

Persons wishing to comment on the draft documents and/or permit applications must submit their comments in writing to the Kansas Department of Health and Environment if they wish to have the comments considered in the decision-making process. Comments should be submitted to the attention of the Livestock Waste Management Section for agricultural related draft documents or applications, or to the Technical Services Section for all other permits, at the Kansas Department of Health and Environment, Division of Environment, Bureau of Water, 1000 SW Jackson St., Suite 420, Topeka, KS 66612-1367.

All comments regarding the draft documents or application notices received on or before July 13, 2019, will be considered in the formulation of the final determinations regarding this public notice. Please refer to the appropriate Kansas document number (KS-AG-19-205/213, KS-AG-R-19-014, KS-Q-19-121/123) and name of the applicant/permittee when preparing comments.

After review of any comments received during the public notice period, the Secretary of Health and Environment will issue a determination regarding final agency action on each draft document/application. If response to any draft document/application indicates significant public interest, a public hearing may be held in conformance with K.A.R. 28-16-61 (28-46-21 for UIC).

All draft documents/applications and the supporting information including any comments received are on file and may be inspected at the offices of the Kansas Department of Health and Environment, Bureau of Water, 1000 SW Jackson St., Suite 420, Topeka, Kansas. These documents are available upon request at the copying cost assessed by KDHE. Application information and components of plans and specifications for all new and expanding swine facilities are available at <http://www.kdheks.gov/feedlots>. Division of Environment offices are open from 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays.

Lee A. Norman, M.D.  
Secretary

Doc. No. 047243

**State of Kansas**

**Department of Health and Environment**

**Notice of Final Decision to Grant a Variance**

The Kansas Department of Health and Environment (KDHE) received a Request for a Variance (Request) from provisions of the Kansas hazardous waste management regulations from the Kansas Department of Revenue, Division of Vehicles on behalf of persons in the State of Kansas who generate airbag waste.

KDHE is providing public notice of its final decision to grant the requested variance in accordance with K.A.R. 28-31-13. A copy of the Request and a copy of the Final Decision to Grant a Variance for Airbag Waste, which includes the conditions that must be met to qualify for the variance, are available at [http://www.kdheks.gov/waste/p\\_regsandstatutes.html](http://www.kdheks.gov/waste/p_regsandstatutes.html).

This variance will facilitate the timely removal of defective airbags, which pose a danger to the citizens of Kan-

sas. Nationally, tens of millions of airbags have been, or are scheduled to be, recalled. The tendency for rupture of these recalled airbag inflators increases with the age of the inflator and long-term exposure to high humidity, so timely removal of the airbags is critical. However, the recall effort could be slowed down because the management of airbag waste would likely result in vehicle dealers and salvage vendors becoming subject to increased regulation associated with higher hazardous waste generation rates. This variance will ensure that persons removing the defective airbags will not be subject to full hazardous waste generator requirements as long as the waste is properly managed in accordance with the variance.

This variance will go into effect on the date this notice of the final decision is published in the Kansas Register. The variance will remain in effect until it is rescinded by the Secretary of the Kansas Department of Health and Environment or until adoption of state regulations renders the variance unnecessary.

Lee A. Norman, M.D.  
Secretary

Doc. No. 047250

**State of Kansas**

**Department for Aging and  
Disability Services**

**Department of Health and Environment  
Division of Health Care Finance**

**Notice of Final Nursing Facility Medicaid Rates  
for State Fiscal Year 2020;  
Methodology for Calculating Rates,  
and Rate Justifications;  
Response to Written Comments;**

**Notice of Intent to Amend the Medicaid State Plan**

Under the Medicaid program, 42 U.S.C. 1396 et seq., the State of Kansas pays nursing facilities, nursing facilities for mental health, and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The Secretary of Aging and Disability Services administers the nursing facility program, which includes hospital long-term care units, and the nursing facility for mental health program. The Secretary acts on behalf of the Kansas Department of Health and Environment Division of Health Care Finance (DHCF), the single state Medicaid agency.

