Understanding the Idaho Skilled Nursing Facility Medicaid rate sheet

There are several data items present on the rate summary sheet sent each quarter to Idaho skilled nursing providers. Understanding each of these data items and their interrelationship with various facility operations is critical to adjusting practices to maximize reimbursement. The purpose of this paper is to explain each section of the rate summary page and identify certain items operators should be watching to ensure they are receiving appropriate reimbursement.

For the purposes of this explanation, the rate sheet will be divided into six sections. These sections are:

1. The case mix tables, located in the upper ¼ of the summary page,
2. The cost detail, located between the CMI table and Rate Calculations,
3. The indirect cost column, located slightly below and left of the center of the page,
4. The direct cost column, located slightly below and to the right of the center of the page,
5. The exempt cost column, located to the right of the direct cost column, and
6. The Summary of Rate Components, located in the lower right corner of the page.

Please refer to the Rate Calculation Worksheet included at the end of this explanation. The six sections are described in detail below.

SECTION 1: THE CASE MIX INDEX TABLE

The case mix table on the Rate Calculation Worksheet looks like this:

	CMI Table	
	Rate Period	C/R Period
Facility Wide:	1.1065	1.1582
Facility Medicaid:	1.1110	1.0872
State-Wide Avg.:	1.1638	1.1467

The Case Mix Index (CMI) is calculated based on the MDS's that are regularly sent by facilities to the state repository. Idaho uses a 34-group RUG III model, nursing weights only. The weights by RUG category are listed on the last page. The state has a computer program which automatically converts the MDS 3.0 to the RUG III grouper system.

Every quarter, each facility receives a report from Myers and Stauffer that lists all patients with MDS's in the state repository, along with each patient's payor status, RUG category, and case mix score. It is imperative that the facility review this information and

send corrections to the state as soon as possible. You cannot change the RUG category on this page, but you can change whether a certain patient was in the facility as of the picture date (the last day of the previous quarter) and their payor status. If a patient's payor status changed from Medicare to Medicaid between the time the MDS was submitted and the end of the picture date (remember you do not need to complete an MDS when taking a patient off Medicare), note on the page the new payor source and the effective date. If a patient is listed on the page and he or she was discharged or expired between the time the MDS was submitted and the picture date and the discharge tracking form has not been submitted to the state repository yet, state that the patient was discharged and list the date of discharge on the patient list.

You cannot add patients to the list who were admitted before the picture date but whose MDS's were not submitted in time to appear on the patient list from Myers and Stauffer. For this reason, you should submit MDS's frequently, and especially just prior to the picture date, to get the most accurate picture of your current patient population.

Although it is required for MDS's to be submitted within 30 days after closing and locking, most facilities submit MDS's on a weekly basis. Not only does this ensure the most up to date information is in the state repository, it reduces potential problems of computer malfunctions or other issues preventing MDS transmission within the allowable time frames. Further, after you submit MDS's to the state, you receive a Validation Report. The MDS submitter should review this document to be sure all MDS's were received and processed correctly and that none were rejected. It is much better to do this with smaller reports on a weekly basis rather than a very large report if you submit only once per month.

The CMI for the Cost Report (C/R) period is an aggregation of the MDS's submitted to the state repository during your particular facility's cost report period. The table includes the average CMI for all patients in your facility during the cost report period, all Medicaid patients in your facility during the cost report period, and the state-wide average case mix score for all patients in Idaho skilled nursing facilities during your facility's cost report period.

The CMI for the Rate Period lists the average case mix index for your facility for the quarter used to determine your rate. Average CMI scores are listed for all patients in your facility for the Rate Period, plus your facility's Medicaid patients only, plus the state wide average CMI for the rate period. The "Rate Period" is always a three month lag, so the MDS's submitted to the state from January 1 through March 31 impacts your reimbursement rates effective July 1 of that year. MDS's submitted from April 1 through June 30 impact your rates effective October 1, and so on.

Out of the six CMI figures listed on the table, only three are used for the current rate calculation quarter: the Facility Wide CMI for the Cost Report Period; the State-Wide Average for the Cost Report Period, and the Facility Medicaid for the Rate Period. The usage of these CMI's is described below under Section 4: Direct Cost Component.

