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 quarterly to account for changes in the Medicaid average case-mix index.

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, 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 HCFA/SNF 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 12 months.

c. Payment rates for services rendered from July 1, 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, 2013, 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, 2012.

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. For rates effective July 1, 2013, and thereafter, inflation is applied from the midpoint of the cost report period to January 1, 2012, using the SNF total market basket index.

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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In no case shall the excess payment allowance exceed ten percent times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

b. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to 65 percent times the difference of the following (if greater than zero):

- The non-direct care patient-day-weighted median times 96 percent,
- Minus a provider's allowable per patient day non-direct care cost.

In no case shall the excess payment allowance exceed eight percent times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

6. **Reimbursement Rate**

The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter and adjusted quarterly to account for changes in the provider's Medicaid average 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.

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 average case-mix index plus the allowed excess payment allowance.
- 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.

In no instance shall a rate component exceed the rate component limit, defined as follows:

- The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times 120 percent times the provider's Medicaid average case-mix index.
- The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based 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.

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7. **Reserve for future use.**

8. **Exceptions to the Rate-Setting Process**

Exceptions to the rate-setting process are made under the following circumstances:

a. Ventilator Incentive

A special rate to care for ventilator-dependent patients is paid to a facility if the patient meets the requirements for skilled and ventilator care. The reimbursement rate is equal to the sum of the Medicare-certified hospital-based nursing facility direct care rate component limit plus the Medicare-certified hospital-based nursing facility non-direct care rate component limit.

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8. **Exceptions to the Rate-Setting Process (Cont.)**

   b. Fraud and Abuse

   When fraud or abuse has been verified, the facility's prospective reimbursement rate shall be adjusted. If the facility's base year cost is subsequently determined to have been based on false or misleading information, an appropriate adjustment shall be made to the base year rate and all resulting overpayments shall be recouped. Such adjustments do not preclude other sanctions authorized by statute or regulation.

9. (Reserved for future use.)

10. **Revaluation of Assets**

    The provisions of Section 1902(a)(13)(c) of the Social Security Act shall be followed.

11. **Provider Appeals**

    In accordance with 42 CFR 447.253(c), if a provider of service is dissatisfied with the determination of the base year allowable cost, the provider may file an appeal and request reconsideration from the Administrator of the Division of Medical Services in the Department. The appeal must be in writing, clearly state the nature of the appeal, and be supported with all relevant data.

    The Administrator of the Division of Medical Services will review the material submitted, render a decision and advise the provider accordingly within a period of 90 days.

12. **Cost Reporting**

    Each participating facility must file an annual uniform cost report. The reporting forms used in Medicare will be used as the facility's Medicaid cost report.

13. **Audits**

    Each participating facility is subject to a periodic audit of its fiscal and statistical records.

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A. Nursing Facilities That Provide Skilled Care (Cont.)

14. Provisions for Government-Owned Facility Proportionate-Share Pool

A proportionate-share pool is created to increase reimbursement to city-owned, county-owned, and state-owned facilities in proportion to their share of the Medicaid days that are provided in these facilities during the reporting period used to set rates.

The pool is created subject to availability of funds and subject to the payment limits of 42 CFR 447.272 (Application of Upper Payment Limits: payments may not exceed the amount that can reasonably be estimated to be paid under Medicare payment principles).

The Social Security Act requires that the Secretary of the Health Care Financing Administration update the Medicare rates in the Federal Register. These are to be published before August 1 of the year preceding the affected federal fiscal year. For the initial period of the Medicare prospective payment system (PPS) beginning on July 1, 1998, and ending on September 30, 1999, the payment rates were published in the May 12, 1998, Federal Register.

For fiscal years 2000 through 2002, the Medicare rates will be increased by a factor equal to the SNF market basket index amount minus 1 percentage point. For subsequent fiscal years, the Medicare rates will increase by the applicable SNF market basket index amount. The fiscal intermediary for the Medicare program also publishes the SNF revised cost limits and prospective payment rates for the state.

