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State/Territory Name: Kentucky

State Plan Amendment (SPA) #: KY 25-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

August 21, 2025

Lisa Lee
275 E. Main St.
Frankfort, KY 40601

RE: TN 25-0004

Dear Commissioner Lee:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Kentucky state plan amendment (SPA) to Attachment 4.19-D KY-25-0004, which was submitted to CMS on March 12, 2025. This plan amendment is amending its State Plan to implement a quality program funded by the provider assessment and clarifying how payment for ancillary services is part of the per diem rate.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Tom Caughey at 517-487-8598 or via email at tom.caughey@cms.hhs.gov.

Sincerely,

Rory Howe

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0004

2. STATE: KY

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 413

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att. 4.19-D Ex. A Pg. 1-3(a) - Pg 2(a) NEW
Att. 4.19-D Ex B Pg. 7, 10,14

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att. 4.19-D Ex. A Pg. 1-3(a)
Att. 4.19-D Ex. B Pg. 7,10,14

9. SUBJECT OF AMENDMENT
The Department is amending its State Plan to implement a quality program funded by the provider assessment. Additionally, the Department is clarifying how payment for ancillary services is part of the per diem rate, using the Kentucky Medicaid Nursing Facility Ancillary Supplemental Schedules

10. 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
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
Lisa D. Lee

12. TYPED NAME
Lisa Lee

13. TITLE
Commissioner

14. DATE SUBMITTED
3/12/2025

15. RETURN TO

FOR CMS USE ONLY

16. DATE RECEIVED
March 12, 2025

17. DATE APPROVED
August 21, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Instructions on Back

KENTUCKY CASE MIX ASSESSMENT AND REIMBURSEMENT SYSTEM

RESIDENT ASSESSMENT

INTRODUCTION

The Kentucky Department for Medicaid Services is implementing a new reimbursement system for price-based nursing facilities participating in the Medicaid program. These facilities include:

1. A free-standing nursing facility;
2. A hospital-based nursing facility;
3. A nursing facility with waiver;
4. A nursing facility with an intellectual disability specialty; and
5. A hospital providing swing bed nursing facility care.

The new price-based reimbursement methodology will consist of a reasonable standard price set for a day of service for rural and urban facilities. This should provide an incentive to providers to manage costs efficiently and economically.

The standard price includes:

1. Standardized wage rates;
2. Staffing *ratios;*
3. Benefits and absenteeism factors; and
4. "Other cost" percentages.

The new price-based reimbursement methodology is dependent on the specific care needs of each Medicaid and dually eligible Medicare resident in a nursing facility. The new methodology will base the resident acuity using the Minimum Data Set (MDS) 3.0 as the assessment tool. The Resource Utilization Group (RUGs) will continue to be used in the phase in schedule listed below. Starting with rates effective July 1, 2024, the Patient Driven Payment Model (PDPM) is the classification tool to place residents into different case-mix groups necessary to calculate the "casemix score". MDS assessments will be classified using the Patient Driven Payment Model nursing group. A time-weighted methodology is used in calculating case mix by determining the number of days that a MD record is active over a calendar quarter rather than captured from a single day during the calendar quarter. The PDPM methodology will be phased in. Beginning April 1, 2025, the case-mix index shall be comprised 100% of the PDPM CMI at full phase in.

This methodology entails a re-determination of a facility's mix of residents each quarter in order to establish a new facility specific nursing rate on a quarterly basis.

b. Non case-mix adjustable portion of the standard price includes an allowance to offset provider assessment, food, non-capital facility related cost, professional supports and consultation, and administration. These costs are reflected on a per diem basis and will be based on Core Based Statistical Area definitions, evaluated every year, using the most recent Federal Office of Management and Budget's Core Based Statistical Area definitions.

For dates of service on or after July 1, 2024, all providers will receive a $41.43 per day add-on rate.

Beginning July 1, 2025, the $41.43 add on rate will be reduced by the following amount:

- For rates effective July 1, 2025, through December 31, 2025, the add-on rate is reduced to $39.84.
- For rates effective January 1, 2026, through June 30, 2026, the add-on rate is reduced to $38.25.
- For rates effective July 1, 2026, through December 31, 2026, the add-on rate is reduced to $36.66
- For rates effective January 1, 2027, the increase to the add on rate is reduced to $35.07

2. Each July 1 the standard price rate will be
   a. Adjusted by an inflation increase using the appropriate CMS Nursing Home without Capital Market Basket. The inflation increase will not be applied to the capital cost component.
   b. Rebased at least once every four (4) years beginning July 1, 2024

3. Capital Cost Add-on:

Each nursing facility will be appraised by November 30, 1999 and the department shall appraise a price- based NF to determine the facility specific capital component again in 2009, thereafter every five (5) years. The appraisal contractor will use the CoreLogic Commercial Express valuation system or its successor for facility depreciated replacement cost. The capital cost component add-on will consist of the following limits:

a. Forty thousand dollars per licensed bed, adjusted every July 1 thereafter by the same value as the NF's depreciated replacement cost;
b. Two thousand dollars per bed for equipment;
c. Ten percent of depreciated replacement cost for land value;
d. A rate of return will be applied, equal to the 20 year Treasury bond plus a 2% risk factor, subject to a 9% floor and 12% ceiling; and
e. In order to determine the facility-specific per diem capital reimbursement, the department shall use the greater of actual bed days or bed days at 90%.

