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REGULATIONS COMPILER

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Health Care Policy

(Amendment)

907 KAR 1:065. Payments for price-based nursing facility services.

RELATES TO: KRS 142.361, 142.363, 216.380, 42 C.F.R. Parts 430, 431, 432, 433, 435, 440, 441, 442, 447, 455, 456, 482.58, 483.10, 483.20, 42 U.S.C. 1395tt, 1396, 1396a, 1396b, 1396c, 1396d, 1396g, 1396l, 1396n, 1396o, 1396p, 1396r, 1396r-2, 1396r-5

STATUTORY AUTHORITY: KRS 142.361(5), 142.363(3), 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the method for determining amounts payable by the Medicaid program for services provided by a price-based nursing facility.

Section 1. Definitions.

(1) "Ancillary service" means a direct service including:

(a) Ancillary services pursuant to 907 KAR 1:023; or

(b) If ordered by a physician:

1. Clinical laboratory procedures; or

2. X-rays or imaging services.

(2) "Appraisal" means an evaluation of a price-based nursing facility building, excluding equipment and land, conducted by the department in accordance with Section 4 of this administrative regulation for the purpose of calculating the depreciated replacement cost of a price-based nursing facility.

(3) "Appraisal base year" means a year in which the department conducts an appraisal of each price-based NF.

(4) "Auxiliary building" means a roofed and walled structure:

(a) Serviced by electricity, heating, and cooling;

(b) Independent of an NF;

(c) Used for administrative or business purposes related to an NF; and

(d) Constructed on the same tract of ground as an NF.

(5) "Capital rate component" means a calculated per diem amount for an NF based on:

(a) The NF's appraised depreciated replacement cost;

(b) A value for land;

(c) A value for equipment;

(d) A rate of return;

(e) A risk factor;

(f) The number of calendar days in the NF's cost report year;

(g) The number of licensed NF beds in the NF; and

(h) The NF's bed occupancy percentage.

(6) "Case-mix" means the time-weighted average price-based NF acuity for Medicaid-eligible and dual-eligible Medicare and Medicaid residents under a Medicare Part A reimbursed stay in a price-based nursing facility, and is based on Minimum Data Set (MDS) 3.0 data classified through the Patient Driven Payment Model (PDPM) resident classification system or equivalent.

(7) "Core based statistical area" or "CBSA" means the designation of metropolitan and micropolitan population centers based on the national census, as published by the Federal Office of Management and Budget.

(8) "Department" means the Department for Medicaid Services or its designee.

(9) "Equipment" means a depreciable tangible asset, other than land or a building, which is used in the provision of care for a resident by an NF staff person.

(10) "Governmental entity" means a unit of government for the purposes of 42 U.S.C. 1396b(w)(6)(A).

(11) "Hospital-based NF" means an NF that:

(a) Is separately identifiable as a distinct part of the hospital; and

(b) If separated into multiple but distinct parts of a single hospital, is combined under one (1) provider number.

(12) "Land" means a surveyed tract or tracts of ground that share a common boundary:

(a) As recorded in a county government office;

(b) Upon which a building licensed as an NF is constructed; and

(c) Including site preparation and improvements.

(13) "Local unit of government" means a city, county, special purpose district, or other governmental unit in the state.

(14) "NF" or "nursing facility" means:

(a) A facility:

1. To which the state survey agency has granted an NF license;

2. For which the state survey agency has recommended to the department certification as a Medicaid provider; and

3. To which the department has granted certification for Medicaid participation; or

(b) A hospital swing bed that provides services in accordance with 42 U.S.C. 1395tt and 1396l, if the swing bed is certified to the department as meeting requirements for the provision of swing bed services in accordance with 42 U.S.C. 1396r(b), (c), (d), 42 C.F.R. 447.280, and 482.58.

(15) "NF building" means a roofed and walled structure serviced by electricity, heating, and cooling and that is also an NF.

(16) "Nursing facility with Medicaid waiver" or "NF-W" means an NF to which the state survey agency has granted a waiver of the nursing staff requirement.

(17) "Provider assessment" means the assessment imposed by KRS 142.361 and 142.363.

(18) "Routine services" means the services covered by the Medicaid program pursuant to 42 C.F.R. 483.10(f)(11)(i).

(19) "Site improvement" means a depreciable asset element, other than an NF building or auxiliary building, on NF land extending beyond an NF's foundation if used for NF-related purposes.

(20) "Standard price" means a facility-specific reimbursement that includes a case-mix adjusted component, noncase-mix adjusted component including an allowance to offset a provider assessment, noncapital-facility related component, and capital rate component.

(21) "State survey agency" means the Cabinet for Health and Family Services, Office of Inspector General, Division of Health Care.

(22) "Time-weighted" means a method of calculating case-mix by determining the number of days that a minimum data set (MDS) record is active over a calendar quarter rather than captured from a single day during the calendar quarter.

Section 2. NF Reimbursement Classifications and Criteria.