Under the Medicare PPS, there are 44 levels of payment based upon a case-mix-adjusted RUG category with a wage index applied for each urban and rural area. The applicable rate for each individual Iowa facility is compared to its Medicaid per diem allowable under this section during a report period.

The difference between the upper payment limit and the facility's per diem is multiplied by the number of Medicaid inpatient days in that facility for the report period. That product is then summed for all Iowa facilities, minus the laboratory, radiology, outpatient, and pharmacy costs. This total is the maximum pool that can be paid for each report period.

An estimated pool for each report period (ending June 30) is calculated and distributed on or about September 1 of that report period. Each facility's distribution amount is based on its estimated proportionate share (based on its share of Medicaid inpatient days) of the pool.

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A. **Nursing Facilities That Provide Skilled Care (Cont.)**

14. Provisions for Government-Owned Facility Proportionate-Share Pool (Cont.)

The estimated pool and the facilities' estimated proportionate share are reconciled after final cost reports are received and final calculations made. Estimated amounts will be compared to final calculations, and necessary adjustments will be made to the facility's estimated distribution in the subsequent distribution.

The initial proportionate share pool is created beginning October 1, 1999. Because this is the three-fourths of the July 1, 1999 through June 30, 2000, reporting period, the pool is prorated to three-fourths. The estimated distribution date for this initial prorated period is on or about September 1, 2000.

The provisions detailed in Attachment 4.19-D, Section A.14, Nursing Facilities That Provide Skilled Care, Provisions for Government-Owned Facility Proportionate-Share Pool, will end effective June 30, 2005.

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B. 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 quarterly to account for changes in the Medicaid average case-mix index.

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, 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 HCFA/SNF 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 12 months.

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c. Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

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. Establishment of Modified Price-Based Reimbursement Rate

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

Cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary, and necessary; and does not exceed:

- What a prudent and cost-conscious buyer would pay a willing seller for the given services or item in an arms-length transaction.
- The limits set out in this attachment.

Only these costs are considered in calculating the Medicaid nursing facility reimbursable cost per diem for purposes of this section.

Non-state-owned nursing facilities are required to complete a financial and statistical report approved by the Department. For purposes of calculating the non-state-owned 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.

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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 July 1, 2013, 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, 2012.

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. For rates effective July 1, 2013, and thereafter, inflation is applied from the midpoint of the cost report period to January 1, 2012, using the SNF total market basket index.

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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(2) For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to zero (0) percent time the difference of the following (if greater than zero):

- The non-direct care non-state-operated patient-day-weighted median times 96 percent, minus
- A provider's allowable non-direct care cost per patient day.

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

For non-state-operated nursing facilities 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 wage index factor specified below times the provider's Medicaid average case-mix index, minus
- The provider's normalized allowable normalized 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.

The wage index factor applied July 1, 2001, through June 30, 2002 shall be 11.46 percent. Beginning July 1, 2002, and thereafter, the wage index factor shall be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based MSA wage indices, as published by the CMS each July. The geographic wage index adjustment shall not exceed $8 per patient day.

(2) For the non-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 non-direct care non-state-operated patient-day-weighted median times 96 percent, minus
- The provider's allowable per patient day non-direct care cost.

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

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e. Reimbursement Rate

The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter and adjusted quarterly to account for changes in the provider's Medicaid average 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.

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 average 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 average 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 average 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.

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Additional reimbursement for non-state-owned nursing facilities based on accountability measures shall also be available beginning July 1, 2002, in amounts up to 3 percent of the sum of the non-state-owned nursing facility direct care patient-day-weighted median plus the non-state-owned nursing facility non-direct care patient-day-weighted median.

See Supplement 3 to Attachment 4.19-D for a description of these accountability measures.

f. Exceptions to the Rate-Setting Process

Exceptions to the rate-setting process are made under the following circumstances:

(1) Ventilator Incentive

A special rate to care for ventilator-dependent patients is paid to a facility if the patient meets the requirements for skilled and ventilator care. The reimbursement rate is equal to the sum of:

- The Medicare-certified hospital-based nursing facility direct care patient-day-weighted median times 120 percent times the provider's Medicaid average case mix index, plus
- The Medicare-certified hospital-based nursing facility non-direct care rate patient-day-weighted median times 110 percent.