4. Renovations to nursing facilities in non-appraisal years:

    a. For facilities that have 60 or fewer beds, re-appraisals shall be conducted if the total renovation cost is $75,000 or more.
    b. For facilities that have more than 60 beds, re-appraisal shall be conducted if the total renovation cost is $150,000.

5. Facilities Protection Period:

4. Renovations to nursing facilities in non-appraisal years:

    a. For facilities that have 60 or fewer beds, re-appraisals shall be conducted if the total renovation cost is $75,000 or more.
    b. For facilities that have more than 60 beds, re-appraisal shall be conducted if the total renovation cost is $150,000.

5. Facilities Protection Period:

    a. Rate Protection - Until July 1, 2002, no NF shall receive a rate under the new methodology that is less than their rate that was set in July 1, 1999 unless a facility's resident acuity changes. However, NFs may receive increases in rates as a result of the new methodology as the Medicaid budget allows.
    b. Case Mix - Until July 1, 2000, no facility will receive an average case-mix weight lower than the casemix weight used for the January I, 1999 rate setting. After July I, 2000, the facility shall receive the casemix weight as calculated by RUGs III or PDPM from data extracted from MDS 3.0 information.
    c. Effective January 1, 2003, county owned hospital-based nursing facilities shall not receive a rate that is less than the rate that was in effect on June 30, 2002.

6. Case-mix Rate Adjustments. Rates will be recomputed quarterly based on revisions in the case mix assessment classification that affects the Nursing Services components.

    Beginning July 1, 2024, PDPM CMIs will have a phase in period as the methodology transitions from RUG to PDPM.. Beginning April 1, 2025, the case-mix index shall be comprised of 100 percent of the PDPM CMI at full phase in

7. Case-mix rate adjustment will be recomputed should a provider or the department find an error.

8. Ancillary Add On. Effective July 1, 2024, ancillary services will be included in the per diem rate calculations and will not be paid outside the per diem rate. Ancillary services include the following:
    a. Speech Therapy
    b. Occupational Therapy
    c. Physical Therapy
    d. Oxygen Services
    e. Laboratory; and
    f. X-ray

    The ancillary add on will be calculated every July 1. Effective July 1, 2024, the ancillary add on will be calculated as the Medicaid ancillary payments from the prior year divided by Medicaid days. Effective July 1, 2025 and after, the ancillary add on component of the rate will be calculated as the lesser of the prior year Medicaid ancillary charges or the posted ancillary fee schedule amounts per unit, divided by the total Medicaid days,

10. Quality Program. Beginning with rates effective July 1, 2025, there shall be a quality add on component in the prospective rate per diem rate, distributed from a pool of funding according to the schedule below:

a. For rates effective July 1, 2025, through December 31, 2025, the quality pool shall be $1.59 multiplied by Medicaid days during the rate period.
b. For rates effective January 1, 2026, through June 30, 2026, the quality pool shall be $3.18 multiplied by Medicaid days during the rate period.
c. For rates effective July 1, 2026, through December 31, 2026, the quality pool shall be $4.77 multiplied by Medicaid days during the rate period.
d. For rates effective January 1, 2027, the quality pool shall be $6.36 multiplied by the Medicaid days during the rate period.

Points will be determined on a tiered scoring allocation system, , based on the following metrics from CMS Care Compare, the Supplemental Medicaid Schedules, and the Kentucky Medicaid Nursing Facility Quality Program Behavioral Health Metric Attestation Statement:

Metric Number	Source Data	Metric Description
1	CMS Care Compare	Percentage of long-stay residents with a urinary tract infection (QM #407)
2	CMS Care Compare	Percentage of long-stay residents experiencing one or more falls with major injury (QM #410)
3	CMS Care Compare	Percentage of long-stay residents with pressure ulcers (QM #479)
4	CMS Care Compare	Percentage of long-stay residents who received an antipsychotic medication (QM #419)
5	Supplemental Medicaid Schedule NF-7	Occupancy Percentage
6	Supplemental Medicaid Schedule NF-7	Medicaid Utilization
7	Behavioral Health Metric Attestation Statement	Center of Excellence-NF Participation

Each metric will be weighted equally in the collection of total points and distributed by the facility's percentage of weighted Medicaid days. The quality add on will be updated on a quarterly basis based on most recent information as of the day preceding the rate effective date.