(1) An NF or a hospital-based NF shall be reimbursed as a price-based NF pursuant to this administrative regulation if:

(a) It provides NF services to an individual who:

1. Is a Medicaid recipient;

2. Meets the NF patient status criteria pursuant to 907 KAR 1:022; and

3. Occupies a Medicaid-certified bed; and

(b)1. It has more than ten (10) NF beds and the greater of:

a. Ten (10) of its Medicaid-certified beds participate in the Medicare program; or

b. Twenty (20) percent of its Medicaid certified beds participate in the Medicare program; or

2. It has less than ten (10) NF beds and all of its NF beds participate in the Medicare program.

(2) An NF-W shall be reimbursed as a price-based NF pursuant to this administrative regulation if it meets the criteria established in subsection (1)(a) of this section.

(3) The following shall not be reimbursed as a price-based NF and shall be reimbursed pursuant to 907 KAR 1:025:

(a) An NF with a certified brain injury unit;

(b) An NF with a distinct part ventilator unit;

(c) An NF designated as an institution for mental disease;

(d) A dually-licensed pediatric facility; or

(e) An intermediate care facility for individuals with an intellectual disability.

Section 3. Reimbursement for Federally-Defined Swing Beds and for Skilled Nursing Facility Services in Critical Access Hospital Swing Beds.

(1) The reimbursement rate for a federally-defined swing bed shall be:

(a) The average rate per patient day paid to freestanding price-based NFs for routine services furnished during the preceding calendar year, excluding any payment made pursuant to Section 14 of this administrative regulation; and

(b) Established effective January 1 of each year.

(2)(a) The department shall reimburse a critical access hospital for skilled nursing facility services in a swing bed at the same rate as established by the Centers for Medicare and Medicaid Services for Medicare.

(b) The department shall pay an interim per diem rate as established by CMS for the Medicare program.

(c) The effective date of a rate shall be the same as used by the Medicare program.

(d) A critical access hospital's final reimbursement for skilled nursing facility services in a swing bed shall reflect any adjustment made by the Centers for Medicare and Medicaid Services.

(e) Total payments made to a critical access hospital for skilled nursing facility services provided in a swing bed under this section shall be subject to the payment limitation established in 42 C.F.R. 447.271.

(f) The provisions established in this subsection shall apply to a critical access hospital that complies with all requirements established in KRS 216.380.

Section 4. Price-based NF Appraisal.

(1) The department shall appraise a price-based NF to determine the facility specific capital component in 2009, and every fifth year, in order to calculate the NF's depreciated replacement cost.

(2) The department shall not appraise equipment or land. A provider shall be given the following values for land and equipment:

(a) Ten (10) percent of an NF's average licensed bed value for land; and

(b) $2,000 per licensed NF bed for equipment.

(3) The department shall utilize the following variables and fields of the nursing home or convalescent center CoreLogic Commercial Express Valuation System to appraise an NF identified in Section 2(1) of this administrative regulation:

(a) Provider number;

(b) Property owner - NF name;

(c) Address;

(d) Zip code;

(e) Section number - the lowest number shall be assigned to the oldest section and a basement, appraised as a separate section, immediately follows the section it is beneath;

(f) Occupancy code - nursing home or substructure;

(g) Average story height;

(h) Construction type;

(i) Number of stories;

(j) Gross floor area (which shall be the determination of the exterior dimensions of all interior areas including stairwells of each floor, specifically excluding outdoor patios, covered walkways, carports, and similar areas). In addition, interior square footage measurements shall be reported for:

1. A non-NF area;

2. A shared service area by type of service; and

3. A revenue-generating area;

(k) Gross perimeter (common walls between sections shall be excluded from both sections);

(l) Construction quality;

(m) Year built;

(n) Building effective age;

(o) Building condition;

(p) Depreciation percent;

(q) Exterior wall material;

(r) Roof covering material and roof pitch;

(s) Heating system;

(t) Cooling system;

(u) Floor finish;

(v) Ceiling finish;

(w) Partition wall structure and finish;

(x) Passenger and freight elevators - actual number;

(y) Fire protection system (sprinklers, manual fire alarms, and automatic fire detection) - percent of gross area served. If both the floor and attic areas are protected by a sprinkler system or automatic detection, the percent of gross area served shall be twice the floor area; and

(z) Miscellaneous additional features, which shall be limited to:

1. Canopies;

2. Entry foyers (sheltered entry ways):

a. The glass and aluminum standard allowance shall be fifty (50) dollars per square foot;

b. Bulkhead standard allowance shall be:

(i) Eleven (11) dollars per square foot for a wood frame;

(ii) Twelve (12) dollars per square foot for a steel frame; or

(iii) Thirty-one (31) dollars per square foot for brick masonry;

3. Loading docks;

4. Code alerts, Wanderguards, or other special electronically-secured doorways, except for a door with a sound detector or sensing unit (the standard allowance shall be $1,420 for each fully-functioning door at the time of appraisal);

5. A door with a sound detector or sensing unit shall have a standard allowance of $865 per door;

6. Automatic sliding doors (the standard allowance shall be $25,450 per doorway);

7. An automatic door opener shall have a standard allowance of $9160 per door;

8. Detached garages or storage sheds (which shall have an attached reinforced concrete floor and a minimum of 200 square feet);

9. Modular buildings or trailers, if the structure has a minimum of 200 square feet, electrical service, and heating or cooling services (the standard allowance shall be eighty (80) dollars per square foot);

10. Walk-in coolers or freezers;

11. Laundry chutes (the standard allowance shall be $2,530 per floor serviced);

12. Dumb waiters (which shall have a minimum speed of fifty (50) feet per minute. The standard allowance shall be $20,500 for the initial two (2) stops for a manual door or $52,520 for the initial two (2) stops for an electric door and $5,050 per additional stop);

