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 individuals with an intellectual disability. 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 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 individuals with an intellectual disability;

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, facilities 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-IIDs (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 to 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 in the approved state plan. 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 individuals with intellectual disabilities 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 a pro-forma cost report until their first full year Medicare cost report is submitted. Thereafter, interim rates will be based on the per diem cost substantiated by the most recently available cost report data.

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.

a. NF/Brain Injury Units means units recognized by the Medicaid agency as specially designated and identified NF units dedicated to, and capable of, providing care to individuals with severe head injury. Facilities providing preauthorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae means a facility appropriately accredited by a nationally recognized accrediting agency or organization. To participate in Kentucky Medicaid the facility or unit must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

Effective for dates of service on or after September 1, 2018, the all-inclusive rate for brain injury unit is $530 per diem, excluding drugs and physician cost. These claims are to be submitted through the pharmacy and physician's programs. For those residents with brain injury and neurobehavioral sequelae, a negotiated per diem rate shall be paid. The negotiated rate shall be a minimum of the approved rate for a Medicaid certified brain injury unit or a maximum of the lesser of the average rate paid by all payers for this service or the facilities usual and customary charges. This rate excludes drugs and physician costs. These claims shall be submitted through the pharmacy and physician's programs.

b. Certified distinct part ventilator nursing facility unit means a preauthorized distinct part unit of not less than twenty (20) beds with a requirement that the facility have a ventilator patient census of at least fifteen (15) patients. The patient census shall be based upon the quarter preceding the beginning of the rate year, or upon the quarter precedent the quarter for which certification is requested if the facility did not qualify for participation as a ventilator care unit at the beginning of the rate year. The unit must have a ventilator machine owned by the facility for each certified bed with an additional backup ventilator machine required for every ten (10) beds. The facility must have an appropriate program for discharge planning and weaning from the ventilator. The fixed rate for hospital based facilities is $460.00 per day, and the fixed rate for freestanding facilities is $250.00 per day. The rates are to be increased based on the IHS Global Insight inflation index for the nursing facility services for each rate year beginning with the July 1, 1997 rate year.

5. 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 described in Attachment 4.19 D, Exhibit B:

   a. NF/institutions for Mental Diseases (IMD) 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). Individuals who turn older than the age of twenty-one (21) while within a dually licensed pediatric facility can remain in care of that facility.

   c. ICF-IID-Intermediate Care Facilities for individuals with an intellectual disability means facilities identified by the Medicaid agency as providing care primarily to the mentally retarded and developmentally disabled.

   d. Veteran's Affairs nursing facilities.

6. 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.

7. 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.

8. 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.

9. 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 free-standing nursing facility;

b. A hospital-based nursing facility;

c. A nursing facility with waiver;

d. A nursing facility with an intellectual disability 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-D 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 CMS Provider Reimbursement Manual-Part 2 (PUB. 15-11) Section 102, 102.1, 102.3 and 104.

Methods and Standards for Determining Price-based Nursing Facility Payments

The methods and standards for the determination of reimbursement rates to price-based nursing facilities is described in the Nursing Facility Reimbursement manual which Is ATTACHMENT 4.19-D, Exhibit B.

Payment 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 standard price is market-based using historical data, salary surveys and staffing ratios. The standard price accounts for the higher wage rates for the urban area and the slightly lower rates for wages in the rural area.

3. The rate also takes into account a facility specific capital cost component based on an appraisal of each facility and the department shall appraise a price-based Nursing Facility to determine the facility specific capital component again in 2009, thereafter, every five (5) years.

4. The standard price be re-based in 2008 and consists of two components: the "case-mix" adjustable portion and the "non-casemix" adjustable portion.

   (1) The "case-mix" adjustable portion consists of wages for direct care personnel, cost associated with direct care, and non-personnel operation cost (supplies, etc.).

(2) The "non-case mix" adjustment portion consists of all other facility cost except capital cost.

6. Case-mix is based on data extracted from the Minimum Data Set 3.0 submitted to the CMS national server as required by CMS and the individual facility case-mix is calculated using the Resource Utilization Group (RUG) III version 5.20.

7. Rates are established prospectively on July 1 of each year and adjusted for "case-mix at the beginning of each quarter during the rate year (January, April, July, and October). A "case-mix" adjustment is the only adjustment made to the rates by the Department.

8. Other adjustments will not be made to the rates except for errors identified by the Department when computing the rate.

9. Facilities protection period shall be in effect until June 30, 2002. No price-based nursing facility will receive a rate under the new methodology that is less than their rate that was set on July1, 1999, adjustment for the facility's "resident acuity". However, nursing facilities may receive increase in rates as a result of the new methodology as the Medicaid budget allows.

10. 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.

11. Payments under this methodology must not exceed $260,997,283 for the period of January 1, 2000 to June 30, 2000.

12. The Department remains at risk for increases in total nursing facility payments that result from higher utilization of beds by Medicaid recipients. The Department reserves the right to adjust rates, to remain within budgeted amount.