Each metric has 100 possible points, for a total possible points of 700. The points assigned to each metric are determined based on the provider's score and tiering, as described in the table below:

Metric Number	Metric Description	Number of Tiers	Source of Tiering Benchmarks and Cut Points
1	Percentage of long-stay residents with a urinary tract infection (QM #407)	5	CMS Nursing Home Five-Star Quality Rating System: Technical Users' Guide
2	Percentage of long-stay residents experiencing one or more falls with major injury (QM #410)	5	CMS Nursing Home Five-Star Quality Rating System: Technical Users' Guide
3	Percentage of long-stay residents with pressure ulcers (QM #479)	5	CMS Nursing Home Five-Star Quality Rating System: Technical Users' Guide
4	Percentage of long-stay residents who received an antipsychotic medication (QM #419)	5	CMS Nursing Home Five-Star Quality Rating System: Technical Users' Guide
5	Occupancy Percentage	5	Tier 1 = 25%, Tier 2 = 60%, Tier 3 = 80%, Tier 4 = 90%, Tier 5 = 95%
6	Medicaid Utilization	5	Tier 1 = 25%, Tier 2 = 60%, Tier 3 = 80%, Tier 4 = 90%, Tier 5 = 95%
7	Center of Excellence-NF Participation	4	Kentucky Medicaid Nursing Facility Quality Program Behavioral Health Metric Attestation Statement

The provider's total points are divided by 700 (the total point possible) and then divided by the number of the provider's Medicaid days. This value is the Quality Adjusted Medicaid Days.

The provider's Quality Adjusted Medicaid Days is divided by the statewide total Quality Adjusted Medicaid Days, which is the Percent of Statewide Medicaid Days.

The annualized quality pool amount is multiplied by the Percent of Statewide Medicaid Days and then divided by the number of annualized Medicaid days to arrive at the quality add on amount. The quality add on amount is then added to the standard price and the ancillary add on component to arrive at the per diem rate.

11.Medicare Upper Payment Limit. Upper payment limit demonstrations will be completed in accordance with guidance issued from CMS, specifically State Medicaid Director Letter #13- 003 and 22-005. Only services covered by the Medicaid program will be included within the UPL test to ensure comparable services are included for both Medicaid and Medicare calculations for the demonstration. This includes the PDPM components of Physical Therapy, Occupational Therapy, Speech Therapy, Nursing Component, Non-Therapy Ancillary, and non- case mix adjusted. Adjustments to specific Medicare components will be made if necessary to account for differences within the reimbursement programs. The UPL demonstration will use day one-hundred as a starting point for the Medicare rate component, for providers included within a PDPM UPL methodology. Providers receiving cost-based reimbursement may utilize a cost based UPL reimbursement methodology

F. The price-based model reimbursement methodology provides for a facility specific capital cost add-on calculated using the CoreLogic Commercial Express Valuation System, a commercial valuation system that estimates the depreciated and non-depreciated replacement cost of a facility.

G. The Office of Inspector General has required the sub- mission of the Minimum Data Set (MDS) since 1992 and DMS sought to use a tool familiar to the nursing facility industry in order to calculate case-mix. The case-mix portion of the rate will utilize the MDS 3.0 and the Resource Utilization Group (RUG) III to calculate the individual facility's average case-mix. Effective with July 1, 2024 rates, CMIs will be calculated using the Patient Driven Payment Model PDPM nursing component based on a phase in schedule. Beginning April 1, 2025, the CMI will be comprised 100% of the PDPM CMI at full phase in.

H. The case-mix portion of the rate will be adjusted quarterly to reflect the facility's case-mix assessments from a previous quarter and to adjust the direct care and non-personnel operation costs (supplies, etc.) portion of the standard price for the current quarter. For example, the rate effective 7/1/2008 - 9/30/2008 will be based on assessments from l/1 /2008 - 3/31/2008 as of 6/30/2008.

SECTION 110. PARTICIPATION REQUIREMENTS

A. The facilities referenced in Section one hundred (100) shall be reimbursed using the methodology described in Section 130. These facilities shall be licensed by the state survey agency (Office of Inspector General) for the Commonwealth of Kentucky and certified for Medicaid participation by the Department for Medicaid Services.

B. A nursing facility, except a nursing facility with waiver, choosing to participate in the Medicaid Program will be required to have twenty (20) percent of its Medicaid certified beds participate in the Medicare program or ten (10) of its Medicaid beds participating in the Medicare program whichever is greater. If the NF has less than ten (10) beds all of its beds shall participate in the Medicare Program.