As required by 42 U.S.C. 1396a(a)(13), as amended by Section 4711 of the Balanced Budget Act of 1997, P.L. No. 105-33, 101 Stat. 251, 507-08 (August 5, 1997), the Secretary of the Kansas Department for Aging and Disability Services (KDADS) is publishing the proposed Medicaid per diem rates for Medicaid-certified nursing facilities for State Fiscal Year 2020, the methodology underlying the establishment of the nursing facility rates, and the justifications for those rates. KDADS and DHCF are also providing notice of the state's intent to submit amendments to the Medicaid State Plan to the U. S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) on or before September 30, 2019.

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### **I. Methodology Used to Calculate Medicaid Per Diem Rates for Nursing Facilities.**

In general, the state uses a prospective, cost-based, facility-specific rate-setting methodology to calculate nursing facility Medicaid per diem rates, including the rates listed in this notice. The state's rate-setting methodology is contained primarily in the following described documents and authorities and in the exhibits, attachments, regulations, or other authorities referenced in them:

A. The following portions of the Kansas Medicaid State Plan maintained by DHCF are being revised:

1. Attachment 4.19D, Part I, Subpart C, Exhibit C-1, inclusive;

The text of the portions of the Medicaid State Plan identified above in section IA.1, but not the documents, authorities and the materials incorporated therein by reference, is reprinted in this notice. The Medicaid State Plan provisions set out in this notice appears in the version which the state currently intends to submit to CMS on or before September 30, 2019. The Medicaid State Plan amendment that the state ultimately submits to CMS may differ from the version contained in this notice.

Copies of the documents and authorities containing the state's rate-setting methodology are available upon written request. A request for copies will be treated as a request for public records under the Kansas Open Records Act, K.S.A. 45-215 et seq. The state may charge a fee for copies, in accordance with Executive Order 18-05. Written requests for copies should be sent to:

Secretary of Aging and Disability Services  
New England Building, Second Floor  
503 S. Kansas Ave.  
Topeka, KS 66603-3404  
Fax: 785-296-0767

#### **A.1 Attachment 4.19D, Part I, Subpart C, Exhibit C-1: Methods and Standards for Establishing Payment Rates for Nursing Facilities**

Under the Medicaid program, the State of Kansas pays nursing facilities (NF), nursing facilities for mental health (NFMH), and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The narrative explanation of the nursing facility reimbursement formula is divided into 11 sections. The sections are: Cost Reports, Rate Determination, Quarterly Case Mix Index Calculation, Resident Days, Inflation Factors, Upper Payment Limits, Quarterly Case Mix Rate Adjustment, Real and Personal Property Fee, Incentive Factors, Rate Effective Date, and Retroactive Rate Adjustments.

##### **1) Cost Reports**

The Nursing Facility Financial and Statistical Report (MS2004) is the uniform cost report. It is included in Kansas Administrative Regulation (K.A.R.) 129-10-17. It organizes the commonly incurred business expenses of providers into three reimbursable cost centers (operating, indirect health care, and direct health care). Ownership costs (i.e., mortgage interest, depreciation, lease, and amortization of leasehold improvements) are reported but reimbursed through the real and personal proper-

ty fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers' accounting records.

All cost reports are desk reviewed by agency auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

##### Calendar Year End Cost Reports:

All providers that have operated a facility for 12 or more months on December 31 shall file a calendar year cost report. The requirements for filing the calendar year cost report are found in K.A.R. 129-10-17.

When a non-arms length or related party change of provider takes place or an owner of the real estate assumes the operations from a lessee, the facility will be treated as an ongoing operation. In this situation, the related provider or owner shall be required to file the calendar year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator for the months during the calendar year in which the new operator was not involved in running the facility. The cost report information from the old and new operators shall be combined to prepare a 12-month calendar year end cost report.

##### Projected Cost Reports:

The filing of projected cost reports are limited to: 1) newly constructed facilities; 2) existing facilities new to the Medicaid program; or 3) a provider re-entering the Medicaid program that has not actively participated or billed services for 24 months or more. The requirements are found in K.A.R. 129-10-17.

##### **2) Rate Determination**

##### Rates for Existing Nursing Facilities

Medicaid rates for Kansas NFs are determined using a prospective, facility-specific rate-setting system. The rate is determined from the base cost data submitted by the provider. The current base cost data is the combined calendar year cost data from each available report submitted by the current provider during 2016, 2017, and 2018.