13. Skylights (the standard allowance shall be fifty-seven dollars per square foot);

14. Operable built-in oxygen delivery systems (valued at $425 per serviced bed);

15. Carpeted wainscoting (the standard allowance shall be eighty (80) dollars per licensed bed);

16. Balconies;

17. Ceiling fans for which the standard allowance shall be $375 for each ceiling fan without a light and $675 for each ceiling fan with a light;

18. Cupolas for which the standard allowance shall be $990 each;

19. Fireplaces;

20. Concrete-lined utility tunnels for which the standard allowance shall be thirty-two dollars per cubic foot; and

21. Mechanical penthouses.

(4) An item listed in subsection (3)(z) of this section shall be subject to the CoreLogic Commercial Express valuation system monetary limit unless a monetary limit is provided for that item in subsection (3)(z) of this section.

(5) The department shall use the corresponding CoreLogic Commercial Express valuation system default value for any variable listed in subsection (3) of this section if no other value is stated for that variable in subsection (3) of this section.

(6) (a) Values from the most recent CoreLogic Commercial Express valuation system tables shall be used during an appraisal.

(b) An adjustment calculation shall be performed if the most recent CoreLogic Commercial Express valuation system tables do not correspond to an appraisal base year.

(7) In addition to an appraisal cited in subsection (1) of this section, the department shall appraise an NF identified in Section 2(1) of this administrative regulation if:

(a) The NF submits written proof of construction costs to the department; and

(b)

1. The NF undergoes renovations or additions costing a minimum of $150,000 and the NF has more than sixty (60) licensed beds; or

2. The NF undergoes renovations or additions costing a minimum of $75,000 and the NF has sixty (60) or fewer licensed beds.

(8) An auxiliary building shall be:

(a) Appraised if it rests on land, as defined in Section 1(12) of this administrative regulation; and

(b) Appraised separately from an NF building.

(9) To appraise an auxiliary building, the department shall utilize a CoreLogic Commercial Express valuation system model, if the model better fits the auxiliary building's use and type.

(10) If an NF building has beds licensed for non-NF purposes or a provider conducts business activities not related to the NF, the appraisal shall be adjusted between NF and non-NF activity. The appraiser shall determine if the adjustment shall be made by dividing the number of licensed NF beds by the total number of beds, or through the use of an adjustment factor determined in accordance with appraisal industry standards by the appraiser, regardless of the occupancy factor. For example, an adjustment factor may be used to apportion the appraisal by the percent of NF square footage relative to the square footage on non-NF-related business activities.

(11) Cost of an appraisal shall be the responsibility of the NF being appraised.

(12) A building held for investment, future expansion, or speculation shall not be considered for appraisal purposes.

(13) The department shall not consider the following location factors in rendering an appraisal:

(a) Climate;

(b) High-wind zone;

(c) Degree of slope;

(d) Position;

(e) Accessibility; or

(f) Soil condition.

Section 5. Standard Price Overview.

(1) Rates shall reflect the differential in wages, property values, and cost of doing business in rural and urban designated areas.

(2) On July 1 of each year, the department shall utilize the most recent Federal Office of Management and Budget's core based statistical area (CBSA) designations to classify an NF as being in an urban or rural area, with metropolitan areas always being classified as urban. The urban and rural designations shall be based on the location of the NF under the CBSA designation.

(3) The department shall utilize an analysis of fair-market pricing and historical cost for the following data:

(a) Staffing ratios;

(b) Wage rates;

(c) Cost of administration, food, professional support, consultation, and nonpersonnel operating expenses as a percentage of total cost;

(d) Fringe benefit levels;

(e) Capital rate component; and

(f) Noncapital facility-related component.

(4) The following components shall comprise the case-mix adjustable portion of an NF's standard price:

(a) The personnel cost of:

1. A director of nursing;

2. A registered nurse (RN);

3. A licensed practical nurse (LPN);

4. A nurse aide;

5. An activities staff person; and

6. A medical records staff person; and

(b) Nonpersonnel operating cost including:

1. Medical supplies; and

2. Activity supplies.

(5) The following components shall comprise the noncase-mix adjustable portion of an NF's standard price:

(a) Administration to include an allowance to offset a provider assessment;

(b) Nondirect care personnel;

(c) Food;

(d) Professional support; and

(e) Consultation.

(6) The following components shall comprise the facility and capital component of an NF's standard price:

(a) The noncapital facility-related component, which shall be a fixed, uniform amount for all price-based NFs; and

(b) The NF's capital rate component, which shall be facility specific.

(7) Excluding capital rate components, the following is an example of an urban and a rural price-based NF's standard price based on rebased wages at the 2024 level:

CBSA Designation	Case-Mix Adjustable Portion of Standard Price	Noncase-Mix Adjustable Portion of Standard Price Without Capital Rate Component	Total Standard Price Excluding Capital Rate Components
Urban	$160.33[~~160.14~~]	$133.70[~~101.81~~]	$294.03[~~261.95~~]
Rural	$136.05[~~135.87~~]	$121.58[~~89.68~~]	$257.63[~~225.55~~]

(8) A price-based NF's standard price may be:

(a) Adjusted for inflation every July 1 using the version of the CMS Nursing Home without Capital Market Basket that was effective on the July 1 that the inflation adjustment occurred; and

(b) Rebased:

1. Effective July 1, 2024; and

2. At least once every four (4) years thereafter.

(9) The department shall adjust an NF's standard price if:

(a) A governmental entity imposes a mandatory minimum wage or staffing ratio increase and the increase was not included in the inflation adjustment; or

(b) A new licensure requirement or new interpretation of an existing requirement by the state survey agency results in changes that affect all facilities within the class. The provider shall document that a cost increase occurred as a result of a licensure requirement or policy interpretation.

