State of Kansas
Department for Aging and Disability Services
Kansas Department of Health and Environment,
Division of Health Care Finance

Notice of Proposed Nursing Facility Medicaid Rates for State Fiscal Year 2022; 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 2022, 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, 2021.

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, 2021. 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 South Kansas Avenue
Topeka, KS 66603-3404
Fax Number: 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 property 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.

<u>Calendar Year End Cost Reports:</u>

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 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 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 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.

Rate Effective Date:	Cut-Off Dates for Quarterly CMI:
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 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.

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, 2021.

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 decimal 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% x $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 Heath 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 x $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 x $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 (5.80), or CMI adjusted staffing < 75th percentile but improved >= 10%	$3.00 $0.50
Staff retention rate >= 75th percentile, 67% Contracted labor < 10% of total direct health care labor costs or Staff retention rate < 75th percentile but increased >= 10% Contracted labor < 10% of total direct health care labor costs	$2.50 $0.50
Medicaid occupancy >= 65%	$0.75
Quality Measures >=75th percentile (670)	$1.25
Total Incentive Add-on Available	**$7.50**

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 will be dropped until they enroll to participate in the next fiscal year.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year, contingent upon participation.
Level 1 Pursuit of Culture Change $0.50	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing 4 PEAK 2.0 cores in Domains 1-4. The home self-reports progress on the action planned cores via phone conference with the PEAK team. The home may be selected for a random site visit. The home must participate in the random site visit, if selected, to continue incentive payment. Homes should demonstrate successful completion of 75% of core competencies selected. A home can apply for Levels 1 & 2 in the same year. Homes that do not achieve Level 2 with three consecutive years of participation at Level 1 may return to a Level 0 or sit out for two years depending on KDADS and KSU's recommendation.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level 2 Culture Change Achievement $1.00	This is a bridge level to acknowledge achievement in Level 1. Homes may receive this level at the same time they are working on other PEAK core areas at Level 1. Homes may receive this incentive for up to 3 years. If Level 3 is not achieved at the end of the third year, homes may start back at Level 0 or 1 depending on KDADS and KSU's recommendation.	Available beginning July 1 following confirmed completion of action plan goals. Incentive is granted for one full fiscal year.
Level 3 Person-	Demonstrates minimum competency as a person-centered care home (see KDADS full criteria). This is confirmed	Available beginning July 1 following confirmed minimum competency as a

Centered Care Home $2.00	through a combination of the following: 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.	person-centered care home. Incentive is granted for one full fiscal year. Renewable bi-annually.
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.

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 nursing facilities. Nursing Facilities for Mental Health 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 NFMHs to work cooperatively and in coordination with Community Mental Health Centers to facilitate the return of persons to the community.

The Quality and Efficiency Incentive Factor is a per diem add-on ranging from zero to seven dollars and fifty cents. 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 3.88, which is 120% of the statewide NFMH median of 3.23. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.55, which is 110% of the statewide NFMH median. Providers with staffing

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

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. The provider will earn one point if the per diem operating expenses are below $26.11, or 90% of the statewide median of $29.01.

NFMH providers may earn up to two points for the turnover rate outcomes measure. Providers with direct health care staff turnover equal to or below 41%, 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 41% but equal to or below 75%, 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 the retention rate outcomes measure. Providers with staff retention rates at or above 76%, the 75th percentile statewide will earn two points. Providers with staff retention rates below 76% but at or above 67%, the 50th percentile statewide, will earn one point.

The table below summarizes the incentive factor outcomes and points:

QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
CMI adjusted staffing ratio >= 120% (3.88) of NF-MH median (3.23), or CMI adjusted staffing ratio between 110% (3.55) and 120%	2, or 1
Total occupancy <= 90%	1
Operating expenses < $26.11, 90% of NF-MH median, $29.01	1
Staff turnover rate <= 75th percentile, 41% Staff turnover rate <= 50th percentile, 75% Contracted labor < 10% of total direct health care labor costs	2, or 1
Staff retention >= 75th percentile, 76% Staff retention >= 50th percentile, 67%	2, or 1
Total Incentive Points Available	**8**

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 survey and certification performance of each NF and NFMH provider will be reviewed quarterly to determine each provider's eligibility for incentive factor payments. In order to qualify for an incentive, factor 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.