(2) Fraud and Abuse

When fraud or abuse has been verified, the facility's prospective reimbursement rate shall be adjusted. If the facility's base year cost is subsequently determined to have been based on false or misleading information, an appropriate adjustment shall be made to the base year rate and all resulting overpayments shall be recouped. Such adjustments do not preclude other sanctions authorized by statute or regulation.

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B. Nursing Facilities That Provide Intermediate Care Including Intermediate Care for Persons with Mental Illness Age 65 and Older (Cont.)

3. Provisions for Government-Owned Facility Proportionate-Share Pool

A proportionate share pool is created to increase reimbursement to city-owned, county-owned, and state-owned facilities in proportion to their share of Medicaid days that are provided in these facilities during the reporting period used to set rates.

The pool is created subject to availability of funds and subject to the payment limits of 42 CFR 447.272 (Application of Upper Payment Limits: payments may not exceed the amount that can reasonably be estimated to be paid under Medicare payment principles).

The Social Security Act requires that the Secretary of the Health Care Financing Administration update the rates in the Federal Register. These are to be published before August 1 of the year preceding the affected federal fiscal year. For the initial period of the Medicare prospective payment system (PPS) beginning on July 1, 1998 and ending on September 30, 1999, the payment rates were published in the May 12, 1998, Federal Register.

For fiscal years 2000 through 2002, the Medicare rates will be increased by a factor equal to the SNF market basket index amount minus 1 percentage point. For subsequent fiscal years, the Medicare rates will increases by the applicable SNF market basket index amount. The fiscal intermediary for the Medicare program also publishes the SNF revised cost limits and prospective payment rates for the state.

Under the Medicare PPS, there are 44 levels of payment based upon a case-mix-adjusted RUG category with a wage index applied for each urban and rural area. The applicable rate for each individual Iowa facility is compared to the facility's Medicaid per diem allowable under this section during a report period.

The difference between the upper payment limit and the facility's per diem is multiplied by the number of Medicaid inpatient days in that facility for the report period. That product is then summed for all Iowa facilities, minus the laboratory, radiology, outpatient, and pharmacy costs. This total is the maximum pool that can be paid for each report period.

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B. Nursing Facilities That Provide Intermediate Care, Including Intermediate Care for Persons with Mental Illness Age 65 and Older (Cont.)

2. Accounting Procedures (Cont.)

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C. Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

1. Introduction

Intermediate care facilities for the mentally retarded receive Medicaid reimbursement based on a prospective per diem rate calculated for each facility. These facilities complete a financial and statistical report approved by the Department to report their actual costs.

Accounting procedures, including designation of classes, setting the maximum allowable cost, and setting the inflation and incentive factors also follow.

2. Accounting Procedures

a. Designation of Classes of ICFs/MR

Two classes of providers are recognized. These are "state-owned" and "non-state-owned" (community-based) intermediate care facilities for the mentally retarded. Costs for each class are analyzed separately, but under a common procedure.

b. Maximum Allowable Cost Ceiling

The Department shall pay 100 percent of a facility's cost until such time as there are eight facilities in a class. Upon the inclusion of the eighth facility in a class, the maximum per diem reimbursement shall be determined at a level where 80 percent of the participating facilities are receiving full coverage of their cost. If there are no facilities at the eightieth percentile, the rate is then calculated to the eightieth percentile.

The December 31, 2000, report of "Unaudited Compilation of Various Costs and Statistical Data" shall be the base period for the calculation. This is the compilation of costs from the most current community-based facility cost reports for each participating facility on file as of December 31, 2000, with the exception of those facilities being paid a budgeted rate.

Effective July 1, 2001, the eightieth percentile maximum is established using the December 31, 2000, compilation.