Section 6. Standard Price Calculation.

(1) Based on the classification of urban or rural, the department shall calculate an individual NF's standard price to be the sum of:

(a) The case-mix adjustable portion of the NF's standard price, adjusted by the NF's current case-mix index pursuant to Section 7 of this administrative regulation;

(b) The noncase-mix adjustable portion of the NF's standard price, which shall include an allowance to offset a provider assessment;

(c) The noncapital facility-related component; and

(d) Pursuant to subsection (2) of this section, the capital rate component.

(2) An NF's capital rate component shall be calculated as follows:

(a) The department shall add the total of:

1. The NF's average licensed bed value, which shall:

a. Be determined by dividing the NF's depreciated replacement cost, as determined from an appraisal conducted in accordance with Section 4 of this administrative regulation, adjusted every July 1 using the RS Means Construction Cost Indexes, and applying the total weighted average annual change of the Kentucky cities by the NF's total licensed NF beds; and

b. Not exceed $80,278[~~79,775~~]effective July 1, 2024[~~2023~~], which shall be adjusted every July 1 thereafter by the same factor applied to the NF's depreciated replacement cost;

2. A value for land, which shall be ten (10) percent of the NF's average licensed NF bed value, established in accordance with subparagraph 1. of this paragraph; and

3. A value for equipment, which shall be $2,000 per licensed NF bed;

(b) The department shall multiply the sum of paragraph (a) of this subsection by a rate of return factor, which shall:

1. Be equal to the sum of:

a. The yield on a twenty (20) year treasury bond as of the first business day on or after May 31 of the most recent year; and

b. A risk factor of two (2) percent; and

2. Not be less than nine (9) percent nor exceed twelve (12) percent;

(c) The department shall determine the NF's capital cost-per-bed day by:

1. Dividing the NF's total patient days by the NF's available bed days to determine the NF's occupancy percentage;

2. If the NF's occupancy percentage is less than ninety (90) percent, multiplying ninety (90) percent by 365 days; and

3. If the NF's occupancy percentage exceeds ninety (90) percent, multiplying the NF's occupancy percentage by 365 days; and

(d) The department shall divide the sum of paragraphs (a) and (b) of this subsection by the NF's capital cost-per-bed day established in paragraph (c) of this subsection to determine an NF's capital rate component.

(3) If a change of ownership occurs pursuant to 42 C.F.R. 447.253(d), the new owner shall:

(a) Receive the capital cost rate of the previous owner unless the NF is eligible for a reappraisal pursuant to Section 4(7) of this administrative regulation; and

(b) File an updated provider application with the Medicaid program pursuant to 907 KAR 1:672, Section 3(4).

(4) A new facility shall be:

(a) Classified as a new facility if the facility does not have a July 1, of the current state fiscal year, Medicaid rate;

(b) Determined to be urban or rural; and

(c) Reimbursed at its standard price, which shall:

1. Be based on a case-mix of 1.0;

2. Be adjusted prospectively based upon no less than one (1) complete calendar quarter of available MDS 3.0 data following the facility's Medicaid certification;

3. Utilize $80,278[~~79,775~~] effective July 1, 2024[~~2023~~], as adjusted through the current state fiscal year as the facility's average licensed NF bed value until the facility is appraised in accordance with Section 4 of this administrative regulation; and

4. Be adjusted, if necessary, following the facility's appraisal if the appraisal determines the facility's average licensed NF bed value to be less than $80,278[~~79,775~~] effective July 1, 2024[~~2023~~], as adjusted through the current state fiscal year.

(5) The amounts calculated pursuant to subsection (4)(c)3. and 4. of this section shall be adjusted annually consistent with the adjustments made to the depreciated replacement cost, as described in subsection (2)(a)1.b. of this section for the capital component calculation.

Section 7. PDPM Adapted Minimum Data Set (MDS) 3.0, and Validation.

(1) A price-based NF's Medicaid MDS data shall be utilized to determine its case-mix index each quarter.

(2) A price-based NF's case-mix index shall be applied to its case-mix adjustable portion of its standard price.

(3) To determine a price-based NF's case-mix index, the department shall:

(a) Calculate case-mix on a time-weighted basis using MDS data:

1. Extracted on the last date of each calendar quarter from the NF's MDS item sets:

a. Included in the PDPM Adapted Minimum Data Set (MDS) - Version 3.0, Resident Assessment and Care Screening; and

b. Transmitted by the NF to the Centers for Medicare and Medicaid Services; and

2. Which, if revised, shall be revised no later than the last date of the quarter following the date on which MDS data was extracted. For example, MDS data submitted after September 30, 2024[~~2023~~], for the purpose of revision to MDS data extracted June 30, 2024[~~2023~~], shall not be utilized;

(b) Classify the data cited in paragraph (a) of this subsection through the Patient Driven Payment Model (PDPM) resident classification system, nursing component; and

(c) Validate the data cited in paragraph (a) of this subsection as follows:

1. The department shall generate a stratified random sample of thirty (30) percent of the Medicaid residents in a price-based NF;

2. The department shall review one (1) MDS assessment from each resident in the sample referenced in subparagraph 1. of this paragraph; and

3. The department shall review medical records corresponding to the individuals included in the sample identified in subparagraphs 1. and 2. of this paragraph to determine if the medical records accurately support the MDS assessments submitted for the sample residents.