Analyzing/Interpretation/Improving the CMI Data

First, look at your baseline. This is your facility CMI scores for the entire facility **for the cost report period**. Compare this average to the state average. Three situations are possible:

Your average Facility-Wide CMI is higher than the state average. This normally means you have a higher Medicare population, and/or you are taking care of an overall higher acuity population than most Idaho skilled nursing facilities. Your facility staff probably does a good job of documenting mood and behaviors, ADLs, restorative care, and other factors that place more patients in higher acuity RUG categories. This also means your facility will have a higher direct care cap, because your facility-specific direct care cap is calculated by dividing the facility-wide case mix index for the cost report period by the state-wide average CMI for the cost report period and multiplying the result by the Per Diem Limit for direct care (explained in more detail under Section 4 below).

Your average Facility-Wide CMI is lower than the state average. You may just be treating lighter care patients overall, but it could also be that your staff aren't documenting items that positively impact your case mix index. See below for suggestions on improving your case mix index.

Your average Facility-Wide CMI is almost the same as the state average. Your facility is neither better nor worse than other Idaho skilled facilities in terms of acuity scores, and you are very close to the average for Medicare census and acuity.

What to do now?

Suppose you want to review your acuity scores to make sure they are accurate, and that your Medicaid rates are based on your current acuity. First, compare the CMI for the rate period with the CMI for the cost report period for all three indicators. For example, if your facility wide CMI scores for the most recent rate period are higher than the cost report period, you are either taking credit for accurate assessments of ADL assistance provided and other factors positively impacting your CMI, or you are simply taking care of an overall higher acuity patient population. On the example CMI table on Page 1, you'll see that the facility-wide CMI for the rate period is lower than the cost report period. While the facility-wide CMI for the rate period is not used for any part of the rate setting process, it does give you an indication of a trend in your overall acuity.

If you feel the need to review the MDS's of patients to make sure those factors impacting the acuity score are accurate, your time would be best spent following these guidelines:

1. Identify all Medicaid patients with acuity scores at or below your facility average CMI. Especially focus on the PA1 patients with an acuity score of 0.49.

2. Find out from the therapists who came off therapy over the past three months and see if they were transitioned into a restorative program.

3. List all patients who are currently on a structured restorative program.

4. Review your Quality Indicators and note all patients who triggered for a decline in ADL's or range of motion.

5. Begin your chart audit of each patient identified above. Questions to answer include:

    a. How frequently is restorative care provided? It must be provided 6 days per week, two activities per day for 15 minutes per activity. If you are only providing restorative nursing care five days per week, it does not count as a restorative program for MDS purposes.

    b. Are restorative minutes documented accurately? Again, it needs to be 15 minutes per day per activity. Further, the restorative program must be overseen by a licensed nurse, and the restorative nursing assistants must have appropriate training.

    c. Is the ADL portion of the care plan appropriate, and does it list interventions that should be done but aren't being done? Are there interventions that should be listed that aren't included in the care plan? Are the goals measurable, and are they reviewed periodically?

    d. Are side rails listed as a mobility device instead of a restraint? If so, is restorative care being provided to make sure the patient is actually using the side rail as a bed mobility device or is the side rail actually a restraint? If the MDS is coded as a 3, 4, or 8 under Bed Mobility, there is a question of whether side rails are appropriately listed as bed mobility devices, and they will probably be deemed restraints by surveyors.

    e. Is the ADL coding accurate? Does it match the aide flow sheets? You should also talk directly with the caregivers on <u>all</u> shifts to be sure the coding is accurate. Remember that column B on Section G1 of the MDS says to code for "Most support provided over all shifts during last 7 days" and that the most support needed by the patient is probably not at 10 am when the restorative aides or therapists are right there, but at 7 am on Sunday morning when the aides provide a 2+ physical assist for bed mobility or transfer. Look especially closely at copy cat charting, where the aides simply put the previous day's or shift's code in the current shift's flow sheet.

f. Have any behaviors occurred over the past several weeks, and have they been appropriately documented in the nurse's notes and behavior sheets, and were those observations transferred over to the MDS?

g. Is there anything out of the ordinary in the nurse's notes, social services notes, therapy notes, or the physician progress notes? For example, there may be something noted in one disciplines' notes that wasn't corroborated in other notes which would impact the acuity score.

h. Can the patient benefit from a Part B therapy program? If that therapy is provided during the assessment window, regardless of how it was paid, it counts as therapy on the MDS and results in a higher RUG score.

i. Are there skin issues that weren't accurately coded on the MDS? Some people do not like to code stage 1 pressure ulcers because they think it results in a survey flag. While this is partially correct, if you are treating a skin issue as a pressure ulcer, it needs to be listed as a pressure ulcer on the MDS. Two or more sites at any stage, or one at stage 3 or 4 result in a RUG category of SS.