11) Retroactive Rate Adjustments

Retroactive adjustments, as in a retrospective system, are made for the following three conditions:

A retroactive rate adjustment and direct cash settlement is made if the agency determines that the base year cost report data used to determine the prospective payment rate was in error. The prospective payment rate period is adjusted for the corrections.

If a projected cost report is approved to determine an interim rate, a settlement is also made after a historic cost report is filed for the same period.

All settlements are subject to upper payment limits. A provider is considered to be in projection status if they are operating on a projected rate and they are subject to the retroactive rate adjustment.

II. Medicaid Per Diem Rates for Kansas Nursing Facilities

A Cost Center Limitations: The state establishes the following cost center limitations which are used in setting rates effective July 1, 2021.

Cost Center	Limit Formula	Per Day Limit
Operating	110% of the Median Cost	$39.13
Indirect Health Care	115% of the Median Cost	$54.45
Direct Health Care	130% of the Median Cost	$129.95
Real and Personal Property Fee	105% of the Median Fee	$10.01

These amounts were determined according to the "Reimbursement Limitations" section. The Direct Healthcare Limit is calculated based on a CMI of 1.0314, which is the statewide average.

B. Case Mix Index: These proposed rates are based upon each nursing facility's Medicaid CMI calculated as the average of the quarterly Medicaid CMI averages with a cutoff dates of January 1, 2021 and April 1, 2021. The CMI calculations use the July 1, 2014 Kansas Medicaid/Medikan CMI Table. In Section II.C below, each nursing facility's Medicaid average CMI is listed beside its per diem rate.

C. Rates: The following list includes the calculated Medicaid rate for each nursing facility provider currently enrolled in the Medicaid program and the Medicaid case mix index used to determine each rate.

Facility Name	City	Daily Rate	Medicaid CMI
Village Manor	Abilene	196.68	0.9207
Alma Manor	Alma	173.66	0.8774
Life Care Center of Andover	Andover	163.81	1.0724
Victoria Falls SNF	Andover	184.69	1.0089
Anthony Community Care Center	Anthony	168.53	0.9184
Medicalodges Health Care Ctr Arkansas	Arkansas City	178.42	0.9840
Arkansas City Presbyterian Manor	Arkansas City	199.88	1.1782
Arma Operator. LLC	Arma	188.75	1.3896
Medicalodges Atchison	Atchison	219.07	1.1255
Atchison Senior Village	Atchison	218.30	0.9976
Dooley Center	Atchison	212.81	0.8343
Attica Long Term Care	Attica	206.22	0.8726
Good Samaritan Society-Atwood	Atwood	224.47	1.0756
Lake Point Nursing Center	Augusta	173.15	1.0451
Baldwin Healthcare & Rehab Center	Baldwin City	195.40	1.2559
Quaker Hill Manor	Baxter Springs	183.10	1.1186
Catholic Care Center Inc.	Bel Aire	223.09	1.1480
Belleville Healthcare Center	Belleville	183.08	1.2160

Mitchell County Hospital LTCU	Beloit	216.76	0.9268
Hilltop Lodge Health and Rehab	Beloit	216.25	1.2740
Bonner Springs Nursing & Rehab Ctr	Bonner Springs	175.03	1.1112
Hill Top House	Bucklin	227.09	0.9755
Buhler Sunshine Home, Inc.	Buhler	224.62	0.9765
Life Care Center of Burlington	Burlington	162.29	1.1014
Eastridge Nursing Home	Centralia	266.73	1.0903
Heritage Health Care Center	Chanute	178.90	1.2288
Diversicare of Chanute	Chanute	183.22	1.2107
Chapman Valley Manor	Chapman	170.82	0.8936
Cheney Golden Age Home Inc.	Cheney	183.85	1.0981
Cherryvale Care Center	Cherryvale	154.51	0.9579
Chetopa Manor	Chetopa	164.13	0.8497
The Shepherd's Center	Cimarron	205.96	0.8699
Medicalodges Clay Center	Clay Center	227.39	1.0680
Clay Center Presbyterian Manor	Clay Center	194.75	1.0108
Clearwater Nursing and Rehab	Clearwater	177.72	1.1080
Park Villa Nursing Home	Clyde	177.49	1.0990
Windsor Place	Coffeyville	190.44	1.1154
Medicalodges Coffeyville	Coffeyville	212.89	1.0779
Windsor Place at Iola, LLC	Coffeyville	183.16	1.0942
Colby Operator, LLC	Colby	178.30	1.2000
Prairie Senior Living Complex	Colby	227.63	0.9998
Pioneer Lodge	Coldwater	174.32	0.7966
Medicalodges Columbus	Columbus	205.19	1.1114
Mt Joseph Senior Village, LLC	Concordia	176.09	1.0785
Sunset Home, Inc.	Concordia	194.18	1.0340
Spring View Manor	Conway Springs	193.14	1.1201
Chase County Operator LLC	Cottonwood Falls	218.59	1.0818
Diversicare of Council Grove	Council Grove	177.53	1.1598
Hilltop Manor Nursing Center	Cunningham	164.57	0.9337
Westview of Derby	Derby	129.90	0.9144
Derby Health and Rehabilitation	Derby	209.24	1.1452
Hillside Village	DeSoto	186.84	0.9830
Trinity Manor	Dodge City	186.81	1.1605
Sunporch of Dodge City	Dodge City	191.23	0.8559
Manor of the Plains	Dodge City	216.22	1.0882
Downs Operator LLC	Downs	213.69	1.3185
Country Care Home	Easton	174.44	1.0408
Parkway Operator LLC	Edwardsville	193.90	1.1805

