State of Kansas
Kansas Health Policy Authority
Department of Social and Rehabilitation Services
Department on Aging

Notice of Final Nursing Facility Medicaid Rates for State Fiscal Year 2009; Methodology for Calculating Final 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 administers the Medicaid nursing facility services payment program which includes hospital long-term care units and the Secretary of Social and Rehabilitation Services administers the nursing facility for mental health program. Both Secretaries act on behalf of the Kansas Health Policy Authority (KHPA). As required by 42 U.S.C. 1396a(a)(13)(A), the Secretary of the Kansas Department of Social and Rehabilitation Services (SRS) and the Secretary of the Kansas Department on Aging (KDOA) are publishing the final Medicaid per diem rates for Medicaid-certified nursing facilities for State Fiscal Year 2009, the methodology underlying the establishment of the final nursing facility rates, and the justifications for those final rates. SRS, KDOA, and KHPA 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, 2008.

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 are maintained by KHPA:

1. Attachment 4.19D, Part I, Subpart C, Exhibit C-1, inclusive;
2. Attachment 4.19D, Part I, Subpart J; and
3. Attachment 4.19D, Part I, Subpart K.

The text of those portions of the Medicaid State Plan identified above in section I.A.1, but not the documents, authorities and the materials incorporated into them by reference, are reprinted in this notice. Those Medicaid State Plan provisions set out in this notice

appear in the versions which the state currently intends to submit to CMS on or before September 30, 2008. The proposed Medicaid State Plan amendments which the state ultimately submits to CMS may differ from the versions 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 will charge a fee for copies. Written requests for copies should be sent to:

Secretary of Aging
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 twelve 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, Retroactive Rate Adjustments, and Comparable Private Pay Rates.

1) Cost Reports

The Nursing Facility Financial and Statistical Report is the uniform cost report. It is included in Kansas Administrative Regulation 30-10-17. 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. 30-10-17.

When a non-arms length 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 on-going 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. 30-10-17.

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 2005, 2006, and 2007.

If the current provider has not submitted a calendar year report between 2005 and 2007, 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. 30-10-18.

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 the midpoint of the rate payment period. 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 rather than the characteristics of the facility should determine 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 and the real and personal property fee. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. 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. 30-10-17.

The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to the midpoint of the rate payment period. This adjustment will be based on the Data Resources, Inc., National Skilled Nursing Facility Market Basket Without Capital Index (DRI Index). The DRI 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 the midpoint of the rate payment period. The provider shall remain in new enrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

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 2005 to 2007. 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 the midpoint of the rate payment period. This adjustment will be based on the Data Resources, Inc., National Skilled Nursing Facility Market Basket Without Capital Index (DRI Index). The DRI 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 the midpoint of the rate payment period. The provider shall remain in change-of-provider status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change of provider status.

Rates for Facilities Re-entering the Program (Reenrollment Status)

The per diem rate for each provider reentering the Medicaid program shall be determined from a projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more. The per diem rate for all other providers reentering the program shall be determined from the base cost data filed with the agency or the most recent cost report filed preceding calendar year 2005.

All cost data used to set rates for facilities reentering the program shall be adjusted to the midpoint of the rate payment period. This adjustment will be based on the Data Resources, Inc., National Skilled Nursing Facility Market Basket Without Capital Index (DRI Index). The DRI 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 the midpoint of the rate payment period. The provider shall remain in reenrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider 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 5.12b, 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 5.12b case mix indices 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 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 per diem 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.

The resident listing cut-off for calculating the average CMIs will be the first day of the quarter before the rate is effective. The following are the dates for the resident listings and the quarter in which the average Medicaid CMIs will be used in the quarterly rate-setting process.

Rate Effective Date:	Cut-Off Date:
July 1	April 1
October 1	July 1
January 1	October 1
April 1	January 1

The resident listings will be mailed to providers prior to the dates the quarterly 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 the midpoint of the rate payment period. The inflation will be based on the Data Resources, Inc., National Skilled Nursing Facility Market Basket Without Capital Index (DRI Index).

The DRI Indices listed in the latest available quarterly publication will be used to determine the inflation tables for the payment schedules processed during the payment rate period. This may require the use of forecasted factors in the inflation table. The inflation tables will not be revised until the next payment rate period.

The inflation factor will not be applied to the following costs:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

The inflation factor for the real and personal property fees will be based on the Data Resources, Inc., National Skilled Nursing Facility Total Market Basket Index (DRI Index). An additional 12 months of inflation will be applied to the real and personal property fees in effect June 1.

6) Upper Payment Limits

There are three types of upper payment limits that will be described. One is the owner/related party/administrator/co-administrator limit. The second is the real and personal property fee limit. The last type of limit is an upper payment limit for each cost center. The upper payment limits are in effect during the payment rate period unless otherwise specified by a State Plan amendment.

Owner/Related Party/Administrator/Co-Administrator Limits:

Since salaries and other compensation of owners are not subject to the usual market constraints, specific limits are placed on the amounts reported. First, amounts paid to non-working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have their compensation limited by the percent of their total work time to a standard work week. A standard work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled, "Statement of Owners and Related Parties." This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in excess of the Kansas Civil Service based salary chart are transferred to the Operating cost center where the excess is subject to the Owner/Related Party/Administrator/Co-Administrator per diem compensation limit.

The Schedule C is an array of non-owner administrator and co-administrator salaries. The schedule includes the calendar year 2007 historic cost reports in the database from all active nursing facility providers. The salary information in the array is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than 12 months with more than 60 beds. The Schedule C for the owner/related party/administrator/co-administrator per diem compensation limit is the first schedule run during the rate setting.