(4) If the department's review, in accordance with subsection (3)(c)3. of this section, of a price-based NF's MDS assessment data reveals that the NF fails to meet the MDS data minimum accuracy threshold, the department shall conduct another review of the same data utilizing an individual or individuals not involved in the initial validation process if the price-based NF requests a reconsideration within ten (10) business days of being notified of the findings of the review.

(5) Only MDS data extracted in accordance with subsection (3)(a)2. of this section shall be allowed during a review or reconsideration.

(6) If a reconsideration of a price-based NF's MDS assessment data, in accordance with subsection (4) of this section, confirms that the NF fails to meet the minimum accuracy threshold, the department shall:

(a) Conduct a conference with the NF to review preliminary findings of the reconsideration; and

(b) Send the final results of the reconsideration to the NF within ten (10) business days of the conference.

(7) In performing validation reviews on MDS data, the department shall:

(a) Notify the NF at the time of the MDS assessment review of any assessment that is not validated and allow the NF to provide supporting documentation that had been utilized to support the assessment;

(b) Consider all MDS supporting documentation provided by the NF prior to the exit conference; and

(c) Not consider MDS supporting documentation provided by the NF after the exit conference has occurred.

(8)

(a) Reconsideration of a price-based NF's MDS assessment data validation shall be provided if the NF:

1. Requests a reconsideration and clearly identifies each specific resident's review and MDS elements that are being disputed;

2. States the basis on which the department's decision on each issue is believed to be erroneous; and

3. Provides a summary supporting the NF's position.

(b) After a reconsideration of a price-based NF's MDS assessment data has been completed, the NF may appeal the department decision regarding the data in accordance with 907 KAR 1:671, Section 9.

(9)

(a) The department shall refer any suspected intentional alteration of clinical documentation or creation of documentation after an MDS assessment has been transmitted to the Office of Inspector General (OIG) for investigation of possible fraud.

(b) A fraud investigation may result in a felony or misdemeanor criminal conviction.

(10) An NF's rate shall be effective beginning on the first date of the second quarter following the MDS extraction date.

(11) An MDS validation review, if conducted, shall be initiated in the ~~month~~ quarter containing the corresponding rate effective date.

(12) A rate sanction shall be applied on the rate effective date following the validation review initiation date.

(13) MDS assessment accuracy thresholds and corresponding rate sanctions shall be established in accordance with this subsection.

(a) If a price-based NF's percentage of accurate MDS assessments is between sixty-five (65) and seventy-nine (79) percent, the price-based NF's rate shall be sanctioned by fifty (50) cents per patient day.

(b) If a price-based NF's percentage of accurate MDS assessments is between forty (40) and sixty-four (64) percent, the price-based NF's rate shall be sanctioned by sixty (60) cents per patient day.

(c) If a price-based NF's percentage of accurate MDS assessments is below forty (40) percent, the price-based NF's rate shall be sanctioned by seventy (70) cents per patient day.

[~~(d) Rate sanctions shall not be applied:~~

~~1. Until the rates effective July 1, 2025 are in effect; and~~

~~2. Except for those rates that are effective on and after July 1, 2025 as specified in subsection (14) of this section.~~]

(14) Beginning with rates effective July 1, 2025, upon conclusion of a departmental review of MDS data, in accordance with this section of this administrative regulation:

(a) The department shall recalculate the facility's case mix index based on the review's findings; and

(b) If a recalculated case mix index results in a change to the NF's established rate or rates, the rate or rates shall be recalculated and any payment adjustment shall be made.

(15) [~~For rates effective April 1, 2024, through June 30, 2024, the rate shall be equal to the rate effective January 1, 2024.~~

~~(16)~~] Beginning July, 1, 2024, the PDPM case-mix index shall be phased in. [~~using the following schedule:~~

~~(a) For rates effective July 1, 2024 through September 30, 2024, the case-mix index shall be comprised of twenty-five (25) percent of the PDPM CMI and seventy-five (75) percent of the RUG-III CMI that was in effect prior to the transition.~~

~~(b) For rates effective October 1, 2024 through December 31, 2024, the case-mix index shall be comprised of fifty (50) percent of the PDPM CMI and fifty (50) percent of the RUG-III CMI that was in effect prior to the transition.~~

~~(c) For rates effective January 1, 2025 through March 31, 2025, the case-mix index shall be comprised of seventy-five (75) percent of the PDPM CMI and twenty-five (25) percent of the RUG-III CMI that was in effect prior to the transition.~~

~~(d)~~](16) Beginning April 1, 2025, the case-mix index shall be comprised of 100 percent of the PDPM CMI at full phase in[~~and zero percent of the RUG-III CMI that was in effect prior to the transition~~].

