CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

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Audrey Tayse Haynes
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Lawrence Kissner
Commissioner

November 25, 2013

Jackie Glaze
Associate Regional Director
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

RE: State Plan Amendment 13-025 - State operated and controlled Veteran's Affairs Nursing Facilities

Dear Ms. Glaze:

Enclosed for your review and approval is Kentucky Title XIX State Plan Amendment No. 13-0023. The purpose of this State Plan Amendment is to provide covered for Medicaid recipients in a state operated and controlled Veteran's Affairs Nursing Facilities.

The Public Notice will be submitted at a later date, but prior to the effective date of this SPA and prior to approval of this SPA.

Also, we have included the funding, tribal and maintenance of effort (MOE) questions below:

Funding Questions:

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19- D of your State plan.

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are

required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

DMS Response - the provider retains all funds

1. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

   DMS Response - Not Applicable

2. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

   DMS Response - Not Applicable

3. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

   DMS Response - Not Applicable

4. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

   DMS Response - Not Applicable

<u>Tribal questions:</u>

The following are questions related to Section 5006(e) of the Recovery Act (Public Law (P.L.) 111-5) requirement for Tribal Consultation, please provide responses to these questions.

a. Is the submittal of this State Plan likely to have a direct impact on Indians or Indian health programs (Indian Health Service, Tribal 638 Health Programs, Urban Indian Organizations).

b. If the submittal of this State Plan is not likely to have a direct impact on Indians or Indian health programs, please explain why not.

c. If the submittal of this State Plan is likely to have a direct impact on Indians or Indian health programs please respond to the following questions.
   1. How did the State consult with the Federally-recognized tribes and Indian health programs prior to submission of this SPA?

   2. If the tribes and Indian health programs were notified in writing, please provide a copy of the notification, the date it was sent and a list of the entities notified. In addition, please provide information about any concerns expressed by the tribes and/or Indian health providers and the outcome.
   3. If the consultation with the tribes and Indians health providers occurred in a meeting please provide a list of invitees, a list of attendees, the date the meeting took place and information about any concerns expressed by the tribes and/or Indian health providers and the outcome.

DMS Response - Not Applicable

Maintenance of Effort (MOE)

A. Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.

MOE Period

- Begins on: March 10, 2010, and
- Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.

Is KY in compliance with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

DMS Response - Yes

B. Section 1905(y) and (z) of the Act provides for increased federal medical assistance percentages (FMAP) for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

This SPA would [ ] / would not [X] violate these provisions, if they remained in effect on or after January 1, 2014.

C.Section 1905(aa) of the Act provides for a "disaster-recovery FMAP" increase effective no earlier than January 1, 2011. Under section 1905(cc) of the Act, the increased FMAP under section 1905(aa) of the Act is not available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

This SPA would [ ] / would not [X] qualify for such increased federal financial participation (FFP) and is not in violation of this requirement.

D. Does KY 13-004 comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims?

DMS Response - Yes

Any questions or correspondence relating to this SPA should be sent to Sharley Hughes.

Please let me know if you have any questions relating to this matter.

Sincerely,

Lawrence Kissner
Commissioner

LK/sjh

Enclosure

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: 13-025

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
January 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:
Section 1919 of the Social Security Act
42 CFR 483 subpart B

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $12.2 million increase
b. FFY 2015 $21.7 million increase

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-D, Page 1-6
Att. 4.19.D, Exhibit B, Page 22 and 23

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

10. SUBJECT OF AMENDMENT:
The purpose of this State Plan Amendment is to provide covered for Medicaid recipients in a Veteran's Affairs state operated and controlled nursing home

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: L N Lee for L.K.

13. TYPED NAME: Lawrence Kissner

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 11/25/13

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:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FACILITY REIMBURSEMENT – METHODS AND PROCEDURES
FOR JANUARY 1, 2000 AND THEREAFTER

The following sections summarize the cost-based and price-based reimbursement methodologies for facilities in Kentucky.

