Methods and Standards for Establishing Payment Rates for Nursing Facility Services

A. Medicare-Certified Hospital-Based Facilities That Provide Only Skilled-Level Care

1. Introduction

Hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care receive Medicaid reimbursement based on a modified price- based case-mix system. This system is based on the provider's allowable costs for two components, direct care and non-direct care, plus a potential excess payment allowance. The case-mix system reflects the relative acuity or need for care of the Medicaid recipients in the nursing facility.

Payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data and adjusted semi-annually to account for changes in the Medicaid day- weighted case-mix index. Effective July 1, 2024, and thereafter there will not be semi-annual updates.

a. The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed $94, and 33.33 percent of the July 1, 2001, modified price- based rate.

   In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

b. Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be:

   - 33.33 percent of the facility's Medicaid rate effective June 30, 200 I, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the HCFNSNF Total Market Basket Index, not to exceed $94, times an inflation factor; and
   - 66.67 percent of the July 1, 2002, modified price-based rate.

   In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor projected for the following l2 months.

c. Payment rates for services rendered from July l, 2003, and thereafter will be 100 percent of the modified price-based rate.

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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.

Effective July 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 January 1, 2020 less an additional 1.5%. Effective July 1, 2024, rates will use the amounts in effect at June 30, 2024.

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 day-weighted case-mix index for the cost report period, 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 01/0l/2001- 12/31/200 I financial reporting period would use the facility-wide day-weighted 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 Medicaid 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 Medicaid cost report with a fiscal year end of the preceding December 31 or earlier. Effective July 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 January 1, 2020 less an additional 1.5%. Effective July 1, 2024, rates will use the amounts in effect at June 30, 2024.

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 day-weighted case-mix index, minus
   - A provider's normalized allowable per patient day direct care costs times the provider's Medicaid day-weighted case-mix index.

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A. Other Non-State-Owned Nursing Facilities

The methodology in this section applies to all nursing facilities that are not state-owned, including facilities for people with mental illness who are aged 65 or over, except for:

- Hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care (see Section A)
- Facilities serving special populations (see Section D)

1. Introduction

Non-state-owned nursing facilities receive Medicaid reimbursement based on a modified price-based case-mix system. This system is based on the provider's allowable costs for two components, direct care and non-direct care, plus a potential excess payment allowance. The case-mix system reflects the relative acuity or need for care of the Medicaid recipients in the nursing facility.

Payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted semi-annually to account for changes in the Medicaid day-weighted case-mix index. Effective July 1, 2024, and thereafter there will not be semi-annual updates.

a. The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 200I, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed $94, and 33.33 percent of the July 1, 2001, modified price- based rate.

   In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

b. Payment rates for services rendered from July **1,** 2002, through June 30, 2003, shall be:

   - 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the HCFNSNF Total Market Basket Index, not to exceed $94, times an inflation factor; and
   - 66.67 percent of the July 1, 2002, modified price-based rate.

   In no case shall the July l, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor projected for the following 12 months.

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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.

For the rate period beginning July 1, 2023, and ending June 30, 2025, 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 70 percent of the facility's license capacity.

Effective July 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 January 1, 2020 less an additional 1.5%. Effective July 1, 2024, rates will use the amounts in effect at June 30, 2024.

c. 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 day-weighted case-mix index for the cost report period, 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 day-weighted case-mix indices for quarters ending 03/31/01, 06/30/01, 09/30/01, and 12/31/01.

d. 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 July 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 January 1, 2020 less an additional 1.5%. Effective July 1, 2024, rates will use the amounts in effect at June 30, 2024.

e. 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 day-weighted case- mix index, minus
- A provider's normalized allowable per patient day direct care costs times the provider's Medicaid day-weighted 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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a. Reimbursement Rate

The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter and adjusted semi-annually to account for changes in the provider's Medicaid day-weighted case-mix index, plus a potential excess payment allowance and a capital cost per diem instant relief add-on for qualifying nursing facilities as described in Supplement 4 to Attachment 4.19-D, not to exceed an overall rate component limit. Effective July 1, 2024, and thereafter there will not be semi-annual updates.

The direct care and non-direct care rate components are calculated as follows:

- The direct care component is equal to the provider's normalized allowable per patient day costs times the provider's Medicaid day-weighted case-mix index plus the allowed excess payment allowance.

  For facilities located in a metropolitan statistical area, the component limit is the direct care non-state-owned nursing facility patient-day- weighted median times 120 percent times the wage index factor times the provider's Medicaid day-weighted case-mix index.

  For facilities not located in a metropolitan statistical area, the component limit is the direct care non-state-owned nursing facility patient-day-weighted median times 120 percent times the provider's Medicaid day-weighted case-mix index.

- The non-direct care component is equal to the provider's allowable per patient day costs plus the allowed excess payment allowance and the capital cost per diem instant relief add-on for qualifying nursing facilities. The component limit is the non-direct care non-state-owned nursing facility patient-day-weighted median times 110 percent or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit as described in Supplement 4 to Attachment 4.19-D.

C. Case Mix Index Calculation

Effective July 1, 2025, resident reimbursement classification and case mix index shall be established utilizing the Patient Driven Payment Model (PDPM) nursing component classification methodology and associated weights, as published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

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From the individual resident case-mix indices, two day-weighted case-mix indices for each Medicaid nursing facility shall be determined four times per year. The quarterly day-weighted-case mix index will be calculated using each assessment that is active during each quarter. The number of days each assessment is active is multiplied by the appropriate case-mix weight. Each quarter the sum of all the days multiplied by the case-mix index is divided by the days to determine the day-weighted case-mix indices.

- The facility-wide day-weighted case-mix index uses all resident day-weighted case- mix indices.
- The Medicaid-day-weighted case-mix index uses the day-weighted case-mix indices for residents where Medicaid is known to be the per diem payer source.

Assessments that cannot be classified to a Patient Driven Payment Model (PDPM) group due to errors are excluded from both day-weighted case-mix index calculations.

D. Limits on Expenses

Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs.

b. Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

c. Bad debts are not an allowable expense.

d. Charity allowances and courtesy allowances are not an allowable expense.

e. Personal travel and entertainment are not allowable as reimbursable costs. Expenses such as rental or depreciation of a vehicle and expenses of travel that include both business and personal costs shall be prorated. Amounts that appear to be excessive may be limited after consideration of the specific circumstances.

(1) Commuter travel by the owners, owner-administrators, administrator, nursing director or any other employee from private residence to facility and return to residence is not an allowable cost.

(2) The expense of one car or one van or both designated for use in transporting patients is an allowable cost.

(3) Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption from public transit coordination requirements after receipt from the Iowa Department of Transportation. shall result in _disallowance of vehicle costs and other costs associated with transporting residents.