Section 8. Limitation on Charges to Residents.

(1) Except for applicable deductible and coinsurance amounts, an NF that receives reimbursement for a resident pursuant to Section 6 of this administrative regulation shall not charge a resident or his representative for the cost of routine or ancillary services.

(2) An NF may charge a resident or his representative for an item pursuant to 42 C.F.R. 483.10(f)(11)(ii) if:

(a) The item is requested by the resident or representative;

(b) The NF informs the resident or representative in writing that there will be a charge; and

(c) Medicare, Medicaid, or another third party does not pay for the item.

(3) An NF shall:

(a) Not require a resident, or responsible representative of the resident, to request any item or services as a condition of admission or continued stay; and

(b) Inform a resident, or responsible representative of the resident, requesting an item or service for which a charge will be made in writing that there will be a charge and the amount of the charge.

(4) Reserved bed days, per resident, for an NF or an NF-W shall be:

(a) Reimbursed for a maximum of thirty (30) days per calendar year due to hospitalization. Accumulated bed reserve days shall follow a resident if the resident relocates to another facility within a calendar year rather than starting over at zero due to relocation;

(b) Reimbursed for a maximum of ten (10) days during a calendar year for leaves of absence other than hospitalization. Accumulated bed reserve days shall follow a resident if the resident relocates to another facility within a calendar year rather than starting over at zero due to the relocation;

(c) Reimbursed at seventy-five (75) percent of a facility's rate.

(5) Except for oxygen therapy, durable medical equipment (DME) and supplies shall:

(a) Be furnished by an NF; and

(b) Not be billed to the department under a separate DMS claim pursuant to 907 KAR 1:479, Section 6(3).

(6) Except as otherwise covered pursuant to Title 907 KAR, dentures, lenses, frames, or hearing aids shall be paid for through the resident's patient liability or spend down amounts and limited to one (1) replacement per item per calendar year.

Section 9. Reimbursement for Required Services Under the Preadmission Screening Resident Review (PASRR).

(1) Prior to an admission of an individual, a price-based NF shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.

(2) The department shall reimburse an NF for services delivered to an individual if the NF complies with the requirements of 907 KAR 1:755.

(3) Failure to comply with 907 KAR 1:755 may be grounds for termination of the NF's participation in the Medicaid Program.

Section 10. Price-Based NF Protection Period and Budget Constraints.

(1) A county-owned hospital-based nursing facility shall not receive a rate that is less than the rate that was in effect on June 30, 2002.

(2) For each year of the biennium, a price-based NF shall:

(a) Receive an adjustment pursuant to Section 5(8) and (9) of this administrative regulation; or

(b) Except for a county-owned hospital-based nursing facility pursuant to subsection (1) of this section, not receive an increase if the price-based NF's rate is greater than its standard price.

Section 11. Cost Report.

(1) A Medicare cost report and the Supplemental Medicaid Schedules shall be submitted pursuant to time frames established in the CMS Medicare Provider Reimbursement Manual - Part 2 (Pub. 15-2) Sections 102, 102.1, 102.3, and 104, using the Instructions for Completing the Medicaid Supplemental Schedules.

(2) A copy of a price-based NF's Medicare cost report shall be submitted for the most recent fiscal year end.

Section 12. Ancillary Services.

(1) Except for [~~oxygen therapy and for~~] ancillary services provided to an individual in a critical access hospital swing bed, the department shall reimburse for an ancillary service [~~that meets the criteria established in 907 KAR 1:023~~]utilizing a per diem component to the rates, updated every July 1.

(a) Prior year utilization based on claims through June 30, 2024, and the corresponding outpatient procedure code rate listed in the Medicaid Physician Fee Schedule established in 907

KAR 3:010, Section 1(17). For oxygen therapy procedure codes, the Medicaid DME Program fee schedule established in 907 KAR 1:479 shall be utilized.

(b) For dates of service July 1, 2024, and after, the volume of services shall be reported by the provider on the Kentucky Medicaid Nursing Facility Ancillary Supplemental Schedules. The schedules on file by the department as of June 1 of each year shall be used to determine the ancillary fees.

(c) The sum from paragraphs (a) and (b) above shall be divided by the number of the provider's paid Medicaid days for the same time period.

[~~(2) The department shall reimburse for an oxygen therapy utilizing the Medicaid DME Program fee schedule established in 907 KAR 1:479.~~]

[~~(3)~~](2) Respiratory therapy and respiratory therapy supplies shall be a routine service.

[~~(4)~~](3) Reimbursement for ancillary services provided to an individual in a critical access hospital swing bed shall be included in the critical access hospital swing bed reimbursement established in Section 3(2) of this administrative regulation.

Section 13. Quality Program.

(1) Beginning with rates effective July 1, 2025, there shall be a quality add on component in the prospective per diem rates, distributed from a pool of combined funding (state and federal share) from the provider assessment.

(a) For rates effective July 1, 2025, through December 31, 2025, the quality pool shall be five (5) percent of the increase to the provider assessment effective July 1, 2024.

(b) For rates effective January 1, 2026, through June 30, 2026, the quality pool shall be ten (10) percent of the increase to the provider assessment effective July 1, 2024.

(c) For rates effective July 1, 2026, through December 31, 2026, the quality pool shall be fifteen (15) percent of the increase to the provider assessment effective July 1, 2024.

