Methods and Standards for Establishing Payment Rates for Nursing Facility Services

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 30 and under and require the skilled level of care
- 70 percent of the residents served require the skilled level of care for neurological disorders
- One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness.
- One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with medical complexity. "Intermediate care facility for persons with medical complexity" means an intermediate care facility for persons with an intellectual disability which provides health and rehabilitation services to individuals who require a skilled nursing level of care, have either a multiple organ dysfunction or severe single organ dysfunction, and requires daily use of medical resources or technology.

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.