The Schedule C is used to set the per diem limitation for all non-owner administrator and co-administrator salaries and owner/related party compensation in

excess of the civil service based salary limitation schedule. The per diem limit for a 50-bed or larger home is set at the 90th percentile on all salaries reported for non-owner administrators and co-administrators. A limitation table is then established for facilities with less than 50 beds. This table begins with a reasonable salary per diem for an administrator of a 15-bed or less facility. The per diem limit for a 15-bed or less facility is inflated based on the State of Kansas annual cost of living allowance for classified employees for the rate period. A linear relationship is then established between the compensation of the administrator of the 15-bed facility and the compensation of the administrator of a 50-bed facility. The linear relationship determines the per diem limit for the facilities between 15 and 50 beds.

The per diem limits apply to the non-owner administrators and co-administrators and the compensation paid to owners and related parties who perform an administrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service based salary chart in other cost centers that are transferred to the operating cost center.

Real and Personal Property Fee Limit

The property component of the reimbursement methodology consists of the real and personal property fee that is explained in more detail in a later section. The upper payment limit will be 105% of the median determined from a total resident day-weighted array of the inflated property fees.

Cost Center Upper Payment Limits

The Schedule B computer run is an array of all per diem costs for each of the three cost centers-Operating, Indirect Health Care, and Direct Health Care. The schedule includes a per diem determined from the base cost data from all active nursing facility providers. Projected cost reports are excluded when calculating the limit.

The per diem expenses for the Operating cost center and the Indirect Health Care cost center less food and utilities are subject to the 85% minimum occupancy for facilities over 60 beds. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs are adjusted by the owner/related party/administrator/co-administrator limit.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted from the midpoint of the cost report period to the midpoint of the rate payment period. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based on the DRI 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.

The final results of the Schedule B run are 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	120% 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 facility's cost report period CMI by the statewide average CMI for the cost report year, 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 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 8 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 $60 and the upper payment limit is based on 120% of the median, then the upper payment limit for the statewide average CMI would be $72 (**D**=120% x $60).

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 Medicaid CMI is divided by the statewide average CMI for the cost data period. This answer, 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 quarterly to account for changes in the Medicaid CMI. To illustrate this calculation take the following situation: The Direct Health Care per diem limit is $72.00 with a statewide average CMI of 1.000, and the facility's direct health care per diem costs are $60.00, and its current Medicaid CMI is 0.9000. Since the per diem costs are less than the limit the Allowable Direct Heath Care Cost is $60.00, 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 answer by the Allowable Direct Health Care Cost. In this case that would result in $54.00 (0.9000/1.0000 x $60.00). 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 quarter rose to 1.1000, the Medicaid Acuity Adjustment would be $66.00 (1.1000/1.0000 x $60.00). 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 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 property fees in effect on June 1, were inflated with 12 months of inflation effective July 1. The inflation factor was from the Data Resources, Inc.-WEFA, National Skilled Nursing Facility Total Market Basket Index (DRI Index). The providers received 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 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. 30-10-25.

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. 30-10-25. 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 Quality and Efficiency Incentive Factor is a per diem add-on ranging from zero to three dollars. It is designed to encourage quality care and efficiency. 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. The most recent cost report data for each provider will be used to determine the outcome measures. Each provider is awarded points based on their outcome 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 4.42, which is 120% of the statewide NF median of 3.68. They will receive one point if the ratio is less than 120% of the NF median but greater than or equal to 4.05, which is 110% of the statewide NF median. Providers with staffing ratios below 110% of the NF median will receive no points for this incentive measure.

Providers may earn up to two points for their occupancy outcome measures. If they have total occupancy greater than or equal to 90% they will earn one point. If they have Medicaid occupancy greater than or equal to 60% they will also earn one point. Providers that meet both of these criteria will receive a total of two incentive points for occupancy outcomes and providers that fail to meet either criterion will receive zero points for occupancy.

Providers may earn one point for low operating expenses. Providers with per diem operating expenses below $22.10, 90% of the statewide median per diem operating expense ($24.55), will earn one point.

Providers may earn up to two points for their turnover rate outcome measure. Providers with direct health care staff turnover equal to or below 46%, 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 equal to or below 70%, 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, providers may earn up to two points for their retention rate outcome measure. Providers with staff retention rates at or above 73%, the 75th percentile statewide will earn two points. Providers with staff retention rates at or above 64%, the 50th percentile statewide will earn one point.

The table below summarizes the incentive factor outcomes and points:

Quality/Efficiency Outcome:	Incentive Points:
1) CMI adjusted staffing ratio >= 120% (4.42) of state median (3.68), or CMI adjusted staffing ratio between 110% (4.05) and 120%	2, or 1
2) Total occupancy >= 90% Medicaid occupancy >= 60%	1 1
3) Operating expenses < $22.10, 90% of state median ($24.55)	1
4) Staff turnover rate <= 75th percentile, 46% Staff turnover rate <= 50th percentile, 70% Contracted labor < 10% of total direct health care labor costs	2, or 1
5) Staff retention >= 75th percentile, 73% Staff retention >= 50th percentile, 64%	2, or 1
Total Incentive Points Available	9

The Schedule E is an array containing the incentive points awarded to each 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: 6-9 points	$3.00
Tier 2: 5 points	$2.00
Tier 3: 4 points	$1.00
Tier 4: 0-3 points	$0.00

Nursing Facility for Mental Health Quality and Efficiency Incentive Factor:

The Quality and Efficiency Incentive plan for Nursing Facilities for Mental Health (NFMH) will be established separately from NF. NFMH serve people who often do not need the NF level of care on a long term basis. There is a desire to provide incentive for NFMH to work cooperatively and in coordination with Community Mental Health Centers to facilitate the return of persons to the community.

The Quality and Efficiency Incentive Factor is a per diem add-on ranging from zero to two dollars. 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 outcome 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 3.49, which is 120% of the statewide NFMH median of 2.91. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.20, 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 or equal to 90% they will earn a point.

NFMH providers may earn one point for low operating expense outcomes measures. They will earn a point if their per diem operating expenses are below $19.43, or 90% of the statewide median of $21.59

NFMH providers may earn up to two points for their turnover rate outcome measure. Providers with direct health care staff turnover equal to or below 26%, 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 equal to or below 40%, the 50th percentile statewide, will earn one point as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs.