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C. Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) (Cont.)

2. Accounting Procedures (Cont.)

c. Actual Allowable Cost and Rate Calculation

The actual allowable cost for ICFs/MR is the actual audited reported cost plus the inflation factor and incentive factor.

For community-based ICFs/MR, an occupancy factor is used in determining the actual per diem rate for the facility. Typically the per diem is arrived at by dividing the actual allowable reported costs by total patient days during the reporting period. Total patient days for purposes of rate determination are actual inpatient days or 80 percent of the licensed capacity of the facility, whichever is greater.

Effective July 1, 2002, for ICFs/MR, the owner/administrator compensation limits are $3,365 per month plus $35.90 for each bed over 60, for a maximum compensation not to exceed $4,986 per month.

New community-based ICFs/MR submit a six-month budget to generate an initial reimbursement rate for their first six months of operation. The budgeted financial and statistical reports do not receive inflation or incentive, but are limited to the maximum allowable cost ceiling.

Following six months of operation as a new community-based Medicaid-certified ICF/MR, the facility must submit a report of actual costs. This financial and statistical report is used to establish a rate which may include inflation but does not include an incentive.

The rate computed from this cost report is adjusted to 100 percent occupancy and continues to be subject to the maximum allowable cost ceiling. Business start-up and organization costs are amortized over a five-year period, according to Medicare and Medicaid standards.

All existing community-based facilities must report costs on a standard fiscal year of July 1 to June 30. Only one cost report is submitted per year.

State-owned ICFs/MR continue to submit semiannual cost reports and are not subject to the maximum allowable cost ceiling.

d. Inflation Factor

An inflation factor equal to the percentage increase of the Consumer Price Index for all urban consumers, U.S. city average. For the period beginning July 1, 2009, and ending June 30, 2010, the percentage increase shall be 3.0% instead of the CPI-U. An inflation factor shall be applied to the first six months and all subsequent cost reports submitted by new and existing ICFs/MR.

e. Incentive Factor

The incentive factor for new facilities shall be applied to the first six-month cost report files ending June 30 after a base rate has been established. The incentive factor for existing ICFs/MR shall be applied annually.

Facilities with a per diem cost percentage increase of less than the percentage increase of the Consumer Price Index shall be given their actual percentage increase plus one-half the difference of the Consumer Price Index less their actual percentage increase. This percentage difference times the actual per diem cost for the annual period just completed is the incentive factor.

For the period beginning July 1, 2009, and ending June 30, 2010, facilities with a per diem cost percentage increase of less than 3.0%, instead of the CPI-U, shall be given their actual percentage increase plus one-half the difference of 3.0%, instead of the CPI-U, less their actual percentage increase. This percentage difference times the actual per diem cost for the annual period just completed is the incentive factor for the period July 1, 2009, through June 30, 2010.

Facilities whose annual per diem cost decreased from the prior year shall be given one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment. One and one-half of the percentage increase of the Consumer Price Index times the actual per diem cost for the annual period just completed is the incentive factor.

For the period beginning July 1, 2009, and ending June 30, 2010, facilities whose annual per diem cost decreased from the prior year shall be given four and one-half percent of their actual per diem as an incentive for cost containment, instead of one and one-half of the percentage increase of the CPI-U.

f. Maximum Allowable Base Rate

(1) New Facilities

Following the first 12 months of operation as a Medicaid-certified ICF/MR, the facility shall submit a cost report for the second six months of operation and an on-site audit of facility costs shall be performed by the accounting firm under contract with the Department. Based on the audited cost report, a rate shall be established for the facility which shall be considered the base rate until rebasing of facility costs occurs.

The maximum allowable base rate for the first annual period will be determined by taking the per diem rate calculated for new facilities for the base period and then multiplying it by the Consumer Price Index and adding it to the base rate. For the period beginning July 1, 2009, and ending June 30, 2010, the percentage increase shall be 3.0%, instead of the CPI-U. See page 9 (paragraph c).

