

Kansas Administrative Regulations

Kansas Department for Children and Families

Article 10.—Adult Care Home Program

30-10-214. ICF-MR rates of reimbursement.

(a) Rates for ICF's-MR.

(1) The determination of per diem rates shall be made, at least annually by the secretary, on the basis of the cost information supplied by the provider, and retained for cost auditing. The cost information for each provider shall be compared with limits established based on the level of care needs of clients to determine the allowable per diem cost.

(2) Ownership allowance shall be determined as follows:

(A) All ICF's-MR initially certified to participate in the medicaid/medikan program prior to July 1, 1991 shall be held to the established ownership allowance.

(B) All ICF's-MR certified on or after July 1, 1991 shall be subject to an absolute cap on ownership costs.

(3) Per diem rates for the following cost centers shall be limited by absolute caps.

(A) The cost center limits shall be based on facility size and level of care. The cost centers and limiting factors shall be:

(i) Direct service based on facility size and level of care. Direct service consists of the room and board and health care cost centers in the ICF-MR financial and statistical report;

(ii) administration based on facility size; and

(iii) plant operating based on total allowable costs;

(B) The absolute caps shall be reviewed at least annually for reasonableness based on the reimbursement model and the allowable historical costs. The absolute caps shall be approved by the secretary or a designated official.

(4) To establish a per diem rate for each provider by facility size and level of care, a factor for inflation may be added to the allowable per diem cost. The per diem rate shall be based on the lower of the actual allowable cost or the absolute cost center limits. A

detailed listing of the computation of the rate shall be provided to each provider. The effective date of the rate for existing facilities shall be in accordance with subsection (a) of K.A.R. 30-10-215.

(b) Comparable service rate limitations.

(1) Intermediate care facilities for the mentally retarded and persons with related conditions. The per diem rate for intermediate care for the mentally retarded and persons with related conditions shall not exceed the rate charged to clients not under the medicaid/medikan program for the same level of care in the ICF-MR and for the same type of service.

(2) All private pay rate structure changes and the effective dates shall be reported on the uniform cost report.

(3) The ICF-MR shall notify the agency of any private pay rate structure changes within 30 days of the effective date of a new medicaid rate.

(4) Providers shall have a grace period to raise the rate or rates charged to clients not under the medicaid/medikan program for the same level of care in the ICF-MR.

(A) The grace period shall end the first day of the third calendar month following the notification date of a new medicaid/medikan rate.

(B) The notification date is the date typed on the letter which informs the provider of a new medicaid/medikan rate.

(C) There shall be no penalty during the grace period if the rate charged to clients not under the medicaid/medikan program is lower than the medicaid/medikan rate for the same level of care in the ICF-MR and for the same type of service.

(D) If the rate charged to clients not under the medicaid/medikan program is lower than the rate charged to medicaid/medikan clients after the grace period, the medicaid/medikan rate will be lowered as of the original effective date of the most recent changes.

(c) Rates for new construction or bed additions. The per diem rate for newly constructed ICF's-MR shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-213. No rate shall be paid until an ICF-MR financial and statistical report is received and approved. Limitations established for existing facilities

providing the same level of care shall apply. The effective date of the per diem rate shall be in accordance with K.A.R. 30-10-215.

(d) Change of provider.

(1) When a new provider makes no change in the facility, number of beds or operations, the interim payment rate for the first 12 months of operation shall be based on the historical cost data of the previous owner or provider. The new owner or provider shall file a 12-month historical cost report within three months after the end of the first 12 months of operation and within three months after the end of the provider's fiscal year established for tax or accounting purposes. The rate determined from the historical cost reports shall be effective in accordance with K.A.R. 30-10-215.

(2) The agency may approve a new rate based on a projected cost report when the care of the clients is certified by the Kansas department of health and environment to be at risk because the per diem rate of the previous provider is not sufficient for the new provider to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

(e) Per diem rate errors.

(1) When the per diem rate, whether based upon projected or historical cost data, is audited by the agency and is found to contain errors, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider no longer operates a facility with an identified overpayment, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation unless other arrangements have been made to reimburse the agency. A net settlement may be made when a provider has more than one facility involved in settlements.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit on the provider's cost reports. Written notice of per diem rate changes and desk review or audit findings shall be sent to the provider. Retroactive adjustments of the rate paid during any projection period shall apply to the same period of time covered by the projected rate.

(3) Providers may request an administrative review of the audit adjustments that result in an overpayment or underpayment within 30 days from the date of the audit

report cover letter. The request shall specify the finding or findings that the provider wishes to have reviewed.

(4) Any audit exception imposed on the agency by the department of health and human services due to provider action may be recovered from the provider.

(f) ICF-MR closure. An ICF-MR may submit a plan to the agency to individually place all residents out of the facility, close the facility permanently and cease operations as a certified ICF-MR.

(1) The plan for ICF-MR closure shall include:

(A) A schedule for the placement of residents out of the facility; and

(B) a projected budget for the cost of operating the facility while closure is occurring.

(2) The plan for ICF-MR closure shall be reviewed for reasonableness. If approved by the secretary, the plan may be implemented as written.

(3) The facility may be reimbursed on a projected basis for cost of operating the facility while closure is occurring according to the agreed upon plan. Reimbursement may exceed limits established for any cost centers for ICF's-MR including but not limited to:

(A) Administration;

(B) ownership allowance;

(C) plant operating; and

(D) direct service, including room and board and habilitation.

(4) After the ICF-MR ceases operation, an audit of the actual costs incurred during implementation of the approved closure plan shall be conducted.

(A) If the actual overall costs incurred during closure are not as great as the costs projected in the approved closure plan, the facility shall repay the difference to the agency.

(B) If the actual overall cost incurred during closure meets or exceeds the projected costs in the approved closure plan, no additional payment shall be made to the ICF-MR.

(5) If the ICF-MR does not close as agreed upon, the ICF-MR must repay the excess of the amount paid under the closure agreement above the regular payments the ICF-MR would have received, based on the most recent historical actual cost report, if the ICF-MR had not submitted a closure plan to the agency.

(g) Provision of services out-of-state. Rates for clients served out-of-state by certified participants in a medicaid program shall be the rate or rates approved by the agency. All payments made for services provided outside the state of Kansas require prior authorization by the agency. The effective date of this regulation shall be October 1, 1992.

(Authorized by and implementing K.S.A. 1991 Supp. 39-708c, as amended by 1992 SB 182, Sec. 5; effective, T-30-12-28-90, Dec. 28, 1990; effective March 4, 1991; amended Oct. 1, 1991; amended Oct. 1, 1992.)

***** Authenticated Kansas Administrative Regulation *****