Finally, NFMH providers may earn up to two points for their retention rate outcome measure. Providers with staff retention rates at or above 82%, the 75th percentile statewide will earn two points. Providers with staff retention rates at or above 72%, the 50th percentile statewide will earn one point.

The table below summarizes the incentive factor outcomes and points:

Quality/Efficiency Outcome:	Incentive Points:
1) CMI adjusted staffing ratio >= 120% (3.49) of state median (2.91), or CMI adjusted staffing ratio between 110% (3.20) and 120%	2, or 1
2) Total occupancy ≤90%	1
3) Operating expenses < $19.43, 90% of NFMH median ($21.59)	1
4) Staff turnover rate <= 75th percentile, 26% Staff turnover rate <= 50th percentile, 40% Contracted labor < 10% of total direct health care labor costs	2, or 1
5) Staff retention >= 75th percentile, 82% Staff retention >= 50th percentile, 72%	2, or 1
Total Incentive Points Available	8

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

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-8 points	$3.00
Tier 2: 5 points	$2.00
Tier 3: 4 points	$1.00
Tier 4: 0-3 points	$0.00

10) Rate Effective Date

Rate effective dates are determined in accordance with K.A.R. 30-10-19. 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.

12) Comparable Private Pay Rates

The last factor considered in determining a provider's Medicaid per diem payment rate is their private pay rate. Providers are reimbursed the lower of the calculated Medicaid rate or their private pay rate. The agency maintains a registry of private pay rates. It is the responsibility of the providers to send in private pay rate updates so that the registry is updated. When new Medicaid rates are determined, if the private pay rate reflected in the registry is lower, then the provider is held to that private pay rate until the provider sends notification that it has a higher private pay rate.

Case Mix Adjustments to Private Pay Rates:

Private pay rates submitted to the agency are adjusted up if a provider's average private pay/other CMI is lower than its Medicaid average CMI. This is accomplished by multiplying the provider's average private pay rate in the private pay registry by the ratio of their Medicaid average CMI to their average private pay/other CMI. This ensures that providers' Medicaid rates are not limited to a lower private pay rate that may be attributed to the lower acuity of the private pay residents. There is no adjustment to private pay rates if the facility's Medicaid average CMI is less than its average private pay/other CMI. There is also no adjustment to private pay rates if the facility's total Medicaid rate is less than its average private pay rate

A.2 Attachment 4.19D, Part I, Subpart J

To compensate providers for increased expenses incurred to raise employees' wages to the new minimum wage effective July 1, 2008 ($6.55), a per diem pass-through will be determined and added on to each qualifying provider's per diem rate. The pass-through per diem will not be subject to cost center limits, and the 85% occupancy rule will not be applied to the calculation of the minimum wage pass-through.

1) Qualifying Providers

In order to qualify for the minimum wage pass-through, a provider must submit a pass-through application on the forms provided by the Kansas Department on Aging. The

application will document the hourly wages of all affected employees prior to the implementation of the new minimum wage. Wage increases made prior to June 1, 2008 will not be eligible for the minimum wage pass-through. Providers will also estimate and report the number of hours each affected employee is expected to work during state fiscal year 2009 (the twelve months beginning July 1, 2008 and ending June 30, 2009). Completed applications must be returned to the Kansas Department prior to September 30, 2008.

2) Per Diem Pass-Through Calculation

The per diem pass-through will be determined by first estimating the total impact of increasing wages to the new minimum wage, and then dividing by resident days to get a per diem add-on. The total impact of increasing wages to the new minimum wage will be determined for each provider through three steps. First the incremental wage increase to the new minimum wage will be calculated for each affected employee. Second the individual impact for each affected employee will be determined by multiplying the incremental wage increase by the estimated hours each affected employee is expected to work during fiscal year 2009. Finally the total impact of the minimum wage increase for each provider will be the sum of the individual impacts determined for each employee. A per diem pass-through add-on will then be calculated by dividing each provider's estimated total impact by the provider's 2007 resident day total.

As an example, consider an employer that has ten employees receiving a wage of $6.05 prior to July 1, 2008. If the employer raises their wages effective July 1, 2008, the incremental wage increase due to the new minimum wage will be $0.50. If each employee is expected to work 2,000 hours during fiscal year 2009, the total impact per employee will be $1,000 ($0.50 x 2,000 hrs). The total estimated impact for the provider will be $10,000 ($1,000 x 10). If the employer provided 10,000 resident days during 2007, the pass-through per diem will be $10,000/10,000 days, or $1.00.

3) Per Diem Limits

No per diem add-on will be implemented that is not equal to or greater than $0.10.

4) Effective Dates

Pass-through applications received prior to June 30, 2008 will be effective July 1, 2008. After that date, each provider's per diem pass-through will be effective on the first day of the month following the receipt of a completed application. No pass-through per diems will be implemented after October 1, 2008.

5) Phasing Out the Pass-Through

The per diem pass-through will be phased out as the effects of the minimum wage increase are reflected in the cost reports. Since it will take several years before all the base cost data reflects the new minimum wage, the pass-through per diems determined

for fiscal year 2009 will be inflated for each subsequent fiscal year. Inflation will be determined using the Data Resources, Inc. National Skilled Nursing Facility Market Basket Without Capital Index.

The pass-through per diems will also be adjusted on a facility-specific basis to reflect the ratio of cost data that includes the new minimum wage costs. For example, a provider that incurs a new expense for raising wages to the minimum wage on July 1, 2008, will have six months of that new cost reflected in their 2008 cost report. When rates are determined for state fiscal year 2010, beginning July 1, 2009, the base cost period will be the 36-month period beginning January 1, 2006 and ending December 31, 2008. Only six months of the 36-month base cost data will reflect the increased cost of raising the minimum wage. Thus 5/6 or 83% of the cost data used to set the fiscal year 2010 rates will not reflect the minimum wage increase. Therefore the inflated minimum wage pass-through from fiscal year 2009 will be paid at 83% for fiscal year 2010.

