Capital Cost Per Diem Instant Relief Add-on and Enhanced Non-direct Care Rate Component Limit

For rates effective October 1, 2007, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations.

A "complete replacement" means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

"Major renovations" means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds $1.5 million. The $1.5 million threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility's financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the $1.5 million threshold.

"New construction" means the construction of a new nursing facility that does not replace an existing licensed and certified facility and requires the provider to obtain a certificate of need pursuant to Iowa Code Chapter 125, division VI.

A. Two types of additional reimbursement are available:

   1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit.

   2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit. The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

B. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care component limit, or both, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

   1. Rectification of a violation of life safety code requirements; or
   2. Providing home- and community-based waiver program services.

A facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent for the two-month period before the request for additional reimbursement is submitted. Medicaid utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total licensed bed capacity as reported on the most current financial and statistical report.
2. The facility meets the accountability measure criteria set forth in Supplement 3 to Attachment 4.19-D Measure 1, deficiency free survey, or Measure 2, regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.
3. The facility has documented active participation in a quality of care program.
4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

In addition, a facility with an eligible project for the purpose of providing home- and community-based waiver program services must also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.
2. Services shall be provided on the direct site of the facility but not as a nursing facility service.
3. Services shall meet all federal and state requirements for Medicaid reimbursement.
4. Services shall include one or more of the following: adult day care as defined by IAC 441--subrule 78.37(1), consumer directed attendant care as defined by IAC 441--subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by IAC 441--subrule 78.41(14), home-delivered meals as defined by IAC 441--subrule 78.37(8), personal emergency response as defined by IAC 441--subrule 78.37(2), and respite as defined by IAC 441--subrule 78.37(6).

C. Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit at 100 Army Post Road, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.
2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

D. Content of request for add-on. A facility's request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a timeline of the project that spans the life of the project.
2. Documentation that the facility meets the applicable qualifications in paragraph B.
3. The period during which the add-on is requested (no more than two years).
4. Whether the facility is also requesting the enhanced non-direct care rate component limit.
5. A copy of the facility's most current depreciation schedule which clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule and that schedule shall include the amount of the depreciation expense for removed assets that is included in the current reimbursement rate.
6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project shall be submitted including the following:
   - The estimated date the assets will be placed into service;
   - The total estimated depreciable value of the assets;
   - The estimated useful life of the assets based upon existing Medicaid and Medicare provisions; and
   - The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.
   - Separately identify any assets that are used to provide non-nursing facility services only.
   - Any cost of the project furnished by a related party or organization must be reported as set forth in Supplement 2 to Attachment 4.19-D, 4c, "Items furnished by related organizations."
7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days shall be determined using the most current submitted financial and statistical report.
8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.
9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

10. A copy of the facility's allocation methodology used to allocate allowable costs between nursing facility services and non-nursing facility services.

E. Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced component limit is requested, including a list of goals for the project and a timeline of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in paragraph B.

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

F. Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for nursing facility services for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual nursing facility total patient days.

1. Nursing facility total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity.

2. The annual estimated property costs for nursing facility services is calculated as the total annual estimated property costs less estimated annual property costs for non-nursing facility services.

3. The total annual estimated property costs for the project is calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

4. A reconciliation between the estimated amounts and actual amounts shall be completed as described in paragraph I.

G. Effective date of capital cost per diem instant relief add-on. A capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit.

H. Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biannual rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biannual rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

I. Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid Enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. For purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid.
2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit. The facility's quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

J. Effective date of enhanced non-direct care rate component limit. An enhanced non-direct care rate component limit shall be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or
2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

K. Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the non-direct care rate component limit amount changes during the period for which a facility is granted the enhanced limit, the approval shall be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

L. Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the Iowa Medicaid Enterprise is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or
2. The facility does not make reasonable progress on any plans required for initial qualification; or
3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or enhanced non-direct care rate component.

M. Change of ownership. Following a change in ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted to the sold nursing facility shall continue under the new owner. Future reimbursement rates shall be determined pursuant to IAC 441--81.6(15) and 81.6(16).