(2) Existing Facilities

The actual per diem cost from the January 1, 1992, to June 30, 1992, cost report shall become the initial allowable base rate for existing facilities. A new maximum allowable base rate will be calculated each year for existing facilities based on the June 30, 1992, cost report until rebasing occurs.

A new maximum allowable base rate will be calculated each year for existing facilities by increasing the prior year's maximum allowable base rate by the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average. For the period beginning July 1, 2009, and ending June 30, 2010, the percentage increase shall be 3.0%, instead of the CPI-U.

(3) All Facilities

The maximum allowable base rate for each period thereafter (until rebasing) will be calculated by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average. For the period beginning July 1, 2009 and ending June 30, 2010, the percentage increase shall be 3.0%, instead of the CPI-U.

Facility rates shall be rebased using the cost report for the year covering state fiscal year 1996 and shall subsequently be rebased each four years. The Department shall allow special rate adjustments between rebasing cycles if:

- An increase in the minimum wage occurs.
- A change in federal regulations occurs which necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes which necessitate the addition of staff or other resources.

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C. **Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) (Cont.)**

- A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure which increase costs. (Documentation and verification will be required).
- A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Reimbursement Rate (Payment Rate)

The budgeted reimbursement rate is the lower of the maximum allowable cost ceiling or the actual allowable per diem rate.

After the first six months of operation, the reimbursement rate is the lower of the maximum allowable cost ceiling or the actual allowable per diem rate.

The reimbursement rate for all subsequent cost reports is the lower of the maximum allowable cost ceiling, the actual allowable per diem rate, or the maximum allowable base rate.

h. Assessment Fee

Effective February 1, 2003, assessment fees paid by licensed intermediate care facilities for the mentally retarded (ICF/MR) that are not operated by the State will be recognized as an allowable cost.

For the purpose of immediately recognizing the cost of the assessment fee, rates shall be recalculated effective February 1, 2003, to reimburse facilities for Medicaid's share of the assessment.

To determine rates paid for services rendered after February 1, 2003, each facility's annual costs reported for periods before February 1, 2003, will be increased as necessary to reflect an amount equal to the annual cost of the assessment fees. These revised costs will then be used to recalculate the allowable payment rate as specified in Section C.2.g. of this plan. This adjustment to reported cost will continue until the providers' cost reports as submitted reflect the full annual cost of the assessment fees.

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C. **Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)** (Cont.)

Effective October 1, 2003, assessment fees paid by licensed intermediate care facilities for the mentally retarded that are operated by the State will be recognized as an allowable cost.

For the purpose of immediately recognizing the cost of the assessment fee, rates for State-operated facilities shall be recalculated effective October 1, 2003, to reimburse the facilities for Medicaid's share of the assessment.

To determine rates paid for services rendered by State-operated facilities after October 1, 2003, each facility's annual costs reported for periods before October 1, 2003, will be increased as necessary to reflect an amount equal to the annual cost of the assessment fees. These revised costs will then be used to recalculate the allowable payment rate as specified in Section C.2.g. of this plan. This adjustment to reported cost will continue until the providers' cost reports as submitted reflect the full annual cost of the assessment fees.

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D. State-Owned Nursing Facilities and Special Population Nursing Facilities

"Special population nursing facility" refers to a nursing facility that serves the following populations:

- 100 percent of the residents served are aged 21 and under and require the skilled level of care
- 70 percent of the residents served require the skilled level of care for neurological disorders

State-owned nursing facilities and special population nursing facilities receive Medicaid payment rates that are updated annually with new cost report data. State-owned and specialty population nursing facilities are required to complete a financial and statistical report approved by the Department.

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 special population nursing facilities enrolled on or after June 1, 1993, the upper limit on the Medicaid reimbursement rate is equal to the sum of the following:

- The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times 120 percent
- The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times 110 percent

E. Case Mix Index Calculation

The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model is used as the resident classification system to determine all case- mix indices, using data from the minimum data set (MDS) submitted by each facility.