Kaw River Operator, LLC	Edwardsville	229.96	1.2503
Edwardsville Operator LLC	Edwardsville	179.96	0.8279
Lakepoint Nursing Center-El Dorado	El Dorado	173.87	0.9614
El Dorado Operator LLC	El Dorado	221.29	1.1529
Morton Co Senior Living Community	Elkhart	180.88	0.9975
Azria Health Woodhaven	Ellinwood	229.25	1.3226
Good Samaritan Society-Ellis	Ellis	182.84	1.0360
Good Sam Society-Ellsworth Village	Ellsworth	184.49	1.0339
Emporia Presbyterian Manor	Emporia	205.96	1.0217
Holiday Resort	Emporia	172.21	1.0261
Flint Hills Care and Rehab Center	Emporia	172.95	1.1647
Enterprise Estates Nursing Center, Inc	Enterprise	176.16	1.0160
Eskridge Operator LLC	Eskridge	180.88	1.0029
Medicalodges Eudora	Eudora	196.45	1.1254
Eureka Nursing Center	Eureka	173.92	1.0352
Kansas Soldiers' Home	Fort Dodge	233.53	0.9633
Medicalodges Fort Scott	Fort Scott	183.37	1.0378
Fowler Residential Care	Fowler	220.99	0.9860
Frankfort Community Care Home, Inc.	Frankfort	193.86	1.0006
Medicalodges Frontenac	Frontenac	181.10	0.9923
Galena Nursing Home	Galena	190.26	1.2424
Garden Valley Retirement Village	Garden City	187.44	1.2008
Ranch House Senior Living	Garden City	199.56	1.0675
Recover Care Meadowbrook Rehab, LLC	Gardner	293.32	1.4685
Medicalodges Gardner	Gardner	183.25	0.8967
Anderson County Hospital	Garnett	215.99	0.8605
Parkview Heights	Garnett	212.31	1.0434
Medicalodges Girard	Girard	181.97	1.0151
The Nicol Home, Inc.	Glasco	165.25	0.8213
Medicalodges Goddard	Goddard	200.86	0.9466
Bethesda Home	Goessel	209.97	0.9378
Topside Manor, Inc.	Goodland	199.40	1.0545
Medicalodges Great Bend	Great Bend	188.65	0.9782
Great Bend Health and Rehab Center	Great Bend	195.59	1.0410
Halstead Health and Rehab Center	Halstead	212.18	1.0492
Haviland Operator, LLC	Haviland	147.90	0.6712
Good Samaritan Society-Hays	Hays	206.37	1.1344
Via Christi Village-Hays	Hays	194.27	1.0875
Diversicare of Haysville	Haysville	177.93	1.1967
Legacy at Herington	Herington	176.05	1.1087
Schowalter Villa	Hesston	241.94	1.0065
Maple Heights of Hiawatha	Hiawatha	146.51	0.9053

