Rate (1)

Indirect Health Care

Total Reported Costs:	$611,527	$724,246	$766,733		
Cost Report Adjustments:	$0	$0	($6,304)		
Total Adjusted Costs:	$611,527	$724,246	$760,429		
Total Inflated Adjusted Costs:	$720,917	$820,991	$804,587		
Total Combined Base Cost:				$2,346,495	
Days Used In Division DHC:	9,378	7,592	7,436	24,406	
				96.14	IDHC Per Diem
				68.78	IDHC Per Diem Cost Limitation
				68.78	DHC Per Diem Rate (2)

Direct Health Care

Total Reported Costs:	$1,245,277	$1,312,212	$1,423,941		
Cost Report Adjustments:	$0	$0	$0		
Total Adjusted Costs:	$1,245,277	$1,312,212	$1,423,941		
Total Inflated Adjusted Costs:	$1,468,032	$1,487,497	$1,506,629		
Total CMI Adjusted Costs:	$1,749,026	$1,808,291	$1,788,237		
Total Combined Base Cost:				$5,345,554	
Days Used In Division DHC:	9,378	7,592	7,436	24,406	
				219.03	Case Mix Adjusted DHC Per Diem
				186.15	DHC Per Diem Cost Limitation
				186.15	Allowable DHC Per Diem Cost [c]
			[c]*([a]/[b])	155.13	Medicaid Acuity Adjustment (3)

Real and Personal Property Fee

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

Calculation of Medicaid Rate

Operating, IDHC, And DHC Rates and RPPF (1) +(2) + (3) +(4):		289.53
Incentive Factor		7.50
PEAK 2.0		1.50
Bed Tax Adjustment		3.30
Medicaid Add-On		19.58
Minimum Wage Adjustment		0.00
Total Medicaid Rate Effective	**07/01/2023**	**321.41**

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

KDADS Provider Number:
KMAP Provider Number:

Facility Name:

Rate Effective Date: 07/01/23

	Incentive Possible	Facility Stats	Incentive Awarded
1. Case Mix Adjusted Nurse Staff Ratio			
Tier 1: At or Above the NF 75th Percentile (5.60)	$ 3.00		$ 3.00
Tier 2: Below the NF 75th Percentile but Improved At or Above 10%	$ 0.50		$ 0.00
		7.63	
Cost Report Year Data:		12/31/2022	
2. Staff Retention			
Tier 1: At or Below the NF 75th Percentile (71%)	$ 2.50		$ 0.00
Tier 2: Above the NF 75th Percentile but Reduced At or Above 10%	$ 0.50		$ 0.00
And Contract Nursing Labor Less than 10% of total DHC Labor Costs (Contract Labor 52%)		73%	
Cost Report Year Data:		12/31/2022	
3. Occupancy Rate			
Medicaid Occupancy At or Above 65%	$ 0.75		$ 0.00
		51%	
Cost Report Year Data:		12/31/2022	
4. Quality Measures			
Score At or Above 75th Percentile (580)	$ 1.25		$ 1.25
		620	
Total Incentive before Survey Adjustment			$ 4.25
0%			$ 0.00
Final Incentive Awarded			**$ 4.25**
Peak 2.0 Incentive	$ 3.00		$ 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

KDADS Provider Number:
KMAP Provider Number:

Facility Name:

Rate Effective Date: 07/01/23

		Incentive Possible	Facility Stats	Incentive Awarded
1.	Case Mix Adjusted Nurse Staff Ratio			
	Tier 1: At or Above 120% of NF-MH Median (3.29)	2		0
	Tier 2: At or Above 110% of NF-MH Median of (3.01)	1		0
	(NF-MH Median is 2.74 for an Average Statewide CMI of 1.0865)			
			2.52	
	Cost Report Year Data:		12/31/2022	
2.	Operating Expense			
	At or Below 90% of NF-MH Median ($34.40)	1	$31.10	1
	Cost Report Year Data:		12/31/2022	
3.	Staff Turnover			
	Tier 1: At or Below the NF-MH 75th Percentile (44%)	2		2
	Tier 2: At or Below the NF-MH 75th Percentile (60%)	1		0
	And Contract Nursing Labor Less than 10% of Total DHC Labor Costs (2.00%)			
			44%	
	Cost Report Year Data:		12/31/2022	
	Staff Retention			
4.	Tier 1: At or Below the NF-MH 75th Percentile (84%)	2		2
	Tier 2: At or Below the NF-MH 75th Percentile (69%)	1		0
			84%	
	Cost Report Year Data:		12/31/2022	
5.	Occupancy Rate			
	Total Occupancy At or Below 90%	1		0
			99%	
	Cost Report Year Data:		12/31/2022	
Total Points Awarded				**5**

Incentive Before Survey Adjustment		$5.00
Survey Adjustment and Reduction	100%	($5.00)
Final Incentive		**$0.00**

Scoring:

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

PEAK 2.0 Incentive		$0.00
Survey Adjustment and Reduction	100%	$0.00

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities – Mental Health

Medicaid Add-On

To compensate and incentivize providers with high Medicaid participation a per diem add-on has been determined and will be paid to each Medicaid provider in SFY24. The per diem will be added to the nursing facility Medicaid per diem rate.

1) Qualifying Providers

All providers currently enrolled in the Medicaid program will be eligible for the add-on.

2) Medicaid Add-On Calculation

Funds allocated for the add-on were divided by Medicaid bed days reported in CY22 nursing facility cost reports which resulted in a flat rate of $19.58 per Medicaid resident. Each facility's Medicaid rate will be determined by adding $19.58 to the facility's SFY24 per diem rate.