6. Personally examine the patient. See for yourself how much independence he or she has, and how much assistance is provided, in transferring, bed mobility, eating, and toilet use.

Using all of the above information, determine if the MDS accurately depicts the patient's condition. You should also determine if that patient is a candidate for Part B therapy or for initiation, modification, or termination of a restorative program.

If you find the MDS is incorrect, follow the correction policy guidelines set by CMS. But also remember that several significant changes to your facility's MDS's may trigger increased scrutiny from surveyors, who may question why there was a breakdown in facility systems and processes that would allow inaccurate assessments to be filed with the state.

Finally, some providers may wish to increase their CMI by providing more therapy services that they usually provide during an assessment window. While this practice will increase the CMI for that rate period, these higher case mix numbers will be averaged into the overall facility CMI when the cost report is filed. Future quarterly CMI adjustments will then be divided by the artificially higher base CMI and potentially reduce rates in future periods. This "double edged sword" reveals a simultaneous benefit and limitation of the SNF reimbursement system: facilities with gradual changes in CMI, census, and costs under the cap can do very well under this payment methodology. Facilities with large variations in CMI, census, and costs will have quarters and years that

are extremely profitable, and other quarters and years in which they will experience financial hardship.

SECTION 2: COST DETAIL AND INFLATION ADJUSTMENT

In the upper one third of the Rate Calculation Worksheet is a section labeled "Inflated Cost Summary." The column under "Cost Detail" contains figures derived from your cost report. If your rate is a finalized rate based on an audited cost report, these totals can be traced directly from the "Schedule of Adjusted Costs" pages of your audit report. If your rate is an interim rate based on reported costs, in order to trace these amounts, you will need to request information from Myers and Stauffer. Myers and Stauffer uses your as-filed cost report and separates cost centers between the direct, indirect, property, and exempt cost centers. The cost report information included here is from the cost report period listed in the upper part of the Rate Calculation Worksheet.

The derivation of the costs on the summary page is detailed in the subsequent pages of the rate sheet calculations. You, or your cost accountant, should be able to track costs listed on the cost report to the rate sheet.

The Inflation Adjustment is no longer used, as it was removed in 2011 Legislature. Rates are now based strictly on historical costs per patient day.

The third column in this section is entitled, "CMI Adjust for Food and Ancillaries or Indirect Ancillary Gross-Up." This column performs two functions. First, food and the direct portion of ancillaries are included in direct care rate calculation, but are not case mix adjusted. Because all costs in the "Direct Cost" column of page one of the rate calculation worksheet are case mix adjusted, that case mix adjustment is reversed here to have a net impact of zero. Therefore, the costs associated with food and direct ancillary expenses are "reverse case mix adjusted" for lack of a better term, so that the entire direct care cost total can be case mix adjusted. Second, this column is also used to gross up ancillary costs. Ancillary costs included in the first column are the costs attributed solely to Medicaid services. Therefore, the Medicaid portion of ancillaries are grossed up by taking Medicaid ancillary cost, dividing by Medicaid days, times total patient days. This is necessary because on page 1 of the Rate Calculation Worksheet, total costs are divided by total days to calculate a per diem. Therefore, ancillary costs associated with just the Medicaid portion should be grossed up to reflect the total cost.

The final column in this section is the sum of the previous three columns, and the totals by line item are then carried below to the columns in the lower one half of the Rate Calculation Worksheet page.

SECTION 3: INDIRECT COST COMPONENT

The lower half of the Rate Calculation Worksheet contains the final rate calculation. The first column of numbers in this section presents the Indirect Cost component of your rate. Indirect costs include primarily overhead cost areas such as administration, housekeeping, dietary costs (except raw food), activities, and so on.

The Indirect Cost Component is calculated according to the process outlined below:

1. The total indirect costs are divided by the total patient days in the cost report period to arrive at the indirect cost per patient day.

2. The cap for the current rate period is listed. It is the amount equal to 117% of the median rate for indirect costs for all Idaho SNFs and is recalculated annually.

3. The facility indirect rate is the lesser of the inflated costs or the cap, so if the facility is below the indirect cap, it only the per diem costs per patient day. If it is over the cap, it will only receive the cap as its indirect cost component of its final rate.

SECTION 4: DIRECT COST COMPONENT

The second column of numbers in the lower half of the Rate Calculation Worksheet contains the derivation of your facility's Direct Cost Component of your Medicaid rate.