Highland Healthcare and Rehab Center	Highland	185.70	1.1612
Dawson Place, Inc.	Hill City	181.06	0.9281
Salem Home	Hillsboro	203.46	1.0091
Parkside Homes, Inc.	Hillsboro	197.41	0.9253
Medicalodges Jackson County	Holton	207.27	1.0713
Mission Village Living Center	Horton	157.33	1.1337
Sheridan County Hospital	Hoxie	223.68	0.9675
Pioneer Manor	Hugoton	208.94	0.8139
Diversicare of Hutchinson	Hutchinson	197.81	1.2594
Good Sam Society-Hutchinson Village	Hutchinson	226.63	1.0750
Hutchinson Operator, LLC	Hutchinson	180.47	1.2448
Wesley Towers	Hutchinson	246.53	1.0775
Medicalodges Independence	Independence	187.99	1.0262
Montgomery Place Nursing Center,LLC	Independence	179.24	1.0403
Pleasant View Home	Inman	195.42	0.9512
Stanton County Hospital- LTCU	Johnson	217.71	0.8860
Valley View Senior Life	Junction City	199.61	1.0069
Medicalodges Post Acute Care Center	Kansas City	188.93	1.0152
Riverbend Post Acute Rehabilitation	Kansas City	202.92	1.1767
Lifecare Center of Kansas City	Kansas City	173.93	0.9908
Providence Place LTCU	Kansas City	239.09	1.2005
Ignite Medical Resort	Kansas City	218.64	1.3967
Golden Oaks Healthcare, Inc.	Kansas City	237.70	1.1979
The Wheatlands	Kingman	176.36	0.9767
Medicalodges Kinsley	Kinsley	221.60	1.1032
Kiowa District Manor	Kiowa	213.08	0.9398
Locust Grove Village	Lacrosse	200.86	1.0081
High Plains Retirement Village	Lakin	228.07	0.9354
Lansing Operator LLC	Lansing	216.86	1.2925
Twin Oaks Health & Rehab	Lansing	222.75	1.2293
Diversicare of Larned	Larned	158.52	1.0165
Lawrence Presbyterian Manor	Lawrence	208.83	1.0099
Brandon Woods at Alvamar	Lawrence	206.55	1.0384
Pioneer Ridge Retirement Community	Lawrence	211.19	1.0697
Medicalodges Leavenworth	Leavenworth	196.14	1.1282
The Healthcare Resort of Leawood	Leawood	269.53	1.3776
Delmar Gardens of Lenexa	Lenexa	175.53	1.0045
Lakeview Village	Lenexa	262.57	1.2390
Westchester Village of Lenexa	Lenexa	247.34	1.1593
Leonardville Nursing Home	Leonardville	179.76	0.9399
Wichita County Health Center	Leoti	260.32	0.8525
Good Samaritan Society-Liberal	Liberal	184.31	1.1541

Wheatridge Park Care Center	Liberal	208.40	1.2451
Lincoln Park Manor, Inc.	Lincoln	200.67	0.9487
Bethany Home Association	Lindsborg	222.12	1.0234
Linn Community Nursing Home	Linn	175.04	1.0366
Sandstone Heights Nursing Home	Little River	242.01	1.0721
Logan Manor Community Health Service	Logan	176.36	0.9870
Louisburg Healthcare and Rehab Center	Louisburg	191.18	1.3189
Good Samaritan Society-Lyons	Lyons	196.59	1.0021
Meadowlark Hills Retirement Community	Manhattan	234.00	1.0285
Stoneybrook Retirement Community	Manhattan	184.30	1.0200
Via Christi Village Manhattan, Inc.	Manhattan	198.57	1.0842
St. Luke Living Center	Marion	200.32	0.9060
Riverview Estates, Inc.	Marquette	183.60	0.9011
Cambridge Place	Marysville	173.30	1.0548
McPherson Operator, LLC	McPherson	176.12	1.1937
The Cedars, Inc.	Mcpherson	217.51	1.0260
Meade District Hospital, LTCU	Meade	213.37	0.8825
Merriam Gardens Healthcare & Rehab	Merriam	220.60	1.2515
Minneapolis Health and Rehabilitation	Minneapolis	170.68	1.1670
Minneola District Hospital-LTCU	Minneola	218.63	0.8931
Bethel Home, Inc.	Montezuma	199.25	0.9692
Moran Manor	Moran	155.30	1.0465
Pine Village	Moundridge	208.95	1.0315
Moundridge Manor, Inc.	Moundridge	206.75	0.8779
Mt. Hope Nursing Center	Mt. Hope	193.71	1.0683
Villa Maria, Inc.	Mulvane	214.52	1.1192
Neodesha Operator LLC	Neodesha	197.57	1.2804
Ness County Hospital Dist.#2	Ness City	213.80	0.9211
Asbury Park	Newton	208.28	0.9344
Kansas Christian Home	Newton	210.52	1.0283
Newton Presbyterian Manor	Newton	223.11	1.0477
Bethel Care Center	North Newton	231.99	0.9589
Andbe Home, Inc.	Norton	177.75	0.9994
Village Villa	Nortonville	185.17	1.1466
Logan County Manor	Oakley	236.67	1.1020
Good Samaritan Society-Decatur Co.	Oberlin	214.73	0.9744
Villa St. Francis Catholic Care Ctr.	Olathe	232.23	1.2106
Azria Health at Olathe	Olathe	227.14	1.2163
Good Samaritan Society-Olathe	Olathe	225.75	1.0641
Evergreen Community of Johnson Count	Olathe	233.74	1.0107
Aberdeen Village, Inc.	Olathe	245.78	1.1070
Nottingham Health & Rehab	Olathe	225.87	1.2211

