Kentucky Department for Medicaid Services

Nursing Facility Rate Updates

Training Held May 30, 2024 - Q&A

The following questions were asked during the live training session held May 30, 2024.

Answers are provided below.

General

Q1: Will the recording and Q&A document be available once the session has been completed?

A1: Yes. The links and files will be available at https://myersandstauffer.com/client-portal/kentucky/

Q2: Will the slides be available for downloading and printing?

A2: Yes. The slides will be posted at https://myersandstauffer.com/client-portal/kentucky/

Q3: When will the 7/1/24 rates will be issued?

A3: These are generally issued the last week of July.

Q4: Will Medicaid mass adjust any July 2024 claims to satisfy the rate changes as rates will not be available at the time of billing?

A4: Yes, if a nursing facility bills before the rates effective 7/1/2024 are the system, then DMS will reprocess those claims. Generally, NFs bill monthly after the end of the month, and therefore the need for mass adjustments will be minimal. However, if a facility bills weekly, then mass adjustments will be made as needed.

Rebasing

Q5: Will the SFY 2025 rebased standard prices consider the increase in costs due to inflation since 2022?

A5: Yes. Market basket inflation has been applied from the 2022 cost reports to SFY 2025 rate setting period.

Appraisals

Q6: How did DMS come up with the per bed maximum allowable amount for Capital component? $80,278 as a maximum value seems low, especially for newer facilities.

A6: This began as the $40,000 maximum per bed value when the system began in 2000. The amount has been inflated every year in lockstep with the inflation adjustment that DMS has applied to the depreciated replacement cost.

Q7: Should all facilities have an appraisal report uploaded to the portal at this time?

A7: No, we are currently in the process of sending those out. They should all be out by 5/31/2024.

Q8: On the capital component, is the 0.37% the actual inflation rate for 7/1/2024 or is that only an example?

A8: This is 7/12th of the full inflation amount from the current RS means publication (inflating costs as of November 2023 from the appraisal reports to the end of June 2024).

PDPM Case Mix Adjustments

Q9: Is there going to be a CMI component included for therapy?

A9: No. Only the PDPM Nursing component will be used.

Q10: What are the assigned PDPM values for residents who are admitted but leave before an MDS assessment is completed (before day 14)?

A10: In this scenario, if the discharge reason is deceased or discharge to hospital, then the assigned PDPM value is LBC2. If the discharge reason is anything other than deceased or discharge to hospital, then the assigned PDPM value is CBC2.

Q11: In cases where the resident leaves before day 14 and MDS admission assessment is not required, would you advise facilities to complete MDS for PDPM value or will there be automatic scores issued for these patients?

A11: Please see the prior response for the assigned PDPM values and follow the RAI Manual when completing MDS assessments.

Q12: If a resident is admitted before the end of the quarter, but the first MDS is not completed by the end of the quarter, will there be a "mean" or average PDPM CMI utilized for the days in that quarter?

A12: No. Days and CMI from the timely assessment completed in the new quarter will be applied starting with the Admission Date in the prior quarter.

Q13: Do we need to set up ARD from 7/1/2024 for PDPM conversion or just continue OBRA schedule?

A13: No, just continue your OBRA schedule.

Q14: Do we need to separate 5 day and OBRA MDS assessments in case the resident has Medicare and Medicaid?

A14: No, combined PPS and OBRA MDS assessments may be done in accordance with the RAI Manual.

Q15: Do we need to complete a new OBRA MDS once a resident converts from private insurance into Medicaid or can we use last completed MDS? And if we do, do we need to correct Medicaid Number in last completed MDS?

A15: No, since facilities are federally required to complete quarterly OBRA assessments, new OBRA assessments are not required when a resident's payment source changes from private insurance to Medicaid. Additionally, Medicaid Number does not need to be input on prior assessments in this scenario.

Q16: How long do MDS coordinators have to make corrections to an MDS? How does this effect the final rate for the facility?

A16: Facilities have until the date before the rate effective date for assessments to be considered in final rate setting. For example, for rates effective July 1, 2024, which use assessments active between January 1, 2024, and March 31, 2024, the cut-off date is June 30, 2024.

Q17: Is KY still a daily snap shot for case mix?