(d) For rates effective January 1, 2027 and after, the quality pool shall be twenty (20) percent of the increase to the provider assessment effective July 1, 2024.

(2) The allowance to offset the provider assessment as determined in Section 5(5)(a) shall be reduced in order to fund the quality pool.

(3) Any leftover funds shall be rolled into the pool for the next state fiscal year.

(4) Points shall 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.

(5) Each metric shall be weighted equally in the collection of total points and distributed by the facility's percentage of weighted Medicaid days.

(6) The quality add on shall be updated on a quarterly basis based on the most recent information as of the day preceding the rate effective date.

Section 14[~~13~~]. Appeal Rights. A price-based NF may appeal a department decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 15[~~14~~]. Supplemental Payments to Nonstate Government-Owned or Operated Nursing Facilities.

(1) Beginning July 1, 2001, subject to state funding made available for this provision by a transfer of funds from a governmental entity, the department shall make a supplemental payment to a qualified nursing facility.

(2) To qualify for a supplemental payment under this section, a nursing facility shall:

(a) Be owned or operated by a local unit of government pursuant to 42 C.F.R. 447.272(a)(2);

(b) Have at least 140 or more Medicaid-certified beds; and

(c) Have a Medicaid occupancy rate at or above seventy-five (75) percent.

(3) For each state fiscal year, the department shall calculate the maximum supplemental payment that it may make to qualifying nursing facilities in accordance with 42 C.F.R. 447.272.

(4) Using the data reported by a nursing facility on a Schedule NF-7 submitted to the department as of December 31, 2000, the department shall identify each nursing facility that meets the criteria established in subsection (2) of this section.

(5) The department shall determine a supplemental payment factor for a qualifying nursing facility by dividing the qualifying nursing facility's total Medicaid days by the total Medicaid days for all qualifying nursing facilities.

(6) The department shall determine a supplemental payment for a qualifying nursing facility by applying the supplemental payment factor established in subsection (5) of this section to the total amount available for funding under this section.

(7) Total payments made under this section shall not exceed the amount determined in subsection (3) of this section.

(8) Payments made under this section shall:

(a) Apply to services provided on or after April 1, 2001; and

(b) Be made on a quarterly basis.

Section 16[~~15~~]. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 17[~~16~~]. Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) "Medicare Provider Reimbursement Manual - Part 2 (Pub. 15-2), Sections 102, 102.1, 102.3, and 104", October 2007;

(b) The "Instructions for Completing the Medicaid Supplemental Schedules", April 2015;

(c) The "Supplemental Medicaid Schedules", April 2015; ~~and~~

(d) The "Kentucky Medicaid Nursing Facility Ancillary Supplemental Schedules," July 2024;

(e) The "Kentucky Medicaid Nursing Facility Ancillary Supplemental Schedules Instructions," July 2024;

(f) The "Kentucky Medicaid Nursing Facility Quality Program Behavioral Health Metric Attestation Statement", February 2025; and

(g)[~~(d)~~] PDPM Adapted Minimum Data Set (MDS)", October 1, 2024[~~2023~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the:

(a) Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.; and

(b) Following location on the department's Web site: https://chfs.ky.gov/agencies/dms/dafm/Pages/default.aspx.

907 KAR 1:065
REVIEWED:

8/1/2025
Date

DocuSigned by:
Lisa Lee
7CB973D215D941E...
Lisa D. Lee, Commissioner
Department for Medicaid Services

APPROVED:

8/1/2025
Date

Signed by:
Steven Stack
A6C077BED9A2471...
Steven J. Stack, M.D., MBA
Secretary
Cabinet for Health and Family Services

PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall, if requested, be held on November 24, 2025, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by November 17, 2025, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends virtually will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation through November 30, 2025. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, KY 40621; Phone: 502-564-7476; Fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 1:065. Payments for price-based nursing facility services.
Agency Contact: Jonathan Scott
Phone Number: (502) 564-4321, ext. 2015
Email: jonathant.scott@ky.gov

Contact Person: Krista Quarles
Phone Number: (502) 564-7476
Email: CHFSregs@ky.gov

Subject Headings: Medicaid, Nursing Facilities, Public Assistance

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes reimbursement for nursing facilities participating in Kentucky Department for Medicaid Services for all non-managed care recipients.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish price-based nursing facility reimbursement provisions.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing price-based nursing facility reimbursement provisions.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing updated reimbursement rates for nursing facilities providing care to Kentucky Medicaid recipients.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This amendment updates the reimbursement methodology for the PDPM case mix. In addition, a nursing home quality payment system will be implemented over multiple years, starting at 5% and ending at 20%. In addition, new materials incorporated by reference are included.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to produce a quality payment system that is present in an approved state plan document.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment is necessary to comply with a received federal approval.

(d) How the amendment will assist in the effective administration of the statutes: The amendment updated the Medicaid nursing home program to coincide with a received federal approval relating to quality payments.

(3) Does this administrative regulation or amendment implement legislation from the previous five years? No.

(4) List the type and number of individuals, businesses, organizations, or state and local

governments affected by this administrative regulation: There are 257 nursing facilities participating with Medicaid that may be affected.