The Healthcare Resort of Olathe	Olathe	246.59	1.3381
Onaga Operator, LLC	Onaga	184.00	1.3348
Osage Nursing & Rehab Center	Osage City	180.19	1.0620
Life Care Center of Osawatomie	Osawatomie	188.02	1.3501
Parkview Care Center	Osborne	161.46	0.9992
Hickory Pointe Care & Rehab Ctr	Oskaloosa	205.96	1.0622
Oswego Operator, LLC	Oswego	183.05	1.2572
Rock Creek of Ottawa	Ottawa	206.88	1.2620
Brookside Manor	Overbrook	164.00	1.0378
Brookdale Overland Park	Overland Park	254.53	1.0706
Garden Terrace at Overland Park	Overland Park	181.81	1.2263
KPC Promise Hospital of Overland Park	Overland Park	252.51	1.5856
Overland Park Center for Rehab & HC	Overland Park	232.54	1.2290
Villa Saint Joseph	Overland Park	226.01	1.0452
Delmar Gardens of Overland Park	Overland Park	204.63	1.0818
Overland Park Nursing & Rehab	Overland Park	238.04	1.2217
Indian Creek Health and Rehab	Overland Park	206.89	1.1899
Village Shalom, Inc.	Overland Park	232.28	1.1387
Tallgrass Creek, Inc.	Overland Park	213.76	1.2625
Shawnee Post Acute Rehab Center	Overland Park	247.00	1.2406
Stratford Commons Rehab & HCC	Overland Park	249.80	1.2116
Colonial Village	Overland Park	229.69	1.1530
ML-OP Oxford, LLC	Oxford	183.35	1.0526
Medicalodges Paola	Paola	134.88	0.7310
North Point Skilled Nursing Center	Paola	196.90	1.0897
Elmhaven East	Parsons	173.76	1.0036
Parsons Presbyterian Manor	Parsons	216.94	1.0733
Good Samaritan Society-Parsons	Parsons	186.00	1.0044
Peabody Operator, LLC	Peabody	155.06	1.0621
Access Mental Health	Peabody	130.00	0.6335
Phillips County Retirement Center	Phillipsburg	197.52	1.0084
Pittsburg Operator LLC	Pittaburg	202.13	1.1754
Medicalodges Pittsburg South	Pittsburg	190.99	1.0615
Via Christi Village Pittsburg, Inc.	Pittsburg	209.22	1.2636
Rooks County Senior Services, Inc.	Plainville	206.50	1.0204
Brighton Gardens of Prairie Village	Prairie Village	249.64	1.3623
Grand Plains - Skilled Nursing	Pratt	138.15	1.0706
Pratt Operator, LLC	Pratt	158.98	1.1780
Prairie Sunset Manor	Pretty Prairie	226.32	1.3576
Protection Valley Manor	Protection	147.77	0.8080
Gove County Medical Center	Quinter	234.28	0.9849
Richmond Healthcare and Rehab Center	Richmond	185.27	1.2945

