

Methods and Standards for Establishing Payment Rates for Nursing Facility Services

For facilities receiving both an ICF and SNF Medicaid rate on June 30, 2001, the June 30, 2001, Medicaid rate referenced above is the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

The subsections below reflect the details of this reimbursement plan.

2. Definition of Allowable Costs and Calculation of Per Diem Costs

Allowable costs are determined using Medicare methods. Cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and is not in excess of what a prudent and cost-conscious buyer would pay for the given services or item. Only these costs are considered in calculating the Medicaid nursing facility reimbursable cost per diem for purposes of this section.

For purposes of calculating the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, facility costs are divided into two components:

- The “direct care component” is the portion attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services.
- The “non-direct care component” is the portion attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

Each nursing facility’s per diem allowable direct care and non-direct care cost shall be established.

Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. For the period beginning July 1, 2021, per diem allowable costs shall be arrived at by dividing total reported allowable costs by total inpatient days during the July 1, 2019 reporting period.

Effective April 1, 2023, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to, April 1, 2023.

3. Cost Normalization

The per diem allowable direct care costs are normalized by dividing a facility’s per diem direct care costs by the facility’s cost report period case-mix index. The facility cost report period case-mix index is the average of quarterly facility-wide average case-mix indices, carried to four decimal places.

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The quarters used in this average are the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2001-12/31/2001 financial reporting period would use the facility-wide average case-mix indices for quarters ending 03/31/01, 06/30/01, 09/30/01, and 12/31/01.

4. Calculation of Patient-Day-Weighted Medians

A patient-day-weighted median is established for each of the Medicare-certified hospital-based nursing facility rate components.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the direct care and non-direct care patient-day-weighted medians shall be calculated using the latest Medicare cost report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001.

Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated, using the latest completed Medicare cost report with a fiscal year end of the preceding December 31 or earlier. Effective April 1, 2023, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period April 1, 2023.

5. Excess Payment Allowance Calculation

The Medicare-certified hospital-based nursing facility excess payment allowance is calculated as follows:

- a. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to zero (0) percent times the difference of the following (if greater than zero):
 - The direct care patient-day-weighted median times 95 percent times the provider’s Medicaid average case-mix index, minus
 - A provider’s normalized allowable per patient day direct care costs times the provider’s Medicaid average case-mix index.

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However, for purposes of calculating the per diem cost for administrative, environmental, and property expenses, total patient days are the greater of the actual inpatient days or 85 percent of the facility’s license capacity.

Effective April 1, 2023, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to April 1, 2023.

b. Cost Normalization

The per diem allowable direct care costs are normalized by dividing a facility’s per diem direct care costs by the facility’s cost report period case-mix index. The facility cost report period case-mix index is the average of quarterly facility-wide average case-mix indices, carried to four decimal places.

The quarters used in this average are the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2001-12/31/2001 financial reporting period would use the facility-wide average case-mix indices for quarters ending 03/31/01, 06/30/01, 09/30/01, and 12/31/01.

c. Calculation of Patient-Day-Weighted Medians

A patient-day-weighted median is established for each of the non-state-owned nursing facility rate components.

The per diem normalized direct care cost for each non-state-owned facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities.

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For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001.

Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated using the latest completed financial and statistical report with a fiscal year end of the preceding December 31 or earlier. Effective April 1, 2023, and thereafter, total reported allowable costs shall be adjusted for inflation, using the SNF total market basket index, from the midpoint of the cost report period to April 1, 2023.

d. **Excess Payment Allowance Calculation**

Two classes of non-state-operated providers are recognized for computing the excess payment allowance calculation.

- Facilities that are located in a metropolitan statistical area (MSA) as defined by CMS.
- Facilities that are not located in an MSA.

For non-state-operated facilities not located in an MSA, the excess payment allowance is calculated as follows:

- (1) For the direct care component, subject to the limit provided below, the excess payment allowance is equal to zero (0) percent times the difference of the following (if greater than zero):
 - The direct care non-state-operated patient-day-weighted median times 95 percent times the provider's Medicaid average case-mix index, minus
 - A provider's normalized allowable per patient day direct care costs times the provider's Medicaid average case-mix index.

In no case shall the excess payment allowance exceed ten percent times the non-state-operated direct care patient-day-weighted median.

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K. Nursing Facility Quality Assurance Assessment Pass-Through and Quality Assurance Rate Add-On

1. Quality assurance assessment pass-through. Effective April 1, 2023, a quality assurance assessment pass-through rate shall be added to the Medicaid reimbursement rate as otherwise calculated pursuant to Section 4.19-D. The quality assurance assessment pass-through rate shall be equal to the quality assurance assessment Medicaid cost divided by Medicaid patient days.
2. Quality assurance assessment rate add-on. Effective April 1, 2023, a quality assurance rate add-on of \$37.00 per patient day shall be added to the Medicaid reimbursement rates as otherwise calculated pursuant to Section 4.19-D.

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