If the current provider has not submitted a calendar year report during the base cost data 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, 2018. 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 pay-

ment 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 diems 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. The rate components 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, 2018. 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, 2018. The provider shall remain in new enrollment status until the base data period is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

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

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 2016-2018. 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, 2018. 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, 2018. The provider shall remain in change-of-provider status until the base data period 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, 2018. 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, 2018. The provider shall remain in reenrollment status until the base data period 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**

Providers are required to submit to the agency the uniform assessment instrument, which is the Minimum Data Set (MDS), for each resident in the facility. The MDS assessments are maintained in a computer database.

The Resource Utilization Groups-III (RUG-III) Version 5.20, 34 group, index maximizer model is used as the resident classification system to determine all case mix indices, using data from the MDS submitted by each facility. Standard Version 5.20 (Set D01) case mix indices developed by the Centers for Medicare and Medicaid Services (CMS) shall be the basis for calculating facility average case mix indices to be used to adjust the Direct Health Care costs in the determination of upper payment limits and rate calculation. Resident assessments that cannot be classified will be assigned the lowest CMI for the State.

Each resident in the facility on the first day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the first day of each calendar quarter. This RUG-III group shall be translated to the appropriate CMI. From the individual resident case mix indices, three average

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case mix indices for each Medicaid nursing facility shall be determined four times per year based on the assessment information available on the first day of each calendar quarter.

The facility-wide average CMI is the simple average, carried to four decimal places, of all resident case mix indices. The Medicaid-average CMI is the simple average, carried to four decimal places, of all indices for residents, including those receiving hospice services, where Medicaid is known to be a per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. The private-pay/other average CMI is the simple average, carried to four decimal places, of all indices for residents where neither Medicaid nor Medicare were known to be the payer source on the first day of the calendar quarter or at any time during the preceding quarter. Case mix indices for ventilator-dependent residents for whom additional reimbursement has been determined shall be excluded from the average CMI calculations.

Rates will be adjusted for case mix twice annually using case mix data from the two quarters preceding the rate effective date. The case mix averages used for the rate adjustments will be the simple average of the case mix averages for each quarter. The resident listing cut-off for calculating the average CMIs for each quarter will be the first day of the quarter. The following are the dates for the resident listings and the rate periods in which the average Medicaid CMIs will be used in the semi-annual rate-setting process.

<u>Rate Effective Date:</u>	<u>Cut-Off Dates for Quarterly CMI:</u>
July 1	January 1 and April 1
January 1	July 1 and October 1

The resident listings will be distributed to providers prior to the dates the semi-annual case mix adjusted rates are determined. This will allow the providers time to review the resident listings and make corrections before they are notified of new rates. The cut off schedule may need to be modified in the event accurate resident listings and Medicaid CMI scores cannot be obtained from the MDS database.

#### 4) Resident Days

##### Facilities with 60 beds or less:

For facilities with 60 beds or less, the allowable historic per diem costs for all cost centers are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data.

##### Facilities with more than 60 beds:

For facilities with more than 60 beds, the allowable historic per diem costs for the Direct Health Care cost center and for food and utilities in the Indirect Health Care cost center are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data. The allowable historic per diem cost for the Operating and Indirect Health Care Cost Centers less food and utilities is subject to an 85% minimum occupancy rule. For

these providers, the greater of the actual resident days for the cost report period(s) used to establish the base cost data or the 85% minimum occupancy based on the number of licensed bed days during the cost report period(s) used to establish the base cost data is used as the total resident days in the rate calculation for the Operating cost center and the Indirect Health Care cost center less food and utilities. All licensed beds are required to be certified to participate in the Medicaid program.

There are two exceptions to the 85% minimum occupancy rule for facilities with more than 60 beds. The first is that it does not apply to a provider who is allowed to file a projected cost report for an interim rate. Both the rates determined from the projected cost report and the historic cost report covering the projected cost report period are based on the actual resident days for the period.

The second exception is for the first cost report filed by a new provider who assumes the rate of the previous provider. If the 85% minimum occupancy rule was applied to the previous provider's rate, it is also applied when the rate is assigned to the new provider. However, when the new provider files a historic cost report for any part of the first 12 months of operation, the rate determined from the cost report will be based on actual days and not be subject to the 85% minimum occupancy rule for the months in the first year of operation. The 85% minimum occupancy rule is then reapplied to the rate when the new provider reports resident days and costs for the 13th month of operation and after.