Fountainview Nursing and Rehab Center	Rose Hill	191.46	1.1030
Rossville Healthcare and Rehab Center	Rossville	188.32	1.2030
Wheatland Nursing & Rehab Center	Russell	170.36	1.0296
Russell Regional Hospital	Russell	239.07	0.9659
Sabetha Nursing Center	Sabetha	166.82	1.0345
Apostolic Christian Home	Sabetha	178.88	0.9466
Smoky Hill Rehabilitation Center	Salina	156.76	1.0110
Kenwood View Health and Rehab Center	Salina	180.68	1.2829
Salina Windsor SNF OPCO, LLC	Salina	171.01	1.1008
Pinnacle Park Nursing and Rehabilitation	Salina	163.96	1.2327
Salina Presbyterian Manor	Salina	183.85	1.0291
Holiday Resort of Salina	Salina	191.35	1.0462
Satanta Dist. Hosp. LTCU	Satanta	213.27	0.9224
Park Lane Nursing Home	Scott City	224.54	1.0059
Pleasant Valley Manor	Sedan	155.26	0.9399
Diversicare of Sedgwick	Sedgwick	191.49	1.1747
Crestview Nursing & Residential Living	Seneca	167.63	1.0753
Life Care Center of Seneca	Seneca	149.25	1.1210
Wallace County Community Center	Sharon Springs	229.44	1.0524
Shawnee Gardens Healthcare and Rehab	Shawnee	183.60	1.3093
Sharon Lane Health and Rehabilitation	Shawnee	204.51	1.2311
Brookdale Rosehill	Shawnee	272.15	1.3543
Smith Center Operator, LLC	Smith Center	174.02	1.1789
Sunporch of Smith County	Smith Center	196.56	0.8648
Mennonite Friendship Manor, Inc.	South Hutchinson	209.91	1.0672
Spring Hill Operator LLC	Spring Hill	219.66	1.2299
Cheyenne County Village,Inc.	St. Francis	229.62	0.9991
Leisure Homestead at St. John	St. John	182.02	0.9482
Community Hospital of Onaga, LTCU	St. Mary's	210.96	0.9610
Prairie Mission Retirement Village	St. Paul	165.08	1.0103
Leisure Homestead at Stafford	Stafford	177.24	0.9346
Sterling Village	Sterling	235.93	1.0466
Solomon Valley Manor	Stockton	207.07	1.0695
Legend Healthcare	Tonganoxie	180.40	1.0447
Brewster Health Center	Topeka	232.47	1.0204
Topeka Presbyterian Manor Inc.	Topeka	239.73	1.1307
Legacy on 10th Ave.	Topeka	159.54	0.9920
McCrite Plaza Health Center	Topeka	234.38	1.1900
Rolling Hills Health Center	Topeka	201.95	1.1200
Topeka Center for Rehab and Healthcare	Topeka	199.45	1.4356
Tanglewood Nursing and Rehabilitation	Topeka	167.39	1.1396

Brighton Place West	Topeka	139.17	0.9586
Countryside Health Center	Topeka	109.84	0.7075
Providence Living Center	Topeka	126.65	0.8154
Brighton Place North	Topeka	117.00	0.7120
Aldersgate Village	Topeka	227.13	1.1068
Recover-Care Plaza West Care Center	Topeka	209.27	1.4012
Lexington Park Nursing and Post Acute	Topeka	224.85	1.0871
Top City Healthcare, Inc.	Topeka	228.46	1.2548
Greeley County Hospital, LTCU	Tribune	202.10	0.8508
Western Prairie Senior Living	Ulysses	205.68	0.9470
Valley Health Care Center	Valley Falls	155.99	0.6440
Trego Co. Lemke Memorial LTCU	Wakeeney	216.58	0.9477
Wakefield Operator LLC	Wakefield	233.24	1.3220
Good Samaritan Society-Valley Vista	Wamego	194.57	0.9974
The Centennial Homestead, Inc.	Washington	184.13	1.0505
Wathena Healthcare and Rehab Center	Wathena	184.13	1.3659
Coffey County Hospital	Waverly	202.16	0.9359
Wellington Operator LLC	Wellington	190.99	1.2186
Sumner Operator, LLC	Wellington	176.52	1.1887
Wellsville Manor	Wellsville	150.75	1.0683
Westy Community Care Home	Westmoreland	166.87	0.9549
Wheat State Manor	Whitewater	182.16	0.9150
Medicalodges Wichita	Wichita	187.64	0.9565
Meridian Rehab and Health Care Center	Wichita	152.62	1.0003
Kansas Masonic Home	Wichita	203.70	1.0450
Homestead Health Center, Inc.	Wichita	243.91	1.1689
Orchard Gardens LLC	Wichita	176.28	1.0908
Wichita Presbyterian Manor	Wichita	219.27	1.1367
Sandpiper Healthcare and Rehab Center	Wichita	164.21	1.2244
Lakepoint Wichita LLC	Wichita	186.63	1.1538
Wichita Center for Rehab and Healthcare	Wichita	201.24	1.3146
Legacy at College Hill	Wichita	164.20	1.0382
Seville Operator, LLC	Wichita	189.89	1.1938
Wichita Operator LLC	Wichita	219.44	1.3072
The Health Care Center@Larksfield Place	Wichita	221.90	1.1236
Life Care Center of Wichita	Wichita	195.58	1.1987
Family Health & Rehabilitation Center	Wichita	209.46	1.1430
Caritas Center	Wichita	211.39	0.7993
Regent Park Rehab and Healthcare	Wichita	230.82	1.1841
Avita Health & Rehab of Reeds Cove	Wichita	201.10	1.1358
Via Christi Village Ridge	Wichita	221.38	1.1876
Via Christi Village McLean, Inc.	Wichita	217.39	1.2043