(5) Provide an analysis of how the entities identified in question (4) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (4) will have to take to comply with this administrative regulation or amendment: Entities will have to comply with quality initiatives that are included as part of this program in order to receive quality payments.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (4): DMS does not anticipate additional costs in complying with quality initiatives.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (4): Facilities will become eligible for additional reimbursement via the quality payments.

(6) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: DMS anticipates that expenditures for nursing facilities will be consistent with appropriations in the current executive branch state budget.

(b) On a continuing basis: DMS anticipates that expenditures for nursing facilities will be consistent with appropriations in the current executive branch state budget.

(7) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.

(8) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The department does not anticipate an increase in funding in order to implement this administrative regulation.

(9) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(10) TIERING: Is tiering applied? (Explain why or why not) Tiering was not applied in this administrative regulation because the administration regulation applies equally to all those individuals or entities regulated by it.

FISCAL IMPACT STATEMENT

907 KAR 1:065: Payments for price-based nursing facility services.
Contact Person: Jonathan Scott
Phone: (502) 564-4321, ext. 2015
Email: jonathant.scott@ky.gov

Contact Person: Krista Quarles
Phone Number: (502) 564-7476
Email: CHFSregs@ky.gov

(1) Identify each state statute, federal statute, or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1)

(2) Identify the promulgating agency and any other affected state units, parts, or divisions: The Department for Medicaid Services is the promulgating agency.

(a) Estimate the following for the first year:

Expenditures: The Department for Medicaid Services (DMS) anticipates no additional expenditures as a result of the amendment.

Revenues: The Department for Medicaid Services (DMS) anticipates no additional revenues as a result of the amendment.

Cost Savings: The Department for Medicaid Services (DMS) anticipates no additional cost savings as a result of the amendment.

(b) How will expenditures, revenues, or cost savings differ in subsequent years? DMS does not anticipate expenditures, revenues, or cost savings as a result of the amendment in subsequent years.

(3) Identify affected local entities (for example: cities, counties, fire departments, school districts): DMS does not anticipate an impact on local entities.

(a) Estimate the following for the first year:

Expenditures: N/A

Revenues: N/A

Cost Savings: N/A

(b) How will expenditures, revenues, or cost savings differ in subsequent years? N/A

(4) Identify additional regulated entities not listed in questions (2) or (3): Nursing facilities

(a) Estimate the following for the first year:

Expenditures: DMS does not anticipate that facilities will experience increased expenditures as a result of the quality measures.

Revenues: DMS does not anticipate that facilities will experience increased revenues as a result of the quality measures.

Cost Savings: DMS does not anticipate that facilities will experience increased cost savings as a result of the quality measures.

(b) How will expenditures, revenues, or cost savings differ in subsequent years? DMS does not anticipate expenditures, revenues, or cost savings in subsequent years.

(5) Provide a narrative to explain the:

(a) Fiscal impact of this administrative regulation: DMS is implementing a required nursing home quality payment program. Nursing facilities will have the opportunity to prove that they qualify for various higher percentage payment based on meeting quality metrics, improved outcomes, and additional payments will result in no cost savings or fiscal impact changes.

(b) Methodology and resources used to determine the fiscal impact: Staff and external contractor review of the approved program and administrative regulation.

(6) Explain:

(a) Whether this administrative regulation will have an overall negative or adverse major economic impact to the entities identified in questions (2) - (4). ($500,000 or more, in aggregate) The administrative regulation will not have a major negative or adverse economic impact – as defined by KRS 13A.010 – on regulated entities.

(b) The methodology and resources used to reach this conclusion: Staff and external contractor review of the approved program and administrative regulation.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 907 KAR 1:065
Agency Contact: Jonathan Scott
Phone Number: (502) 564-4321, ext. 2015
Email: jonathant.scott@ky.gov

Contact Person: Krista Quarles
Phone Number: (502) 564-7476
Email: CHFSregs@ky.gov

(1) Federal statute or regulation constituting the federal mandate. 42 USC 1396r(f)(6) and 42 CFR 483.20.

(2) State compliance standards. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

(3) Minimum or uniform standards contained in the federal mandate. 42 CFR 483.20 requires a nursing facility to conduct a resident assessment of each resident.

(4) Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This administrative regulation does not set stricter requirements.

(5) Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Neither stricter nor additional standards nor responsibilities are imposed.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:065. Payments for price-based nursing facility services.

Summary of Material Incorporated by Reference

The "Kentucky Medicaid Nursing Facility Ancillary Supplemental Schedule," July 2024 version provides the revenue and procedure codes for therapy services. This document contains twelve (12) pages.

The "Kentucky Medicaid Nursing Facility Ancillary Supplemental Schedule Instructions," July 2024 version provides the instructions and process for requesting reimbursement for therapy services. This document contains three (3) pages.

The "PDPM Adapted Minimum Data Set (MDS)," October 1, 2024, version establishes identification information, specific health information, and diagnosis information that is taken for nursing home recipients or potential nursing home recipients. This is a standard questionnaire for health care providers to use for nursing home recipients of potential nursing home recipients. This document contains fifty-eight (58) pages.

The "Kentucky Medicaid Nursing Facility Quality Program Behavioral Health Metric Attestation Statement", February 2025 version is an attestation statement for providers to attest that the appropriate actions have been completed in order to qualify for the incentive payment for the behavioral health metric in the nursing facility quality program. This document contains four (4) pages.

The total number of pages incorporated by reference is 77.