#### 5) Inflation Factors

Inflation will be applied to the allowable reported costs from the calendar year cost report(s) used to determine the base cost data from the midpoint of each cost report period to December 31, 2018. 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

#### 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 lim-

its 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.

Schedule C is an array of non-owner administrator and co-administrator salaries. The schedule includes the calendar year 2018 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. Schedule C for the owner/related party/administrator/co-administrator per diem compensation limit is the first schedule run during the rate setting.

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 is 105% of the median determined from a total resident day-weighted array of the property fees in effect April 1, 2019.

Cost Center Upper Payment Limits

Schedule B 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, 2018. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based on the IHS Global Insight, CMS Nursing Home Without Capital Market Basket Index.

Certain costs are exempt from the inflation application when setting the upper payment limits. They include owner/related party compensation, interest expense, and real and personal property taxes.

Schedule B is the median compilations. These compilations are needed for setting the upper payment limit for each cost center. The median for each cost center is weighted based on total resident days. The upper payment limits will be set using the following:

Operating	110% of the median
Indirect Health Care	115% of the median
Direct Health Care	130% of the median

Direct Health Care Cost Center Limit:

The Kansas reimbursement methodology has a component for a case mix payment adjustment. The Direct Health Care cost center rate component and upper payment limit are adjusted by the facility average CMI.

For the purpose of setting the upper payment limit in the Direct Health Care cost center, the facility cost report period CMI and the statewide average CMI will be calculated. The facility cost report period CMI is the resident day-weighted average of the quarterly facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/20XX-12/31/20XX financial and statistical reporting period would use the facility-wide average case mix indices for quarters beginning 04/01/XX, 07/01/XX, 10/01/XX and 01/01/XY. The statewide average CMI is the resident day-weighted average, carried to four dec-

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imal places, of the facility cost report period case mix indices for all Medicaid facilities.

The statewide average CMI and facility cost report period CMI are used to set the upper payment limit for the Direct Health Care cost center. The limit is based on all facilities with a historic cost report in the database. There are three steps in establishing the base upper payment limit.

The first step is to normalize each facility's inflated Direct Health Care costs to the statewide average CMI. This is done by dividing the 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 inflated case mix adjusted 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 \$80 and the upper payment limit is based on 130% of the median, then the upper payment limit for the statewide average CMI would be \$104 ( $D=130\% \times \$80$ ).

#### 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 date. The facility's 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 facility's direct health care per diem cost is \$80.00, the Direct Health Care per diem limit is \$104.00, and these are both tied to a statewide average CMI of 1.000, and the facility's current Medicaid CMI is 0.9000. Since

the per diem costs are less than the limit the Allowable Direct Health Care Cost is \$80.00, and this is matched with the statewide average CMI of 1.0000. To calculate the Medicaid Acuity Adjustment, first divide the Medicaid CMI by the statewide average CMI, then multiply the result by the Allowable Direct Health Care Cost. In this case that would result in \$72.00 ( $0.9000/1.0000 \times \$80.00$ ). Because the facility's current Medicaid CMI is less than the statewide average CMI the Medicaid Acuity Adjustment moves the direct health care per diem down proportionally. In contrast, if the Medicaid CMI for the next semi-annual adjustment rose to 1.1000, the Medicaid Acuity Adjustment would be \$88.00 ( $1.1000/1.0000 \times \$80.00$ ). Again the Medicaid Acuity Adjustment changes the Allowable Direct Health Care Per Diem Cost to match the current Medicaid CMI.

#### 8) Real and Personal Property Fee

The property component of the reimbursement methodology consists of the real and personal property fee (property fee). The property fee is paid in lieu of an allowable cost of mortgage interest, depreciation, lease expense and/or amortization of leasehold improvements. The fee is facility specific and does not change as a result of a change of ownership, change in lease, or with re-enrollment in the Medicaid program. The original property fee was comprised of two components, a property allowance and a property value factor. The differentiation of the fee into these components was eliminated effective July 1, 2002. At that time each facility's fee was re-established based on the sum of the property allowance and value factor. The providers receive the lower of the inflated property fee or the upper payment limit.

For providers re-enrolling in the Kansas Medical Assistance program or providers enrolling for the first time but operating in a facility that was previously enrolled in the program, the property fee shall be the sum of the last effective property allowance and the last effective value factor for that facility. The property fee will be inflated to 12/31/08 and then compared to the upper payment limit. The property fee will be the lower of the facility-specific inflated property fee or the upper payment limit.