A17: No. Kentucky continues to use a time weighted system where it looks at the entire quarter, and not a point in time snapshot. This transition from point in time to time weighted occurred in 2008.

Q18: Can we complete OBRA MDS at end of one quarter and in the beginning of Next Quarter (so may be only 5-7 days in between) to carry over extra care rendered?

A18: You won't need to do this because the rosters use a time weighted system and the number of days that each assessment is active will be used in calculating the average CMI. MDS Assessments should be completed according to the RAI Manual.

Q19: Will Myers and Stauffer post a calendar with Posting Dates and Transmission Cut-Off Dates?

A19: Yes, a calendar will be added to the Myers and Stauffer website.

Q20: Will you be releasing statewide PDPM CMI averages when Q1 2024 finalized?

A20: These will be released on Myers and Stauffer's website (https://myersandstauffer.com/client-portal/kentucky/) after the July 2024 rates have been finalized and posted.

Provider Tax

Q21: What is the current bed tax rate for SNF and what will it be going to 7/1/2024?

A21: Please see the below comparison:

Provider Tax Class	**Rate Effective 7/1/2013 – 6/30/2024**	**Rate Effective 7/1/2024**
Hospital Based NF	$3.64	$5.63
NF with ICF and fewer than 60 beds	$1.82	$2.82
NF with less than 60,000 days	$12.85	$19.89
NF with greater than 60,000 days	$4.12	$6.38

The current allowance is $9.64, and effective July 1, 2024, it will be increased by $31.79 to $41.43. This has been communicated to the Department of Revenue.

Quality Program

Q22: For the quality program, it is using high risk residents with pressure ulcers? The new QM is now just residents with pressure ulcers. CMS retired the high risk pressure ulcers. Is this going to change to what CMS is now using?

A22: Since implementation will be in SFY 2026, this will give time for the new pressure ulcer measure to be in place and to be used for reporting.

Q23: What does Medicaid utilization mean for the quality program?

A23: The Medicaid utilization metric will be used alongside the other metrics as a means to balance out the scores for facilities that may not perform as well with the MDS Quality Measures due to receiving residents with these conditions from other care settings.

Q24: Have parameters been determined for each measure of the new quality program? Is there a calculation model yet?

A24: This is still being discussed for implementation in SFY 2026.

Bed Reserve

Q25: Will the change for all facilities being paid 75% of their per diem rate apply to leave of absence days in addition to hospital leave days?

A25: Yes, this change applies to both types of bed reserve days.

Q26: Can facilities go ahead and apply their systems change for 75% bed reserve reimbursement for the 7/1/24 effective date?

A26: Yes.

Ancillary Add On

Q27: Do ancillaries include drugs?

A27: No. Over the counter pharmaceuticals are included in the per diem rate and the pharmacy program will continue to separately reimburse prescription drugs.

Q28: Do facilities still need to have these charges on their UB04's that are billed to Medicaid, but Medicaid will pay at a zero payment?

A28: No, you don't have to bill at all for ancillary services on and after July 1, 2024. You will need to keep track of the services you are providing (to report on the Ancillary Supplemental Schedules), but you do not need to bill.

Q29: Will you be required to call in ancillary oxygen services?

A29: No, prior authorizations will no longer be required as of July 1, 2024.

Q30: Are the ancillary services reported on the Ancillary Supplemental Schedules based on Medicaid only residents?

A30: Yes, you will only complete the Medicaid Ancillary Supplemental Schedules for the same services you are billing Medicaid today for your Medicaid only residents. (Medicare B is not included.)

Q31: Can you share an Excel version of the Ancillary Supplemental Schedule?

A31: Yes, this will be shared to the Myers and Stauffer website (https://myersandstauffer.com/client-portal/kentucky/) once it is finalized.

Q32: Where is the NF-7 schedule (referenced on the Summary tab of the Ancillary Supplemental Schedules) ?

A32: This is part of the Kentucky Medicaid Supplemental Schedules for your annual cost report submission, which can be downloaded at https://myersandstauffer.com/client-portal/kentucky/

Q33: For Ancillary add-on at 7/1/24, will it be based on claims paid in CY 2023?

A33: Yes.