During the phasing out of the minimum wage pass-through, if the per diem add-on falls below $0.10, it will be removed from the rate calculation.

6) Auditing and Adjustments

Each qualifying providers' application and supporting documentation for the minimum wage pass-through will be subject to desk review and field audit and may by revised based on those findings. Corrections that result in a $0.10 or greater per diem change to the pass-through will be implemented. Retroactive rate adjustments will be made when necessary.

A.3 Attachment 4.19D, Part I, Subpart K

To compensate providers for increased expenses incurred due to the transfer of responsibility for all durable medical equipment to the nursing home program, a per diem pass-through will be determined and added on to each provider's per diem rate. The pass-through per diem will not be subject to cost center limits, and the 85% occupancy rule will not be applied to the calculation of the DME pass-through.

1) Qualifying Providers

All providers with costs reported on line 507 of the Medicaid cost report will be eligible to receive the DME pass-through.

2) Per Diem Pass-Through Calculation

The per diem pass-through will be determined by dividing the inflated unadjusted costs reported on line 507 for the base cost data period effective July 1, 2008, by the non-Medicaid days reported for the same period. Non-Medicaid resident days will be determined by subtracting Medicaid resident days from total resident days.

As an example, consider a provider that reported $1,000 on line 507 for each year in the base cost data period from 2005 through 2007. The cost will first be inflated for each year based on the DRI factors applied to cost data used to determine the base reimbursement rates. For 2005 the inflated cost would be $1,134, for 2006 the inflated costs would be $1,089, and for 2007 the inflated costs would be $1,055. The total inflated costs would be $3,278. If the provider reported 30,000 resident days during the base cost data period and 20,000 Medicaid days, the non-Medicaid resident day total would be 10,000 (30,000 – 20,000). The DME pass-through per diem would then be $0.33 ($3,278 / 10,000 rounded to the nearest hundredth).

3) Per Diem Limits

No per diem add-on will be implemented that is not equal to or greater than $0.10.

4) Effective Dates

The durable medical equipment pass-through will be effective July 1, 2008.

5) Phasing Out the Pass-Through

The per diem pass-through will be phased out as the effects of transferring responsibility for all DME to the nursing home program are reflected in the cost reports. Since it will take several years before all the base cost data reflects the new DME expenses, the pass-through per diems determined for fiscal year 2009 will be inflated for each subsequent fiscal year. Inflation will be determined using the Data Resources, Inc. National Skilled Nursing Facility Market Basket Without Capital Index.

The pass-through per diems will also be adjusted on a facility-specific basis to reflect the ratio of cost data that includes the new DME expenses. For example, most providers will begin incurring the additional DME expenses on July 1, 2008. Their 2008 cost reports will reflect six months of that expense. When rates are determined for state fiscal year 2010, beginning July 1, 2009, the base cost period will be the 36-month period beginning January 1, 2006 and ending December 31, 2008. Only six months of the 36-month base cost data will reflect the increased cost of DME. Thus 5/6 or 83% of the cost data used to set the fiscal year 2010 rates will not reflect the new DME expense. Therefore the inflated DME pass-through from fiscal year 2009 will be paid at 83% for fiscal year 2010.

During the phasing out of the minimum wage pass-through, if the per diem add-on falls below $0.10, it will be removed from the rate calculation.

6) Auditing and Adjustments

Each qualifying providers' cost report and supporting documentation used to determine the DME pass-through will be subject to desk review and field audit and may by revised based on those findings. Corrections that result in a $0.10 or greater per diem change to

the pass-through will be implemented. Retroactive rate adjustments will be made when necessary.

II. Final 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, 2008.

Cost Center	Limit Formula	Per Day Limit
Operating	110% of the Median Cost	$28.82
Indirect Health Care	115% of the Median Cost	$41.64
Direct Health Care	120% of the Median Cost	$82.18
Real and Personal Property Fee	105% of the Median Fee	$8.62

These amounts were determined according to the "Reimbursement Limitations" section. The Direct Healthcare Limit is calculated based on a CMI of 0.9763, which is the statewide average.

B. Case Mix Index. These final rates are based upon each nursing facility's Medicaid average CMI calculated with a cutoff date of April 1, 2008, using the July 1, 2008 Kansas Medicaid/Medikan CMI Table. In Section II.C below, each nursing facility's Medicaid average CMI is listed beside its final per diem rate.

C. Final Nursing Facility Per Diem Rates and CMI. 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	139.68	0.9720
Alma Manor	Alma	143.89	0.9153
Life Care Center of Andover	Andover	145.79	1.1749
Anthony Community Care Center	Anthony	129.62	1.0224
Medicalodges Arkansas City	Arkansas City	155.57	0.9139
Medicalodge North of Arkansas City	Arkansas City	140.80	0.9737
Arkansas City Presbyterian Manor	Arkansas City	151.87	1.0416
Deseret Nursing & Rehab. at Arma, Inc.	Arma	109.73	0.8809
Ashland Health Center - LTCU	Ashland	151.90	0.9425
Medicalodges Atchison	Atchison	147.13	1.0483
Atchison Senior Village	Atchison	144.72	0.9362
Dooley Center	Atchison	138.05	0.6650
Attica Long Term Care	Attica	150.70	0.9990
Good Samaritan Society-Atwood	Atwood	138.67	0.9206
Lake Point Nursing Center	Augusta	115.26	0.9063
Baldwin Care Center	Baldwin City	136.58	1.1541