Direct costs include nursing and social service salaries and benefits, nursing supplies, Medicaid-related ancillaries, and raw food. The Direct Cost Component is calculated as follows:

1. The total direct costs from the upper section of the Rate Calculation Worksheet are listed on the first line this column, and this total is divided by the total patient days for the cost report period to arrive at the direct cost per patient day.

2. The state cap on Direct Costs is shown as the Per Diem Limit. This cap is an overall state cap, and the cap is adjusted for each facility based on that facility's overall acuity for the cost report period compared to the state average acuity. The facility-specific cap is calculated by dividing the facility-wide average CMI for the cost report period by the state average CMI for the cost report period and multiplying the result by the state cap. Using the CMI table on page 1, the facility-wide CMI for the cost report period is 1.1582, and the state average CMI for the same period was 1.1467. The formula and resulting facility-specific cap is shown below:

$$\frac{\text{Facility-wide CMI}}{\text{State Avg CMI}} = \frac{1.1582}{1.1467} = 1.0100$$

Therefore, because the facility has an overall acuity slightly higher than the state average (exactly 1 percent higher than the state average), it makes sense that it would have a higher cap.

3. The lower of the inflated cost per patient day (described in #1 of this section) or the facility-specific cap on direct costs is then adjusted to reflect the assumed ratio of costs associated with Medicaid patients compared to all other patients (private, Medicare, VA, insurance, etc.) in the facility. This adjustment divides the Facility Medicaid CMI for the Rate Period by the Facility Wide CMI for the cost report period. Using the case mix table on page 1, the resulting calculation is:

$$\frac{\text{Medicaid avg CMI}}{\text{Facility-wide CMI}} = \frac{1.1110}{1.1582} = 0.9592$$

The direct cost component, and the customary charge calculation (below) are the only parts of the Medicaid rate that changes throughout the year. The change to the direct portion of the rate is based solely on acuity scores for Medicaid patients for the period ending 90 days prior to the current rate period (MDS's submitted between January 1 and March 31 will impact direct care rates effective July 1-September 30).

SECTION 5: EXEMPT COSTS AND NATCEP

Exempt costs include property taxes, property insurance, utilities, and costs associated with the Nurse Aide Training and Certification Evaluation Program (NATCEP). For hospital-based providers, exempt costs also include property costs. These are pass-through costs not subject to any limitation.

SECTION 6: SUMMARY OF RATE COMPONENTS

The lower right corner of the Rate Calculation Worksheet contains the summary of all of the individual components of your facility's Medicaid rate. It also includes the property component, which is defined in detail in Idaho rule. In general, the property rate for free-standing nursing facilities is based on the Marshall-Swift Valuation Index, and the age of all nursing facilities in Idaho have been frozen at their age in 1991 for facilities constructed on or before that date.

Look at your own Medicaid rate sheet to see how these components add up. Remember there is also an additional 2.7 percent reduction because Idaho's budget shortfalls during 2009-2011. This amount was replaced with a provider tax so the facilities will get this amount returned to them through a different program.

Finally, your Medicaid rate is limited to the lesser of the sum of rate components or the customary charge. The customary charge is calculated as your semi-private room rate plus the Medicaid charges of reimbursable ancillaries. The ancillary portion is inflated to the rate period using the same method for inflating costs, and is also case mix adjusted by dividing facility Medicaid CMI for the rate period by facility Medicaid CMI for the cost report period. The result of the Medicaid ancillary portion is divided by Medicaid days and is added to your semi-private room rate. For this reason, it is imperative that you charge out all appropriate ancillary services and supplies to all patients, including those whose primary payor is the Medicaid program.

Medicaid RUG Categories and Weights

RAD	1.928	IB2	0.902
RAC	1.632	IB1	0.798
RAB	1.491	IA2	0.662
RAA	1.239	IA1	0.598
SE3	2.398	BB2	0.869
SE2	1.958	BB1	0.737
SE1	1.645	BA2	0.638
		BA1	0.522
SSC	1.591		
SSB	1.469	PE2	1.012
SSA	1.439	PE1	0.917
		PD2	0.932
CC2	1.211	PD1	0.842
CC1	1.116	PC2	0.799
CB2	1.061	PC1	0.736
CB1	0.981	PB2	0.702
CA2	0.886	PB1	0.638
CA1	0.794	PA2	0.543
		PA1	0.490