Providers entering the Kansas Medical Assistance program for the first time, who are operating in a building for which a fee has not previously been established, shall have a property fee calculated from the ownership costs reported on the cost report. This fee shall include appropriate components for rent or lease expense, interest expense on real estate mortgage, amortization of leasehold improvements, and depreciation on buildings and equipment. The process for calculating the property fee for providers entering the Kansas Medical Assistance program for the first time is explained in greater detail in K.A.R. 129-10-25.

There is a provision for changing the property fee. This is for a rebasing when capital expenditure thresholds are met (\$25,000 for homes under 51 beds and \$50,000 for homes over 50 beds). The original property fee remains constant but the additional factor for the rebasing is added. The property fee rebasing is explained in greater detail in K.A.R. 129-10-25. The rebased property fee is subject to the upper payment limit.

**9) Incentive Factors**

An incentive factor will be awarded to both NF and NF-MH providers that meet certain outcome measures criteria. The criteria for NF and NF-MH providers will be determined separately based on arrays of outcome measures for each provider group.

Nursing Facility Quality and Efficiency Incentive Factor:

The Nursing Facility Incentive Factor is a per diem amount determined by four per diem add-ons providers can earn for various outcomes measures. Providers that maintain a case mix adjusted staffing ratio at or above the 75th percentile will earn a \$3.00 per diem add-on. Providers that fall below the 75th percentile staffing ratio but improve their staffing ratio by 10% or more will earn a \$0.50 per diem add-on. Providers that achieve a staff retention rate at or above the 75th percentile will earn a \$2.50 per diem add-on as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers that have a staff retention rate lower than the 75th percentile but that increase their staff retention rate by 10% or more will receive a per diem add-on of \$0.50 as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers that have a Medicaid occupancy percentage of 65% or more will receive a \$0.75 per diem add-on. Finally, providers that maintain quality measures at or above the 75th percentile will earn a \$1.25 per diem add-on. The total of all the per diem add-ons a provider qualifies for will be their incentive factor.

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

Incentive Outcome	Incentive Add-Ons
CMI adjusted staffing ratio ≥ 75th percentile (5.14), or CMI adjusted staffing < 75th percentile but improved ≥ 10%	\$3.00 \$0.50
Staff retention rate ≥ 75th percentile, 72% Contracted labor < 10% of total direct health care labor costs 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 (640)	\$1.25
<b>Total Incentive Add-on Available</b>	<b>\$7.50</b>

The Culture Change/Person-Centered Care Incentive Program

The Culture Change/Person-Centered Care Incentive Program (PEAK 2.0) includes six 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 three levels (Level 0 – Level 2) are intended to encourage quality improvement for homes that have not yet met the minimum competency requirements for a person-centered care home. Homes can earn the Level 1 and Level 2 incentives simultaneously as they progress toward the minimum competency level.

Level 3 recognizes those homes that have attained a minimum level of core competency in person-centered care. Level 4 and Level 5 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.

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 plan. 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 Level 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.
Level 3 Person-Centered Care Home \$2.00	Demonstrates minimum competency as a person-centered care home (see KDADS full criteria). This is confirmed through a combination of the following: High score on the KCCI evaluation tool. Demonstration of success in other levels of the program. Performing successfully on a Level 2 screening call with the KSU PEAK 2.0 team. Passing a full site visit.	Available beginning July 1 following confirmed minimum competency as a person-centered care home. Incentive is granted for one full fiscal year. Renewable bi-annually.

*Separate the Kansas Learning and Incentive Program*

(continued)

Level & Per Diem Incentive	Summary of Required Nursing Home Action	Incentive Duration
Level 4 Sustained Person-Centered Care Home \$2.50	Homes earn person-centered care home award two consecutive years.	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies. Incentive is granted for two fiscal years. Renewable bi-annually.
Level 5 Person-Centered Care Mentor Home \$3.00	Homes earn sustained person-centered care home award and successfully engage in mentoring activities suggested by KDADS (see KDADS mentoring activities). Mentoring activities should be documented.	Available beginning July 1 following confirmation of mentor home standards. Incentive is granted for two fiscal years. Renewable bi-annually.