13. 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.

14. The Department shall require the submission of the most recent Medicare cost report and the Medicaid Supplemental Schedules included in the manual to be used for historical data.

15. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.

16. 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.

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

PUBLIC PROCESS FOR DETERMINING RATES FOR LONG-TERM CARE FACILITIES

The State has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Beginning April 2, 2001 and ending June 30, 2005, subject to the availability of funds, the Department will make supplemental payments to qualifying nursing facilities on a quarterly basis. The Department will use the following methodology to determine these payments:

1) For each state fiscal year, the Department will calculate the maximum addition payments that it can make to non-state government-owned or operated nursing facilities as set forth at 42 CFR Section 447.272 (a)(2) and 42 CFR Section 447.272 (b).

2) The Department will use the latest cost report data on file with the Department as of December 31, 2000 to identify the nursing facilities eligible for supplemental payments. To be eligible for supplemental payments the nursing facility must:

   a) Be a nursing facility owned or operated by a local unit of government;
   b) Have at least 140 or more Medicaid certified beds; and
   c) Have Medicaid occupancy at or above 75%.

   A qualifying nursing facility is an eligible facility that is owned or operated by a local unit of government that has entered into an Intergovernmental Transfer Agreement with the Commonwealth.

3) The Department will determine the amount of supplemental payments it will make to qualifying nursing facilities in a manner not to exceed the upper limit amount as calculated in 1 above.

4) Using the cost report data on file as of December 31, 2000, the Department will identify the total Medicaid days reported by the qualifying nursing facilities as identified in 2 above.

5) The Department will divide the total Medicaid days for each qualifying county-owned or operated nursing facility as determined in 2 above by the total Medicaid days for all qualifying facilities to determine the payment supplementation factor.

6) The Department will apply each qualifying county-owned or operated nursing facility's payment supplementation factor determined in 5 above to the total supplemental payment amount identified in 3 above to determine the payment to be made to each qualifying nursing facility.

Effective for services provided on and after September 1, 2001, the Department will make pediatric supplemental payments on a quarterly basis to qualifying nursing facilities. The Department will use the following methodology to determine these payments:

1. For the period of 9/01/01 through 6/30/02 and annually thereafter (7/01 through 6/30), the Department shall establish a pool of $550,000 to be distributed to qualified facilities based upon their pro rata share of Medicaid patient days.

2. A nursing facility qualifies for a pediatric supplemental payment if it meets the following criteria:

   a. Is located within the Commonwealth of Kentucky;
   b. Has a Medicaid occupancy at or above 85%;
   c. Provides services only to children under age twenty-one (21); and
   d. Has forty (40) or more licensed beds.

Reimbursement for SFY 2002- 2003

A. Excluding nursing facilities with brain injury units, intermediate care facilities for individuals with an intellectual disability and state-owned nursing facilities, rates for cost-based nursing facilities will be the rates in effect on June 30, 2002.

B. Rates for price-based nursing facilities will be established in accordance with the methodology described in Attachment 4.19-D, Exhibit A.

Effective retroactively to February 21st, 2024, and effective for affected services provided through June 30, 2024, all Long Term Care providers that are providing long term care services are eligible to receive interim payments for FFS (Fee for Service) Claim types in amounts representative of up to thirty days (30) of claims payments for FFS that are not otherwise paid as a result of the Change Healthcare cybersecurity incident. The average 30-day payment is based on the total claims for FFS paid to the Kentucky Medicaid provider, inclusive of all Medicaid base payments for FFS claims made under the Medicaid State Plan, between August 1, 2023, and October 31, 2023, divided by three (3). The payment will be made for services provided through June 30, 2024, on a formal request only basis from the provider. This is not an advanced payment or prepayment prior to services furnished by providers, this is an interim payment based on services provided but the rendering provider is unable to submit the appropriate claim(s) due to the cybersecurity incident. These payments will be reconciled to the final payment amount the provider was eligible to receive under the Medicaid State Plan for FFS claims during the timeframe for which it was receiving interim payments under this provision. The reconciliation will be completed within 60 days following the last day of the quarter in which the state is able to again process payments for claims *following the resolution of the Change Healthcare cybersecurity incident. If the reconciliation results in discovery of an overpayment to the provider, the state will attempt to recoup the overpayment amounts within 60 days and will return the federal share within the timeframe specified in 42 CFR 433.316 and 433.320 regardless of whether the state actually recoups* the overpayment amount from the provider, unless an exception applies under 42 CFR part 433, subpart F. If the reconciliation results in an underpayment to the provider, the state will make an additional payment to the provider in the amount of the underpayment within 60 days. The state will follow all applicable Program Integrity requirements relating to interim payments to providers and the associated reconciliation process. The state will ensure that the Individual, Group and Entity Provider Types receiving payments under this interim methodology for FFS will continue to furnish medical and professional care to Medicaid beneficiaries during the interim payment period and that access to services is not limited.