ADULT CARE HOME PROGRAM 129-10-18. Per diem rates of reimbursement. (a) Per diem rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, using base-year cost information submitted by the provider and retained for cost auditing and analysis.

(A) The base year utilized for cost information shall be reestablished at least once every seven years.

(B) A factor for inflation may be applied to the base-year cost information.

(C) For each provider currently in new enrollment, reenrollment, or change of ownership status, the base year shall be determined in accordance with subsections (c), (d), and (e), respectively.

(2) Per diem rates shall be limited by cost centers, except where there are special level-of-care facilities approved by the United States department of health and human services. The upper payment limits shall be determined by the median in each cost center plus a percentage of the median, using base-year cost information. The percentage factor applied to the median shall be determined by the agency.

(A) The cost centers shall be as follows:

(i) Operating;

(ii) indirect health care; and

(iii) direct health care.

(B) The property component shall consist of the real and personal property fee as specified in K.A.R. 129-10-25.

(C) The upper payment limit for the direct health care cost center shall be a statewide base limit calculated on each facility's base-year costs adjusted for case mix.

(i) A facility-specific, direct health care cost center upper payment limit shall be calculated by adjusting the statewide base limit by that facility's average case mix index.

(ii) Resident assessments used to determine additional reimbursement for ventilator-dependent residents shall be excluded from the calculation of the facility's average case mix index.

(3) Each provider shall receive an annual per diem rate to become effective July 1 and, if there are any changes in the facility's average Medicaid case mix index, an adjusted per diem rate to become effective January 1.

(4) Resident assessments that cannot be classified shall be assigned to the lowest case mix index.

(5) To establish a per diem rate for each provider, a factor for incentive may be added to the allowable per diem cost.

(6)(A) Resident days shall be determined from census information corresponding to the base-year cost information submitted by the provider.

(B) The total number of resident days shall be used to calculate the per diem costs used to determine the upper payment limit and rates in the direct health care cost center. The total number of resident days shall be used to calculate the per diem costs used to determine the upper payment limit and rates for food and utilities in the indirect health care cost center.

(C) For homes with more than 60 beds, the number of resident days used to calculate the upper payment limits and rates in the operating cost center and indirect health care cost center, less food and utilities, shall be subject to an 85 percent minimum occupancy requirement based on the following:

(i) Each provider that has been in operation for 12 months or longer and has an occupancy rate of less than 85 percent for the cost report period, as specified in K.A.R. 129-10-17, shall have the number of resident days calculated at the minimum occupancy of 85 percent.

(ii) The 85 percent minimum occupancy requirement shall be applied to the number of resident days and costs reported for the 13th month of operation and after. The 85 percent minimum occupancy requirement shall be applied to the interim rate of a new provider, unless the provider is allowed to file a projected cost report.

(iii) The minimum occupancy rate shall be determined by multiplying the total number of licensed beds by 85 percent. In order to participate in the Kansas medical assistance program, each nursing facility provider shall obtain proper certification for all licensed beds.

(iv) Each provider with an occupancy rate of 85 percent or greater shall have actual resident days for the cost report period, as specified in K.A.R. 129-10-17, used in the rate computation.

(7) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(8) The effective date of the rate for existing providers shall be in accordance with K.A.R. 129-10-19.

(b) Per diem rate limitations based on comparable service private-pay charges.

(1) Rates of reimbursement shall not be limited by private-pay charges.

(2) The agency shall maintain a registry of private-pay per diem rates submitted by providers.

(A) Each provider shall notify the agency of any change in the private-pay rate and the effective date of that change so that the registry can be updated.

(i) Private-pay rate information submitted with the cost reports shall not constitute notification and shall not be acceptable.

(ii) Providers may send private-pay rate notices by certified mail so that there is documentation of receipt by the agency.

(B) The private-pay rate registry shall be updated based on the notification from the providers.

(C) The effective date of the private-pay rate in the registry shall be the later of the effective date of the private-pay rate or the first day of the following month in which complete documentation of the private-pay rate is received by the agency.

(i) If the effective date of the private-pay rate is other than the first day of the month, the effective date in the registry shall be the first day of the closest month. If the effective date is after the 15th, the effective date in the register shall be the first day of the following month.

(ii) For new facilities or new providers coming into the Medicaid program, the effective date of the private-pay rate shall be the date on which certification is issued.