Standard Version 5.12b case-mix indices developed by CMS are the basis for calculating the average case-mix index and are used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate.

Each resident in the facility with a completed and submitted assessment is assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index.

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From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year, based on the last day of each calendar quarter.

- The facility-wide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices.
- The Medicaid-average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payer source on the last day of the calendar quarter.

Assessments that cannot be classified to a RUG-III group due to errors are excluded from both average case-mix index calculations.

F. 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.

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(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners.

Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When the facility provides maintenance to these persons, the value of these benefits is deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Effective July 1, 2001, the base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is $3,296 per month plus $35.16 per month per licensed bed capacity for each bed over 60, not to exceed $4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor based on the latest HCFA Total Skilled Nursing Facility Market Basket Index published before July 1.

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(2) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(3) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. People involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community, not to exceed 60 per-cent of the allowable rate for the administrator on a semiannual basis. Ownership is defined as an interest of 5 percent or more.

i. Management fees shall be limited on the same basis as the owner administrator's salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. Depreciation may be included as a patient cost based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, 1983 edition. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made.

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost. Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

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l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

"Related" means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies. Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

Charges by the supplier are allowable costs when the facility demonstrates by convincing evidence that:

(1) The supplying organization is a bona fide separate organization.

(2) A substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization.

(3) The services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions.

(4) The charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies.

m. When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be based on the cost of the facility plus the landlord's other expenses and a reasonable rate of return, not to exceed actual rent payments.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be no more than the amortized cost of the facility plus the landlord's other expenses. The landlord must be willing to provide documentation of these costs for rental arrangements.

n. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the state health planning process.

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o. Reasonable legal fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid decertification are allowable costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs following the decertification date.

G. Termination or Change of Owner

The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. No increase in the value of property is allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements).

When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

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H. Audit Procedure for Nursing Facilities and ICFs/MR

The Department has a contract with an accounting firm to provide for audits to verify the accuracy and reasonableness of cost reports furnished by providers.

Nursing facilities submit cost reports for review by the accounting firm. The accounting firm provides an analysis of cost reports (desk reviews) within three months after their submission by the provider.

Approximately ten percent of the nursing facilities (NFs) and intermediate care facilities for persons with mental retardation (ICFs/MR) are to be selected each year for an on-site audit. Criteria for choosing the sample include but are not limited to facilities that have had a change of ownership, multi-level facilities, and facilities that have had a high frequency of errors in prior cost reporting periods.

On-site audits cover the following areas:

- Proper charges to personal allowance funds
- Manual instructions relating to reserve bed days
- Payment rate as compared to health facility customary charges
- Client participation
- Analysis of client days
- Discharge dates of clients
- Duplicate payments
- Supplementation
- Examination of expense items to determine whether they are allowable.

At the conclusion of each desk review or on-site audit, the accounting firm shall forward to the Division of Medical Services a report of its findings. Reports shall be retained for a period of five years.

I. Appeals by Facilities Regarding Payment Rate Determinations

A facility may submit additional evidence and request prompt administrative review of payment rates by filing an appeal with the Division of Medical Services. Appeals are heard by staff of the Department of Inspections and Appeals, under contract to the Department of Human Services.

J. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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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 the first day of the quarter following approval from CMS 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 the first day of the quarter following approval from CMS, a quality assurance rate add-on of $10.00 per patient day shall be added to the Medicaid reimbursement rates as otherwise calculated pursuant to Section 4.19-D.

L. Payment Adjustment for Provider Preventable Conditions

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19(D)

_X_ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable conditions identifies below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services*) of the plan:

Claims data with dates of service on or after September 1, 2011 will be reviewed retroactively and those fitting the criteria for PPCs will be identified. Providers will be supplied information identifying claims with the potential PPCs and will be given the opportunity to review and respond to any discrepancies. For any provider-confirmed PPCs payment will be adjusted by recouping payment for the patient day(s) in which the PPC event occurred. Recoupment will be for the amount of the per diem that was in effect for the date(s) of service that the PPC event occurred.