Quaker Hill Manor	Baxter Springs	124.77	1.1874
Catholic Care Center Inc.	Belaire	156.89	1.0095
Great Plains of Republic County, Inc.	Belleville	155.77	0.9388
Belleville Health Care Center	Belleville	112.22	0.9548
Great Plains of Mitchell County, Inc.	Beloit	158.73	0.9780
Hilltop Lodge Nursing Home	Beloit	138.96	1.0138
Bonner Springs Nurs. and Rehab. Ctr	Bonner Springs	128.19	0.9784
Hill Top House	Bucklin	148.95	1.0500
Buhler Sunshine Home, Inc.	Buhler	155.33	1.0117
Life Care Center of Burlington	Burlington	129.23	1.0429
Caney Nursing Center	Caney	82.99	0.8038
Eastridge Nursing Home	Centralia	142.23	0.9106
Heritage Health Care Center	Chanute	121.87	1.0848
Chanute Health Care Center	Chanute	127.73	0.9438
Applewood Rehabilitation	Chanute	78.08	0.7749
Chapman Valley Manor	Chapman	117.21	0.8775
Cheney Golden Age Home Inc.	Cheney	135.32	0.9684
Cherryvale Care Center	Cherryvale	128.25	1.0396
Chetopa Manor	Chetopa	107.75	1.0059
The Shepherd's Center	Cimarron	123.19	0.8850
Medicalodges Clay Center	Clay Center	156.98	1.0100
Clay Center Presbyterian Manor	Clay Center	167.44	1.0822
Clearwater Ret. Community	Clearwater	123.64	0.9840
Community Care Inc.	Clifton	99.15	0.8733
Park Villa Nursing Home	Clyde	98.75	0.6913
Coffeyville Regional Medical Center	Coffeyville	232.02	1.8342
Windsor Place	Coffeyville	130.18	0.9745
Medicalodges Coffeyville	Coffeyville	132.14	1.0125
Deseret Nursing & Rehab at Colby	Colby	127.15	0.9707
Prairie Senior Living Complex	Colby	146.54	0.8637
Pioneer Lodge	Coldwater	113.35	0.8375
Medicalodges Columbus	Columbus	167.90	1.1378
Mt Joseph Senior Village,LLC	Concordia	119.38	0.9442
Sunset Home, Inc.	Concordia	139.65	0.9554
Spring View Manor	Conway Springs	99.26	0.8425
Golden Living Center-Chase Co	Cottonwood Falls	131.25	1.1633
Council Grove Healthcare Center	Council Grove	122.20	1.0034
Hilltop Manor	Cunningham	103.66	0.8971
Westview of Derby	Derby	121.53	0.9613
Hillside Village	Desoto	138.41	1.0100
Dexter Care Center	Dexter	126.89	0.9953
Lane County Hospital - LTCU	Dighton	145.68	1.0450
Trinity Manor	Dodge City	138.11	1.0031
Good Samaritan Society-Dodge City	Dodge City	126.91	0.9113
Manor of the Plains	Dodge City	156.11	1.0023
Medicalodges Douglass	Douglass	148.50	0.9479
Golden Living Center-Downs	Downs	124.50	1.0071
Country Care Home	Easton	127.71	0.8958

Golden Living Center-Parkway	Edwardsville	127.93	0.9238
Golden Living Center-Kaw River	Edwardsville	138.18	1.0310
Golden Living Center-Edwardsville	Edwardsville	114.57	0.8537
Lakepoint Nursing Center-El Dorado	El Dorado	128.32	1.1298
Golden Living Center-El Dorado	El Dorado	112.98	0.9818
Morton County Hospital	Elkhart	130.20	0.9403
Woodhaven Care Center	Ellinwood	121.77	0.9706
Good Samaritan Society-Ellis	Ellis	145.29	0.9425
Good Sam. Society - Ellsworth Village	Ellsworth	150.61	1.1242
Emporia Presbyterian Manor	Emporia	152.78	0.9773
Holiday Resort	Emporia	128.88	1.0063
Flint Hills Care Center, Inc.	Emporia	105.69	0.9167
Emporia Rehabilitation Center	Emporia	103.99	0.8836
Enterprise Estates Nursing Ctr., Inc.	Enterprise	114.24	1.0370
Golden Living Center-Eskridge	Eskridge	101.18	0.8259
Medicalodges Eudora	Eudora	133.34	0.9909
Medicalodges Eureka	Eureka	149.22	1.0415
Medicalodge of Ft. Scott	Fort Scott	158.92	1.0581
Fort Scott/Marmaton Valley	Fort Scott	125.42	1.0748
Fowler Nursing Home	Fowler	156.25	1.0529
Frankfort Community Care Home, Inc.	Frankfort	130.48	1.0663
Golden Living Center-Fredonia	Fredonia	116.86	1.0278
Sunset Manor, Inc	Frontenac	115.96	1.0005
Emerald Pointe Health & Rehab Ctr	Galena	120.59	0.8700
Galena Nursing & Rehab Center	Galena	137.15	1.1856
Garden Valley Retirement Village	Garden City	132.74	0.9671
Homestead Health and Rehab. Center	Garden City	139.29	0.9038
Meadowbrook Rehab Hosp., LTCU	Gardner	182.81	1.2315
Medicalodges Gardner	Gardner	143.83	0.9315
Anderson County Hospital	Garnett	146.46	0.8272
Golden Heights Living Center	Garnett	138.81	0.9991
The Heritage	Girard	114.00	1.1594
The Nicol Home, Inc.	Glasco	131.32	0.9386
Medicalodges Goddard	Goddard	158.82	0.9752
Bethesda Home	Goessel	158.53	0.9488
Good Sam. Society-Sherman County	Goodland	143.18	1.0065
Cherry Village Benevolence	Great Bend	123.57	1.0789
Great Bend Health & Rehab Center	Great Bend	135.66	1.0002
Halstead Health and Rehab Center	Halstead	130.02	0.9574
Lakewood Rehab Center of Haviland	Haviland	86.77	0.6372
St. John's of Hays	Hays	128.79	1.0041
St. Johns Victoria	Hays	131.16	0.9790
Good Samaritan Society-Hays	Hays	116.60	0.8736
Haysville Healthcare Center	Haysville	135.96	0.9643
Medicalodges Herington	Herington	118.03	0.9141
Schowalter Villa	Hesston	166.45	1.0142
Maple Heights of Hiawatha	Hiawatha	127.47	0.9774
Highland Care Center	Highland	140.49	0.9721

Dawson Place, Inc.	Hill City	118.27	0.8984
Hillsboro Community Medical Center	Hillsboro	140.45	0.9064
Parkside Homes, Inc.	Hillsboro	146.39	1.0604
Medicalodges Jackson County	Holton	142.06	0.9964
Tri County Manor Living Center, Inc.	Horton	139.48	1.0889
Howard Twilight Manor	Howard	132.22	0.9355
Sheridan County Hospital	Hoxie	130.50	0.8120
Stevens County Hospital	Hugoton	169.95	1.0732
Pinecrest Nursing Home	Humboldt	122.80	0.9863
Golden Plains	Hutchinson	134.08	0.9295
Good Sam. Society-Hutchinson Village	Hutchinson	149.60	1.0429
Deseret Nurs. & Rehab at Hutchinson	Hutchinson	118.52	1.0323
Wesley Towers	Hutchinson	169.14	1.0292
Ray E. Dillon Living Center	Hutchinson	142.62	0.8053
The Regal Estate of Glenwood	Independence	121.47	1.0304
Heatherwood Estates	Independence	102.34	1.0088
Pleasant View Home	Inman	153.58	0.9610
Iola Nursing Center	Iola	94.33	0.9763
Windsor Place at Iola, LLC	Iola	130.11	1.0073
Cheyenne Lodge, Inc.	Jamestown	116.05	1.0210
Hodgeman Co Health Center-LTCU	Jetmore	186.57	1.3467
Stanton County Hospital- LTCU	Johnson	152.30	0.9080
Valley View Senior Life	Junction City	116.82	0.8628
Good Samaritan Society-Junction City	Junction City	144.87	0.9737
Medicalodges Post Acute Care Center	Kansas City	150.07	0.9785
Kansas City Presbyterian Manor	Kansas City	161.86	0.9749
Medicalodges Kansas City	Kansas City	152.76	0.9717
Lifecare Center of Kansas City	Kansas City	134.87	0.9456
Deseret Nurs. & Rehab at Kensington	Kensington	115.75	0.9488
The Wheatlands	Kingman	128.78	1.0014
Medicalodges Kinsley	Kinsley	140.13	0.8141
Kiowa Hospital District Manor	Kiowa	137.12	0.9178
Rush Co. Memorial Hospital	La Crosse	124.60	0.8275
Rush County Nursing Home	Lacrosse	131.17	0.9700
High Plains Retirement Village	Lakin	157.71	0.9209
Golden Living Center-Lansing	Lansing	125.86	1.0735
Larned Healthcare Center	Larned	139.27	0.9788
St. Joseph Memorial Hospital	Larned	151.41	0.9643
Lawrence Presbyterian Manor	Lawrence	158.54	0.9670
Brandon Woods Retirement Comm.	Lawrence	152.18	0.9596
Pioneer Ridge Retirement Community	Lawrence	135.14	0.8229
Medicalodges Leavenworth	Leavenworth	157.01	0.9744
Delmar Gardens of Lenexa	Lenexa	140.24	1.0263
Lakeview Village	Lenexa	152.70	0.8746
Leonardville Nursing Home	Leonardville	108.29	0.9757
Wichita County Health Center	Leoti	150.68	0.9133
Good Samaritan Society-Liberal	Liberal	140.33	0.9609
Wheatridge Park Care Center	Liberal	138.93	0.9118

Mid-America Healthcare-Lincoln	Lincoln	129.85	1.0122
Bethany Home Association	Lindsborg	147.79	0.9014
Linn Community Nursing Home	Linn	115.15	0.9121
Sandstone Heights	Little River	142.00	1.0095
Logan Manor Community Health Serv.	LOGAN	146.69	1.0917
Louisburg Care Center	Louisburg	144.95	1.1071
Golden Living Center-Lucas	Lucas	129.06	1.1580
Good Samaritan Society-Lyons	Lyons	143.16	0.9929
Meadowlark Hills Retirement Comm.	Manhattan	163.31	0.9712
Stoneybrook Retirement Community	Manhattan	134.43	0.9894
St. Joseph Village, Inc.	Manhattan	149.41	1.0265
Jewell County Hospital	Mankato	142.66	0.9893
St. Luke Living Center	Marion	135.73	0.9168
Golden Living Center-Marion	Marion	115.05	1.0050
Riverview Estates, Inc.	Marquette	134.41	0.9444
Cambridge Place	Marysville	129.93	1.1056
Deseret Nurs. & Rehab. McPherson	McPherson	149.88	0.9819
The Cedars, Inc.	McPherson	157.65	0.9398
Meade District Hospital, LTCU	Meade	157.62	0.9272
Trinity Nursing & Rehab Ctr.	Merriam	163.60	1.0282
Great Plains of Ottawa County, Inc.	Minneapolis	132.43	1.1140
Good Samaritan Society-Minneapolis	Minneapolis	132.48	0.9628
Minneola District Hospital	Minneola	160.75	0.9719
Bethel Home, Inc.	Montezuma	144.36	0.9206
Moran Manor	Moran	123.40	1.2783
Memorial Home for the Aged	Moundridge	153.36	0.9481
Moundridge Manor, Inc.	Moundridge	139.68	0.9070
Mt. Hope Nursing Center	Mt. Hope	124.84	0.9010
Villa Maria- Mulvane	Mulvane	138.77	1.0523
Golden Keys Nursing Home	Neodesha	103.23	0.8668
Golden Living Center-Neodesha	Neodesha	122.61	1.1310
Ness County Hospital Dist.#2	Ness City	152.08	0.9312
Bethel Care Centre	Newton	149.13	1.0359
Asbury Park	Newton	163.64	0.9979
Kansas Christian Home	Newton	166.39	1.1729
Newton Presbyterian Manor	Newton	167.16	1.0650
Andbe Home, Inc.	Norton	137.43	0.8869
Village Villa	Nortonville	147.97	1.1127
Logan County Manor	Oakley	160.65	0.9710
Decatur County Hospital	Oberlin	138.35	0.9660
Good Sam. Society-Decatur County	Oberlin	132.39	0.9094
Villa St. Francis	Olathe	153.98	1.0305
Pinnacle Ridge Nursing and Rehab	Olathe	126.04	1.0169
Royal Terrace Nrsg. & Rehab. Center	Olathe	145.66	0.9430
Good Samaritan Society-Olathe	Olathe	151.20	0.9859
Johnson County Nursing Center	Olathe	173.71	1.0897
Aberdeen Village, Inc.	Olathe	175.13	1.1000
Deseret Nursing & Rehab at Onaga	Onaga	152.91	1.0953

Peterson Health Care, Inc.	Osage City	112.51	0.9579
Osage Nursing & Rehab Center	Osage City	134.81	1.0788
Life Care Center of Osawatomie	Osawatomie	134.79	1.0313
Parkview Care Center	Osborne	128.71	0.9741
Hickory Pointe Care & Rehab Ctr	Oskaloosa	127.31	0.8877
Deseret Nursing & Rehab at Oswego	Oswego	123.99	1.0585
Ottawa Retirement Village	Ottawa	130.18	1.1269
Brookside Manor	Overbrook	121.77	0.8994
Garden Terrace at Overland Park	Overland Park	144.31	0.9862
Indian Meadows Healthcare Center	Overland Park	203.03	1.3636
Manorcare Hlth Serv. of Overland Park	Overland Park	161.86	1.0820
Villa Saint Joseph	Overland Park	169.89	1.1537
Delmar Gardens of Overland Park	Overland Park	147.26	0.9099
Overland Park Nursing & Rehab	Overland Park	158.36	1.0252
Indian Creek Healthcare Center	Overland Park	159.95	0.9729
Village Shalom, Inc.	Overland Park	163.77	0.9774
Riverview Manor, Inc.	Oxford	116.88	0.9235
Medicalodge of Paola	Paola	110.44	0.6858
North Point Skilled Nursing Center	Paola	139.78	1.0908
Elmhaven East	Parsons	107.04	0.9935
Elmhaven West	Parsons	112.91	1.0183
Parsons Presbyterian Manor	Parsons	151.41	1.0781
Good Samaritan Society-Parsons	Parsons	123.39	0.9034
Legacy Park	Peabody	141.56	1.0033
Westview Manor of Peabody	Peabody	78.01	0.6371
Phillips County Hospital LTCU	Phillipsburg	148.30	0.8881
Phillips County Retirement Center	Phillipsburg	121.02	0.9714
Medicalodges Pittsburg South	Pittsburg	154.05	1.1019
Mt. Carmel Regional Medical Ctr. SNF	Pittsburg	225.78	1.7900
Golden Living Center-Pittsburg	Pittsburg	111.21	0.9622
Cornerstone Village	Pittsburg	137.25	1.0121
Rooks County Senior Services, Inc.	Plainville	144.83	0.9271
Pratt Regional Medical Center	Pratt	134.81	0.9513
Lakewood Senior Living of Pratt, LLC	Pratt	114.84	0.9403
Prescott Country View Nursing Center	Prescott	103.99	0.9082
Prairie Sunset Manor	Pretty Prairie	149.96	0.9331
Protection Valley Manor	Protection	109.01	0.8191
Gove County Medical Center	Quinter	157.28	0.9355
Grisell Memorial Hosp Dist #1-LTCU	Ransom	156.12	0.9621
Richmond Healthcare & Rehab Center	Richmond	143.59	1.1468
Lakepoint Nursing Ctr-Rose Hill	Rose Hill	126.82	0.9686
Rossville Healthcare & Rehab Center	Rossville	134.30	1.0498
Wheatland Nursing & Rehab Center	Russell	120.97	1.0515
Russell Regional Hospital	Russell	173.35	1.1080
Sabetha Nursing Center	Sabetha	135.17	0.9987
Apostolic Christian Home	Sabetha	130.48	1.0241
Smokey Hill Rehabilitation Center	Salina	122.04	0.9693
Kenwood View Nursing Center	Salina	115.28	0.9468

Windsor Estates	Salina	126.47	0.9312
Pinnacle Park Nursing and Rehabilitation	Salina	115.49	0.9659
Salina Presbyterian Manor	Salina	163.09	1.0400
Holiday Resort of Salina	Salina	131.10	0.9300
Satanta Dist. Hosp. LTCU	Satanta	168.34	1.0873
Park Lane Nursing Home	Scott City	142.90	0.9144
Pleasant Valley Manor	Sedan	110.19	1.0465
Sedgwick Healthcare Center	Sedgwick	155.14	0.9933
Crestview Manor	Seneca	108.21	1.0286
Life Care Center of Seneca	Seneca	121.01	0.9540
Good Samaritan Society	Sharon Springs	117.02	0.8950
Shawnee Gardens Nursing Center	Shawnee	148.82	1.1929
Sharonlane Health Services	Shawnee	124.39	0.9345
Smith County Memorial Hospital LTCU	Smith Center	121.41	0.8414
Deseret Nurs. & Rehab at Smith Center	Smith Center	111.46	0.8510
Mennonite Friendship Manor, Inc.	South Hutchinson	156.56	0.9609
Golden Living Center-Spring Hill	Spring Hill	125.15	1.0050
Good Sam. Society-St. Francis Village	St. Francis	142.58	0.9133
Leisure Homestead at St. John	St. John	140.36	0.9773
Community Hospital of Onaga, LTCU	St. Mary's	147.94	0.9074
Prairie Mission Retirement Village	St. Paul	123.11	0.8844
Leisure Homestead at Stafford	Stafford	110.44	0.8744
Sterling Presbyterian Manor	Sterling	149.21	0.9830
Solomon Valley Manor	Stockton	146.39	1.1144
Seasons of Life Living Center	Syracuse	153.00	0.9276
Tonganoxie Care Center	Tonganoxie	128.82	0.9859
Brewster Place	Topeka	162.24	0.9642
Topeka Presbyterian Manor Inc.	Topeka	162.79	0.9986
Eventide Convalescent Center, Inc.	Topeka	108.77	0.8831
Topeka Community Healthcare Center	Topeka	132.60	1.0135
McCrite Plaza Health Center	Topeka	137.51	0.9805
Rolling Hills Health Center	Topeka	149.15	1.0283
Manorcare Health Services of Topeka	Topeka	145.40	0.9957
Westwood Manor	Topeka	124.08	0.9515
IHS of Brighton Place	Topeka	104.59	0.7800
Countryside Health Center	Topeka	107.40	0.7130
Providence Living Center	Topeka	92.40	0.7407
Brighton Place North	Topeka	85.29	0.6910
Aldersgate Village	Topeka	164.65	0.9810
Plaza West Care Center, Inc.	Topeka	157.17	1.0779
Lexington Park Nrsng & Post Acute	Topeka	155.19	0.9528
Greeley County Hospital, LTCU	Tribune	151.64	0.9100
Western Prairie Care Home	Ulysses	152.35	0.9956
Valley Health Care Center	Valley Falls	110.78	0.6267
Trego Co. Lemke Memorial LTCU	Wakeeney	146.09	0.8694
The Lutheran Home - Wakeeney	Wakeeney	114.10	0.8327
Golden Living Center-Wakefield	Wakefield	136.10	1.2274
Good Samaritan Society-Valley Vista	Wamego	149.41	1.0025

The Centennial Homestead, Inc.	Washington	93.12	0.8111
Wathena Healthcare and Rehab Ctr	Wathena	135.66	1.0339
Coffey County Hospital	Waverly	144.19	0.8100
Golden Living Center-Wellington	Wellington	123.31	1.0709
Deseret Nurs. & Rehab at Wellington	Wellington	136.55	0.8697
Wellsville Manor Care Center	Wellsville	131.84	0.9792
Westy Community Care Home	Westmoreland	116.92	0.9190
Wheat State Manor	Whitewater	143.62	0.9492
Medicalodges Wichita	Wichita	153.78	0.9609
Meridian Nursing & Rehab Center	Wichita	122.43	0.9788
Kansas Masonic Home	Wichita	162.59	1.0927
Homestead Health Center, Inc.	Wichita	146.43	1.0152
Deseret Nursing & Rehab at Wichita	Wichita	124.74	0.9977
Wichita Presbyterian Manor	Wichita	172.22	1.0963
Sandpiper Bay Hlth. & Retirement Ctr.	Wichita	128.67	1.0662
Lakepoint Nursing and Rehab-Wichita	Wichita	138.39	0.9515
Manorcare Health Services of Wichita	Wichita	136.14	0.9710
College Hill Nursing and Rehab Center	Wichita	133.78	0.9316
Lakewood Senior Living of Seville	Wichita	119.60	0.9593
Golden Living Center-Wichita	Wichita	125.86	0.9172
Wichita Nursing Center	Wichita	104.85	0.7845
The Health Care Ctr@Larksfield Place	Wichita	158.18	0.9260
Life Care Center of Wichita	Wichita	145.55	1.1694
Via Christi Hope	Wichita	134.58	0.9878
Golden Living Center-Wilson	Wilson	135.30	1.3031
Jefferson Co. Memorial Hospital-LTCU	Winchester	143.82	0.9435
Good Samaritan Society-Winfield	Winfield	144.78	1.0324
Cumbernauld Village, Inc.	Winfield	150.11	0.8694
Winfield Rest Haven, Inc.	Winfield	138.80	0.9353
Deseret Nurs. & Rehab Yates Center	Yates Center	134.39	0.9900

III. Justifications for the Final Rates

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

2. The final rates are calculated according to a methodology which satisfies the requirements of K.S.A 39-708c(x) and K.A.R. Article 30-10 implementing that statute and applicable federal law.

3. The State's analyses project that the final rates:
   a. Would result in payment, in the aggregate of 96.78% of the Medicaid day weighted average inflated allowable nursing facility costs statewide; and
   b. Would result in a maximum allowable rate of $161.26; with the total average allowable cost being $144.26.

c.	Estimated average rate July 1, 2008	$136.26
	Average payment rate July 1, 2007	$129.00
	Amount of change	$7.26
	Percent of change	5.63%

4. Estimated annual aggregate expenditures in the Medicaid nursing facility services payment program will increase by approximately $14 million.

5. The state estimates that the final 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 294 nursing facilities (representing 97% of all the licensed nursing facilities in Kansas) participate in the Medicaid program, while an additional 40 hospital-based long-term care units are also certified to 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 each of the 105 counties in Kansas;

   c. The statewide average occupancy rate for nursing facilities participating in Medicaid is 84.1%;

   d. The statewide average Medicaid occupancy rate for participating facilities is 55.8%; and

   e. The final rates would cover 96.84% of the estimated Medicaid 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 final methodology will result in compliance with the federal regulation.

IV. The State's Response to Written Comments on the Published Proposals

The state received one letter with comments to the Notice of Proposed Nursing Facility Medicaid Rates for State Fiscal Year 2009, Methodology for Calculating Proposed Rates, and Rate Justifications; Notice of Intent to Amend the Medicaid State Plan and Request for Comments published in the April 24, 2008 Kansas Register. The state thanks the commenters for their interest, efforts and suggestions. The state reviewed, discussed, and considered those comments before approving the final rate-setting methodology and the final per diem rates published in this notice.

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, 2008.

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Secretary of Aging
Kansas Department on Aging

Don Jordan
Secretary
Kansas Department of Social and
Rehabilitation Services

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