Participation Requirements

To participate in the Medicaid Program, the facilities are required to be licensed as nursing facilities or as an intermediate care facility for the mentally retarded and developmentally disabled. Hospitals provide swing-bed hospital nursing facility care shall not be required to have the hospital beds licensed as NF beds. All nursing facilities (NFs) must participate in Medicare in order to participate in Medicaid, except for those NFs with waivers of the nursing requirements (who are prohibited by statute from participation in Medicare).

Audits

The state agency reviews all cost reports for compliance with administrative thresholds. Costs will be limited to those cost found reasonable. Overpayments found in audits under this paragraph will be accounted for in accordance with federal regulations.

Cost-Based Facilities

The following facilities shall ~~remain~~ be included in the cost-based facility methodology:

a. A nursing facility with a certified brain injury unit;

b. A nursing facility with a distinct part ventilator unit;

c. A nursing facility designed as an institution for mental disease;

d. A dually-licensed pediatric nursing facility;

e. An intermediate care facility for the mentally retarded and developmentally disabled; and

f. Veteran's Affairs (VA) state operated and controlled nursing facility.

Cost Reports for Cost-Based Facilities

With the exception of the VA nursing homes, fFacilities shall use a uniform cost reporting form for submission at the facility's fiscal year end. The single state agency shall set a uniform rate year for cost-based NF's and ICF-MRs (July 1-June 30) by taking the latest available cost data which is available as of May 16 of each year and trending the facility costs to July 1 of the rate year. For the VA facilities, the Medicare 2540-10 will be the cost report version used.

1. If the latest available cost report period has not been audited or desk reviewed prior top rate setting, the prospective rates shall be based on cost reports which are not audited or desk reviewed subject to adjustment when the audit or desk review is completed. If desk reviews or audits are completed after May 16, but prior to universal rate setting for the next rate year, the desk review or audited data shall be used.

2. Partial year or budgeted cost data may be used if a full year's data is unavailable. Unaudited reports shall be subject to adjustment to the audited amount.

3. Facilities paid on the basis of partial year or budgeted cost reports shall have their reimbursement settled back to allowable cost.

Allowable Cost

Allowable costs are cost found necessary and reasonable by the single state agency using Medicare Title XVIII-A principles except as otherwise stated. Bad debts, charity and courtesy allowances for non-Title XIX patients are not included in allowable costs. A return on equity is not allowed.

Methods and standards for Determining Reasonable Cost-Related Payments

The methods and standards for the determination of reimbursement rates to non-Veteran's Affairs nursing facilities and intermediate care facilities for the mentally retarded and developmentally disabled is as described in the Nursing Facility Reimbursement manual which is Attachment 4.19-D, Exhibit B. For VA facilities, the interim rates will be based on the per diem cost substantiated by the most recently settled cost report.

Payments Rates resulting from Methods and Standards

1. Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.

2. The rates take into account economic trends and conditions since costs are trended to the beginning of the rate year (July 1) and then indexed for inflation for the rate year using Global Insight inflation index.

3. Interim rates are established on July 1 of each year. Interim rates will be adjusted to include the cost of staffing ratio increases, level of service increases, to accommodate changes of circumstances affecting resident patient care, to correct errors in the rates (whether due to action or inaction of the state or the facilities), or to address displacement of residents. Rates shall be adjusted to an audited cost base if an unaudited cost report has been used due to new construction or other specified reasons which requires using an unaudited cost report.

4. The Medicare Upper Payment Limit (UPL) described in Exhibit B, Section 705 of this attachment is subject to increase to take into account any costs incurred to comply with Federal requirements or a combination of Federal and State requirements that were not in effect during the Medicare UPL base year. These requirements are actions that increase costs as a result of staffing ratio increases, level of service increases, to accommodate changes of circumstances affecting patient care, or to address displacement of residents. The increase will be equal to the average per diem cost of complying with such requirements times the total number of Medicaid patient days in the Medicare UPL current year as defined in Exhibit B, Section 705.

5. The following special classes of nursing facilities are addressed in the Medicaid cost-based methodology regulation:

6. The following special classes of nursing facilities are addressed in the Medicaid cost-based methodology regulation and are reimbursed at full reasonable and allowable cost in accordance with methodology determined by the state regulations:

   a. NF/Institutions for Mental Diseases (IMO) means facilities identified by the Medicaid agency as providing nursing facility care primarily to the mentally ill.

   b. NF/Dually licensed pediatric nursing facilities means facilities identified by the Medicaid agency as providing nursing facility care to residents under the age of twenty-one (21).

   c. ICF/MRIDD-Intermediate Care Facilities for Mentally Retarded and Developmentally Disabled means facilities identified by the Medicaid agency as providing care primarily to the mentally retarded and developmentally disabled.

   d. Veteran's Affairs nursing facilities.

7. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment.

8. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program. A sufficient number of providers assures eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

9. Participation in the program is limited to providers of service who accept, as payments in full, the amounts paid in accordance with the State Plan.

10. Payments will be made by Medicaid for Medicare Part A and Part B coinsurance in accordance with Attachment 4.19 B, Supplement 1.

Price-Based Nursing Facilities

The following facilities are reimbursed by the price-based nursing facility methodology:

a. A non-governmental free-standing nursing facility;

b. A hospital-based nursing facility;

c. A nursing facility with waiver;

d. A nursing facility with mental retardation specialty; and

e. A hospital providing swing bed nursing facility care.

Costs Reports for Price-Based Nursing Facilities

Price-based nursing facilities must submit the latest Medicare cost report and the Medicaid supplement schedules attached to Attachment 4.19-0 Exhibit-B. The Medicaid Supplement Schedules are utilized for statistical data. The Medicare Supplemental Cost Schedules are utilized for historical data.

The Medicare cost report and Medicaid supplement schedules shall be submitted to the Department pursuant to time frames established in HCFA Provider Reimbursement Manual-Part 2 (PUB. 15-11) Section 102, 102.1, 102.3 and 104.

FACILITY REIMBURSEMENT – METHODS AND PROCEDURES
FOR JANUARY 1, 2000 AND THEREAFTER

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Payments Rates resulting from Methods and Standards

1. Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.

2. The rates take into account economic trends and conditions since costs are trended to the beginning of the rate year (July 1) and then indexed for inflation for the rate year using Global Insight inflation index.

3. Interim rates are established on July 1 of each year. Interim rates will be adjusted to include the cost of staffing ratio increases, level of service increases, to accommodate changes of circumstances affecting resident patient care, to correct errors in the rates (whether due to action or inaction of the state or the facilities), or to address displacement of residents. Rates shall be adjusted to an audited cost base if an unaudited cost report has been used due to new construction or other specified reasons which requires using an unaudited cost report.

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   a. NF/Institutions for Mental Diseases (IMO) means facilities identified by the Medicaid agency as providing nursing facility care primarily to the mentally ill.

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   d. Veteran's Affairs nursing facilities.

7. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment.

8. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program. A sufficient number of providers assures eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

9. Participation in the program is limited to providers of service who accept, as payments in full, the amounts paid in accordance with the State Plan.

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The Medicare cost report and Medicaid supplement schedules shall be submitted to the Department pursuant to time frames established in HCFA Provider Reimbursement Manual-Part 2 (PUB. 15-11) Section 102, 102.1, 102.3 and 104.

SECTION 220. INTRODUCTION TO COST-BASED REIMBURSEMENT SYSTEM

A. The Department for Medicaid Services has established a prospective reimbursement system for non-governmental 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 the Mentally Retarded and Developmentally Disabled (ICF/MRIDD).

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: *1).* 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/MR/DDs 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/MR/DDs. Total reimbursement to state owned or operated ICF/MR/DDs 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, 447.272, and 447.304. 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 duplicate costs incurred by the operating entity.

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

E. The payment system also contains various restrictions on allowable costs that are designed to assure that Medicaid payment is limited to the cost of providing adequate resident care.

SECTION 230. PARTICIPATION REQUIREMENTS

PARTICIPATION REQUIREMENTS. Cost-based non-governmental nursing facilities participating in the Department for Medicaid program shall be required to have at least twenty (20) percent of its beds 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.