C. The Medicaid Program shall reimburse all Medicaid beds in a nursing facility at the same rate. The Medicaid rate established for a facility is the average rate for all Medicaid participating beds in that individual facility.

H. The capital cost component shall be an “add-on” to the “non case-mix” adjusted portion of the rate.

I. Ancillaries are services for which a separate charge is submitted and include:

1. Speech Therapy;
2. Occupational Therapy;
3. Physical Therapy;
4. Oxygen Services;
5. Laboratory; and
6. X-ray.

J. Ancillary therapy services are reimbursed as part of the per diem rate, updated every July 1. Effective July 1, 2024, the ancillary add on will be calculated as the Medicaid ancillary payments from the prior year divided by Medicaid days. Effective July 1, 2025 and after, the ancillary add on will be calculated as the prior year Medicaid ancillary charges divided by the total Medicaid days, limited to the posted ancillary fee schedule amounts per unit

K. Beginning July 1, 2025, a quality “add on” will be included in the NF per diem rate, distributed from a pool of combined funding (state and federal share) from the provider assessment.

1. The schedule below will be used to determine the quality pool:
   - For rates effective July 1, 2025, through December 31, 2025, the quality pool shall be $1.59 multiplied by Medicaid days during the rate period.
   - For rates effective January 1, 2026, through June 30, 2026, the quality pool shall be $3.18 multiplied by Medicaid days during the rate period.
   - For rates effective July 1, 2026, through December 31, 2026, the quality pool shall be $4.77 multiplied by Medicaid days during the rate period.
   - For rates effective January 1, 2027, the quality pool shall be $6.36 multiplied by the Medicaid days during the rate period.
2. The provider assessment allowance per diem payment - will be reduced in order to fund the quality pool. Any quality pool funds not expended will be transferred into the pool for the next state fiscal year.
3. Points will be determined on a tiered scoring allocation system, as set by the Department, based on metrics from CMS Care Compare, the Supplemental Medicaid Schedules, and the Kentucky Medicaid Nursing Facility Quality Program Behavioral Health Metric Attestation Statement and may be adjusted periodically. Each metric will be weighted equally in the collection of total points and distributed by the facility’s percentage of weighted Medicaid days. The quality add on will be updated on a quarterly basis based on most recent information as of the day preceding the rate effective date.

L. Oxygen concentrator limitations. Effective October 1, 1991, the allowable cost of oxygen concentrator rentals shall be limited as follows:

1. A facility may assign a separate concentrator to any resident who has needed oxygen during the prior or current month and for whom there is a doctor’s standing order for oxygen. For the charge by an outside supplier to be considered as an allowable cost, the charge shall be based upon actual usage. A minimum charge by an outside supplier is allowable if this charge does not exceed twenty-five (25) percent of the Medicare Part B maximum. The minimum charge is allowable if the concentrator is used less than an average of two (2) hours per day during the entire month (for example, less than 60 hours during a thirty (30) day month). The maximum allowable charge by the outside supplier shall not exceed one hundred (100) percent of the Medicare Part B maximum. For the maximum charge to a facility to be considered as the allowable cost, the concentrator shall have been used on average for a period of at least eight (8) hours per day for the entire month (for example, 240 hours during a thirty (30) day month). In those cases where the usage exceeds that necessary for the minimum charge and is less than the usage required for the maximum charge, the reimbursement shall be computed by dividing the hours of usage by

cost rate of the previous owner unless the NF is eligible for re-appraisal pursuant to section IV B of this manual.

SECTION 150. ON-SITE REVIEWS AND VALIDATION

A. On a quarterly basis, beginning April 1, 2024, the department shall perform a review of the NFs. The review will consist of a minimum of 30 percent of the Medicaid residents, reviewing one MDS assessment completed by the NF from each resident.. The department shall validate the MDS assessments by using the Long Term Care Facility Resident Assessment Instrument User's Manual.

B. Should the department invalidate a NF's MDS, resulting in the NF not meeting the minimum accuracy threshold, the NF may request a reconsideration of findings from the department within ten (10) business days. The department shall receive a written request by the NF that the department reconsider the invalidation. The department shall conduct the second validation with ten (10) business days of receipt of the request and notify the provider in writing of the decision. A provider may appeal the second validation per 907 KAR 1:671, Sections 8 and 9.

SECTION 160. LIMITATION ON CHARGES TO RESIDENTS.

A. 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.

B. A NF may charge a resident or his representative for an item if the resident requests the item and 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).

C. 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.

D. A NF may charge a resident for the cost of reserving a bed if requested by resident or interested party after the fourteenth (1 4th1) day of a temporary absence from the facility pursuant to 907 KAR 1:022.