DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

FEB 10 2015

Mr. Lawrence Kissner
Commissioner
Commonwealth of Kentucky
Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6 W-A
Frankfort, KY 40621

RE: State Plan Amendment (SPA) 14-007

Dear Mr. Kissner:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 14-007. Effective August 1, 2014 this amendment proposes to revise the nursing facility reimbursement methodology for determining payment rates. Specifically, this revision will allow Veteran's Affairs nursing facilities to include the cost of prescription drugs in the annual cost report as an ancillary service cost.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of August 1, 2014. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely,

Timothy Hill
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 14-007

2. STATE: Kentucky

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: August 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 Budget Neutral
b. FFY 2015 Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-D, Page 22-23

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
The purpose of this SPA is allow State operated and controlled Veteran's Affairs (VA) nursing facilities to include prescription drugs cost in their cost report as routine costs.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Lawrence Kissner

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 6/25/14

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: FEB 10 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director FMG

23. REMARKS:

FORM HCFA-179 (07-92)

SECTION 220. INTRODUCTION TO COST-BASED REIMBURSEMENT SYSTEM

A. The Department for Medicaid Services has established a prospective reimbursement system for costs-based facilities. Cost based facilities include the following:
   1. Institutions for Mental Diseases (IMD's);
   2. Pediatric Nursing Facilities; and
   3. Intermediate Care facilities for individuals with an intellectual disability (ICF-IID).
   4. Veteran's Affairs (VA) state operated and controlled nursing facility.

The reimbursement methodology for the facilities listed is outlined here. Also included in this section are the facilities that are reimbursed by all- inclusive rates. The payment method is designed to achieve two major objectives: *I).* To assure that needed facility care is available for all eligible recipients including those with higher care needs and, 2). To assure Department for Medicaid Services control and cost containment consistent with the public interest and the required level of care.

B. 1. This cost-based system is designed to provide a reasonable return in relation to cost but also contains factors to encourage cost containment. Under this system, payment shall be made to state owned or operated, non-state but government owned or operated, and non-governmental ICF-IIDs on a prospectively determined basis for routine cost of care with no year-end adjustment required other than adjustments which result from either desk reviews or field audits.

   2. Effective with the eight month period ending June 30, 2006, and continuing annually thereafter on a state fiscal year basis, a year-end cost settlement will be required for state owned or operated ICF-IID. Total reimbursement to state owned or operated ICF-IID in aggregate shall be limited to the lesser of actual costs or the amount the state reasonably estimates would have been paid under Medicare Payment Principles. The determination will be in conformance with the standards and methods as expressed in 42 CFR 447.257 and 447.272. Cost associated with prescription drugs should be removed from the routine cost. Central Office Overhead costs for facilities that are state owned, but not state operated should be adjusted to remove costs that are determined in accordance with Medicare reimbursement principles to duplicate costs incurred by the operating entity.

   3. Effective with the period ending June 30, 2014, and continuing annually thereafter on a state fiscal year basis, a year-end cost settlement will be required for state owned or operated VA facilities. Total reimbursement to VA's in aggregate shall be limited to the lesser of actual costs or the amount the state reasonably estimates would have been paid under Medicare Payment Principles. The determination will be in conformance with the standards and methods as expressed in 42 CFR 447.257 and 447.272. Effective for dates of service on or after August 1, 2014, cost associated with prescription drugs will be included as an ancillary cost. Both routine and ancillary cost shall be determined in accordance with Medicare reimbursement principles. Central Office Overhead costs for facilities that are state owned, but not state operated should be adjusted to remove costs that are determined in accordance with Medicare reimbursement principles to duplicate costs incurred by the operating entity. An interim per diem inclusive of routine, capital, and ancillary costs will be established based on the most recently submitted Medicare cost report for the July 1 rate-setting period. Costs, excluding capital, will be trended and indexed utilizing Global Insight inflation

factors. A pro-forma cost report will be used for the initial rate-setting period if the Medicare cost report is not available. Once a desk review has been completed to review for allowable costs, and allow for Medicaid claims to process and paid through the MMIS for the period, a final cost settlement will be completed.

C. Ancillary services as defined, shall be reimbursed on a cost basis with a year-end retroactive settlement. As with routine cost, ancillary services are subject to both desk reviews and field audits that may result in retroactive adjustments.

D. The basis of the prospective payment for cost is the most recent annual cost report data (available as of May 16) trended to the beginning of the rate year and indexed to the mid-point of the prospective rate year. The routine cost is divided into two major categories: Nursing Services Cost and All Other Cost.

SECTION 230. PARTICIPATION REQUIREMENTS

PARTICIPATION REQUIREMENTS. Except for ICF-IID's and VA's, cost-based facilities participating in the Department for Medicaid program shall be required to have at least ten (10) of its Medicaid certified beds participating in the Medicare Program or twenty (20) percent of its beds if greater, but not less than ten (10) beds; for a facility with less than ten (10) beds, all beds participate in the Medicare Program.

SECTION 240. REIMBURSEMENT FOR REQUIRED SERVICES UNDER THE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR) FOR VENTILATOR UNITS, BRAIN INJURY UNITS, IMDS, AND PEDIATRIC FACILITIES.

A. Prior to admission of an individual, a nursing facility shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.

B. The department shall reimburse a nursing facility for services delivered to an individual if the facility complies with the requirements of 907 KAR 1:755

C. Failure to comply with 907 KAR 1:755 may be grounds for termination of nursing the facility participation in the Medicaid Program.

SECTION 250. LIMITATION ON CHARGES TO RESIDENTS.

F. Except for applicable deductible and coinsurance amounts, a NF that receives reimbursement for a Medicaid resident shall not charge a resident or his representative for the cost of routine or ancillary services.

G. A NF may charge a resident or his representative for an item if the resident requests the item, the NF informs the resident in writing that there will be a charge. A NF shall not charge a resident for an item or service if Medicare or Medicaid pays for the item pursuant to 42 CFR 483.1 0(c)(8)(ii).

H. A NF shall not require a resident or an interested party to request any item or services as a condition of admission or continued stay. A NF shall inform the resident or an interested party requesting an item or service that a charge will be made in writing that there will be a charge and the amount of the charge.