Mount St Mary	Wichita	239.30	1.0560
Healthcare Resort of Wichita	Wichita	202.09	1.4178
Wilson Operator LLC	Wilson	217.47	1.3857
F W Huston Medical Center	Winchester	159.20	0.9524
Winfield Senior Living Community	Winfield	203.07	1.0246
Cumbernauld Village, Inc.	Winfield	225.50	0.9198
Winfield Rest Haven II LLC	Winfield	224.51	1.0541
Kansas Veterans' Home	Winfield	219.32	1.0406
Yates Operator, LLC	Yates Center	180.85	1.3818

III. Justifications for the Rates

1. The proposed rates are calculated according to the rate-setting methodology in the Kansas Medicaid State Plan and pending amendments thereto.

2. The proposed rates are calculated according to a methodology which satisfies the requirements of K.S.A. 39-708c(x) and the DHCF regulations in K.A.R. Article 129-10 implementing that statute and applicable federal law.

3. The State's analyses project that the rates:
   a. Would result in payment, in the aggregate of 91.80% of the Medicaid day weighted average inflated allowable nursing facility costs statewide; and
   b. Would result in a maximum allowable rate of $233.54 (for a CMI of 1.0314); with the total average allowable cost being $195.25.

4. Estimated annual aggregate expenditures in the Medicaid nursing facility services payment program will not change substantially as the FY 2021 reimbursement parameters are being continued.

5. The state estimates that the rates will continue to make quality care and services available under the Medicaid State Plan at least to the extent that care and services are available to the general population in the geographic area. The state's analyses indicate:

   a. Service providers operating a total of 318 nursing facilities and hospital-based long-term care units (representing 96.5% of all the licensed nursing facilities and long-term care units in Kansas) participate in the Medicaid program;

   b. There is at least one Medicaid-certified nursing facility and/or nursing facility for mental health, or Medicaid-certified hospital-based long-term care unit in 99 of the 105 counties in Kansas;

   c. The statewide average occupancy rate for nursing facilities participating in Medicaid is 77.74%;

d. The statewide average Medicaid occupancy rate for participating facilities is 60.11%; and

e. The rates would cover 93.11% of the estimated Medicaid direct health care costs incurred by participating nursing facilities statewide.

6. Federal Medicaid regulations at 42 C.F.R. 447.272 impose an aggregate upper payment limit that states may pay for Medicaid nursing facility services. The state's analysis indicates that the methodology will result in compliance with the federal regulation.

IV. Request for Comments; Request for Copies

The state Requests providers, beneficiaries and their representatives, and other concerned Kansas residents to review and comment on the proposed rates, the methodology used to calculate the proposed rates, the justifications for the proposed rates, and the intent to amend the Medicaid State Plan. Persons and organizations wishing to submit comments must mail, deliver, or fax their signed, written comments before the close of business on May 17, 2021 to:

Georgianna Correll
Facility Program and Finance Director
Kansas Department for Aging and Disability Services
New England Building
503 South Kansas Avenue
Topeka, KS 66603-3404 Fax Number: 785-296-0256

V. Notice of Intent to Amend the Medicaid State Plan

The state intends to submit Medicaid State Plan amendments to CMS on or before September 30, 2021.

Laura Howard
Secretary
Kansas Department for Aging and Disability Services

Sarah Fertig
Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance