

Nursing Home Payment Project

Division of Medicaid & Long-Term Care

The following are key points underlying the new rate methodology for nursing facility Medicaid rates effective July 1, 2020 and forward.

1. The initial model base year is 6/30/18. 6/30/18 cost report data used to compute Maximums and Minimums for the Direct Nursing and Support Services rate components.
2. There will be separate Maximums and Minimums for Urban and Rural facilities. The total gap between each Maximum and Minimum is 28%.
3. Maximums:
 - a. Direct Nursing Maximums are 105% of the Urban/Rural medians.
 - b. Support Services Maximums are 100% of the Urban/Rural medians.
 - c. Base Year Direct Nursing Maximums: Urban = \$115.08; Rural = \$107.30.
 - d. Base Year Support Services Maximums: Urban = \$94.74; Rural = \$84.47.
 - e. Base Year Maximums are before the application of the inflation factor¹ specific to each subsequent rate period.
4. Minimums:
 - a. Direct Nursing Minimums are 77% of the Urban/Rural medians.
 - b. Support Services Minimums are 72% of the Urban/Rural medians.
 - c. Base Year Direct Nursing Minimums: Urban = \$84.39; Rural = \$78.69.
 - d. Base Year Support Services Minimums: Urban = \$68.21; Rural = \$60.82.
 - e. Base Year Minimums are before the application of the inflation factor specific to each subsequent rate period.
5. Facilities with 6/30/18 costs/day over the Maximum will be reduced to the Maximum.
Facilities with 6/30/18 costs/day under the Minimum will be raised to the Minimum.
Facilities with 6/30/18 costs/day between the Minimum and Maximum will not be lowered or raised.
6. For July 1, 2020 – June 30, 2021 rates, the Base Year Direct Nursing and Support Services Maximums, Minimums, and individual facility costs/day amounts will be adjusted by an inflation factor based on available QAA funding, legislative appropriations for the 2020-21 rate period, and updated Medicaid days data.

¹ The inflation factor for state fiscal year 2021 is 1.51%.

7. For July 1, 2020 – June 30, 2021 rates, the Fixed Cost rate component computed from the base year 6/30/18 cost report data, updated with approved increases, will be used.
 - a. Requests for increases to a facility’s Fixed Cost rate component may be approved by the Medicaid Director or Designee if total allowable Fixed costs increase by at least 20% over the base year Fixed costs.
 - i. Approved increases to the Fixed Cost rate component from July through December 2020 will be effective January 1, 2021.
 - ii. Approved increases to the Fixed Cost rate component from January through June 2021 will be effective July 1, 2021.
8. On facility sales, the buyer’s allowable fixed asset cost basis for Medicaid purposes will be the lower of the purchase price or the Medicaid book value at the time of sale. There will no longer be Recapture of Depreciation on sales of nursing facilities.
9. No changes to the computation of the QAA (provider tax) component.
10. Bedhold days currently paid at the reduced Level 105 rate, will now be paid at the actual casemix rate of the resident.
11. A Quality component will be included. MLTC will use the “Quality Measures” Component of the CMS Nursing Facility Star Rating system, found here:
<https://www.medicare.gov/nursinghomecompare/search.html>
 - a. 5 star = \$10.00/day;
 - b. 4 star = \$6.75/day;
 - c. 3 star = \$3.50/day;
 - d. 1 star, 2 star, and NR = no add-on.
 - e. The add-on applies to all care levels 101-180.
 - f. It is projected the Quality component uses 2.9% of the available NF funding.
 - g. Rates will be adjusted every January 1st (based on the published rating as of November 1st) and July 1st (based on the published rating as of May 1st).²
12. Rates for 2020-21 will be transitioned by reducing projected gains and losses by 50%.
 - a. For example, if Facility A is projected to “gain” \$100,000 under the new method, a transition rate component will be used to reduce the rates so the projected gain would be \$50,000.
 - b. Conversely, if Facility B is projected to “lose” \$100,000 under the new method, a transition rate component will be used to increase the rates so the projected loss would be only \$50,000.
 - c. Rates for the second year, 2021-22, and subsequent years, would not include a transition rate component.
13. Facilities without 6/30/18 base year cost report data will receive the applicable Urban/Rural average rates for the Direct Nursing, Support Services, and Fixed Cost rate components, plus facility -specific QAA and Quality add-ons.

² There may be a deficiency gateway requirement in future years, but there will not be one in state fiscal year 2021. A deficiency requirement would be assessed if a facility has two G Level or above substantiated deficiencies, or any single IJ substantiated deficiency in a single state fiscal year the provider will not be eligible for the quality component for the following state fiscal year, even if they earn a 3, 4, or 5 Star Rating

14. Subsequent base year periods will be selected by DHHS from cost report periods ending one to four years after the current base year. Specifically, the next base year may be 6/30/19, 6/30/20, 6/30/21, and/or 6/30/22.