(3) The average private-pay rate for comparable services shall be included in the registry. The average private-pay rate may consist of the following variables:

(A) Room rate differentials. The weighted average private-pay rate for room differentials shall be determined as follows:

(i) Multiply the number of private-pay residents in private rooms, semiprivate rooms, wards, and all other room types by the rate charged for each type of room. Sum the resulting products of each type of room. Divide the sum of the products by the total number of private-pay residents in all rooms. The result, or quotient, is the weighted average private-pay rate for room differentials.

(ii) Each provider shall submit documentation to show the calculation of the weighted average private-pay rate if there are room rate differentials.

(iii) Failure to submit the documentation shall limit the private-pay rate in the registry to the semiprivate room rate.

(B) Level-of-care rate differentials. The weighted average private-pay rate for level-of-care differentials shall be determined as follows:

(i) Multiply the number of private-pay residents in each level of care by the rate they are charged to determine the product for each level of care. Sum the products for all of the levels of care. Divide the sum of the products by the total number of private-pay residents in all levels of care. The result, or quotient, is the weighted average private pay rate for the level-of-care differentials.

(ii) Each provider shall submit documentation to show the calculation of the weighted average rate when there are level-of-care rate differentials.

(iii) Failure to submit the documentation may delay the effective date of the average private-pay rate in the registry until the complete documentation is received.

(C) Extra charges to private-pay residents for items and services may be included in the weighted average private-pay rate if the same items and services are allowable in the Kansas medical assistance program rate.

(i) Each provider shall submit documentation to show the calculation of the weighted average extra charges.

(ii) Failure to submit the documentation may delay the effective date of the weighted average private-pay rate in the registry until the complete documentation is received.

(4) The weighted average private-pay rate shall be based on what the provider receives from the resident. If the private-pay charges are consistently higher than what the provider receives from the residents for services, then the average private-pay rate for comparable services shall be based on what is actually received from the residents. The weighted average private-pay rate shall be reduced by the amount of any discount received by the residents.

(5) The private-pay rate for Medicare skilled beds shall not be included in the computation of the average private-pay rate for nursing facility services.

(6) When providers are notified of the effective date of the Kansas medical assistance program rate, the following procedures shall be followed:

(A) If the private-pay rate indicated on the agency register is lower, then the Kansas medical assistance program rate, beginning with its effective date, shall be calculated as follows:

(i) If the average Medicaid case mix index is greater than the average private-pay case mix index, the Kansas medical assistance program rate shall be the lower of the private-pay rate adjusted to reflect the Medicaid case mix or the calculated Kansas medical assistance rate.

(ii) If the average Medicaid case mix index is less than or equal to the average private-pay case mix index, the Kansas medical assistance program rate shall be the average private-pay rate.

(B) Providers who are held to a lower private pay rate and subsequently notify the agency in writing of a different private-pay rate shall have the Kansas medical assistance program rate adjusted on the later of the first day of the month following the date upon which complete private-pay rate documentation is received or the effective date of a new private-pay rate.

(c) Per diem rate for new construction or a new facility to the program.

(1) The per diem rate for any newly constructed nursing facility or a new facility to the Kansas medical assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 129-10-17.

(2) The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to the base-year period.

(3) The provider shall remain in new enrollment status until the base year is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider.

(4) Each 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.

(5) No rate shall be paid until a nursing facility financial and statistical report is received and processed to determine a rate.

(d) Change of provider.

(1) The payment rate for the first 24 months of operation shall be based on the base-year historical cost data of the previous owner or provider. If base year data is not available, data for the most recent calendar year available preceding the base-year period shall be adjusted to the base-year period and used to determine the rate. If the 85 percent minimum occupancy requirement was applied to the previous provider's rate, the 85 percent minimum occupancy requirement shall also be applied to the new provider's rate.

(2) 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. The data shall be adjusted to the base-year period.

(3) The provider shall remain in change-of provider status until the base year is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider.

(4) Each 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.

(e) Determination of the per diem rate for nursing facility providers reentering the Medicaid program.

(1) The per diem rate for each provider reentering the Medicaid program shall be determined from either of the following:

(A) 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; or

(B) the base-year cost report filed with the agency or the most recent cost report filed preceding the base year, if the provider has actively participated in the program during the most recent 24 months.

(2) If the per diem rate for a provider reentering the program is determined in accordance with paragraph (e)(1)(A), the cost data shall be adjusted to the base-year period.

(3) The provider shall remain under reenrollment status until the base year is reestablished. During this time, the cost data used to determine the initial rates shall be used to determine all subsequent rates for the provider.

(4) Each factor for inflation that is applied to cost data for established providers shall be applied to the cost data for providers in reenrollment status.

(5) If the per diem rate for a provider reentering the program is determined in accordance with paragraph (e)(1)(A), a settlement shall be made in accordance with subsection (f).

(f) Per diem rate errors.

(1) If the per diem rate, whether based upon projected or historical cost data, is audited by the agency and found to contain an error, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider with an identified overpayment is no longer enrolled in the Medicaid program, the settlement shall be recouped from a facility owned or operated by the same provider or that provider’s corporation, unless other arrangements have been made to reimburse the agency. A net settlement may occur if a provider has more than one facility involved in settlements. In all cases, settlements shall be recouped within 12 months of the implementation of the corrected rates, or interest may be assessed.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit of the provider's cost reports. Written notice of this per diem rate change and of the audit findings shall be sent to the provider. Retroactive adjustment of the rate paid from a projected cost report shall apply to the same period of time covered by the projected rate.

(3) Each provider shall have 30 days from the date of the audit report cover letter to request an administrative review of an audit adjustment that results in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

(4) An interim settlement, based on a desk review of the historical cost report covering the projected cost report period, may be determined after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on the rate after an audit of the historical cost report.

(5) A new provider that is not allowed to submit a projected cost report, as specified in K.A.R. 129- 10-17, for an interim rate shall not be entitled to a retroactive settlement for the first year of operation.

(g) Out-of-state providers.

(1) The per diem rate for out-of-state providers certified to participate in the Kansas medical assistance program shall be the rate approved by the agency.

(2) Each out-of-state provider shall obtain prior authorization by the agency.

(h) Reserve days. Reserve days as specified in K.A.R. 30-10-21 shall be paid at 67 percent of the Kansas medical assistance program per diem rate.

(i) Determination of rate for ventilator-dependent resident.

(1) The request for additional reimbursement for a ventilator-dependent resident shall be submitted to the agency in writing for prior approval. Each request shall include the following:

(A) Sections A, I, and O in the nursing home comprehensive "minimum data set" ("MDS") of the centers for Medicare and Medicaid services (CMS);

(B) a current client assessment, referral, and evaluation (CARE) plan for the resident;

(C) a physician's order for ventilator use, including the frequency of ventilator use and a diagnosis that requires use of a ventilator; and

(D) a treatment administration record or respiratory therapy note showing the number of minutes used for the ventilator per shift.

(2) All of the following conditions shall be met in order for a resident to be considered ventilator dependent:

(A) The resident is not able to breathe without mechanical ventilation.

(B) The resident uses a ventilator for life support 24 hours a day, seven days a week.

(C) The resident has a tracheostomy or endotracheal tube.

(3) The provider shall be reimbursed at the Kansas medical assistance program daily rate determined for the nursing facility plus an additional amount approved by the agency for the ventilator dependent resident.

(4) No additional amount above that figured at the Kansas medical assistance program daily rate shall be allowed until the service has been authorized by the agency.

(5) The criteria shall be reviewed quarterly to determine if the resident is ventilator-dependent. If a resident is no longer ventilator-dependent, the provider shall not receive additional reimbursement beyond the Kansas medical assistance program daily rate determined for the facility.

(6) The additional reimbursement for the ventilator-dependent resident shall be offset to the cost center of benefit on the nursing facility financial and statistical report.

(j) Rate modification; secretary's discretion.

(1) Any of the requirements of this regulation may be waived by the secretary and a nursing facility's or nursing facility for mental health's per diem rate of reimbursement may be modified by the secretary if the secretary determines that both of the following conditions are met:

(A) Exceptional circumstances place residents of nursing facilities and nursing facilities for mental health in jeopardy of losing the availability of, or access to, "routine services and supplies,"

“ancillary services and other medically necessary services,” “specialized mental health rehabilitation services,” or “specialized services,” as defined in K.A.R. 30-10-1a.

(B) The jeopardy can likely be avoided or reduced by modifying the per diem rate of reimbursement for a nursing facility or nursing facility for mental health.

(2) If the secretary exercises discretion pursuant to this subsection, the increase in the per diem rate of reimbursement shall not exceed the state average rate for reimbursement.

(Authorized by K.S.A 2015 Supp. 65-1,254 and 75-7403; implementing K.S.A. 2015 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008; amended Feb. 5, 2016.)