KENTUCKY CASE MIX ASSESSMENT AND REIMBURSEMENT SYSTEM

RESIDENT ASSESSMENT

INTRODUCTION

The Kentucky Department for Medicaid Services is implementing a new reimbursement system for price-based nursing facilities participating in the Medicaid program. These facilities include:

1. A free-standing nursing facility;
2. A hospital-based nursing facility;
3. A nursing facility with waiver;
4. A nursing facility with an intellectual disability specialty; and
5. A hospital providing swing bed nursing facility care.

The new price-based reimbursement methodology will consist of a reasonable standard price set for a day of service for rural and urban facilities. This should provide an incentive to providers to manage costs efficiently and economically.

The standard price includes:

1. Standardized wage rates;
2. Staffing *ratios;*
3. Benefits and absenteeism factors; and
4. "Other cost" percentages.

The new price-based reimbursement methodology is dependent on the specific care needs of each Medicaid and dually eligible Medicare resident in a nursing facility. The new methodology will base the resident acuity using the Minimum Data Set (MDS) 3.0 as the assessment tool. The Resource Utilization Group (RUGs) is the classification tool to place resident into different case-mix groups necessary to calculate the "casemix score". A time-weighted methodology is used in calculating case mix by determining the number of days that a MOS record is active over a calendar quarter rather than captured from a single day during the calendar quarter.

This methodology entails a re-determination of a facility's mix of residents each quarter in order to establish a new facility specific nursing rate on a quarterly basis.

One of the objectives of the new case-mix system is to mirror the resident assessment process used by Medicare and therefore not require the facilities to use two case-mix assessment tools to determine resident acuity. The second objective for using the MDS 3.0 and RUGS Ill is to improve reimbursement for facilities providing services for residents with higher care needs in order to improve access to care for those recipients.

1. There will be two major categories for the standard price:

    a. Case-mix adjustable portion includes wages for personnel that provide or are associated with direct care and non- personnel operation costs (supplies, etc). The case-mix adjustable portion will be separated into urban and rural designations based on Core Based Statistical Area definitions, every four years, using the most recent Federal Office of Management and Budget's Core Based Statistical Area definitions; and

b. Non case-mix adjustable portion of the standard price includes an allowance to offset provider assessment, food, non-capital facility related cost, professional supports and consultation, and administration. These costs are reflected on a per diem basis and will be based on Core Based Statistical Area definitions, every four years, using the most recent Federal Office of Management and Budget's Core Based Statistical Area definitions.

For dates of service on or after July 1, 2017, rates are increased $9.64 per day as an allowance to offset a provider assessment.

2. Each July 1 the rate will be adjusted by an inflation allowance using the appropriate IHS Global Insight. The inflation allowance will not be applied to the capital cost component or the $29 add-on described below.

3. $29 Add-on:

For dates of service effective July 1, 2022, an add-on amount of twenty-nine dollars ($29) will be included in the non case-mix adjustable portion of the per diem rate. The add-on will be included in the Administration line of the calculation, and will not receive annual inflationary adjustments. The $29 add-on will continue until the standard price is rebased.

4. Capital Cost Add-on:

Each nursing facility will be appraised by November 30, 1999 and the department shall appraise a price-based NF to determine the facility specific capital component again in 2009, thereafter every five (5) years. The appraisal contractor will use the Marshall & Swift Boeckh Building Valuation System (BVS) for facility depreciated replacement cost. The capital cost component add-on will consist of the following limits:

a. Forty thousand dollars per licensed bed, adjusted every July 1 thereafter by the same value as the NF's depreciated replacement cost;
b. Two thousand dollars per bed for equipment;
c. Ten percent of depreciated replacement cost for land value;
d. A rate of return will be applied, equal to the 20 year Treasury bond plus a 2% risk factor, subject to a 9% floor and 12% ceiling; and
e. In order to determine the facility-specific per diem capital reimbursement, the department shall use the greater of actual bed days or bed days at 90%.

5. Renovations to nursing facilities in non-appraisal years:

a. For facilities that have 60 or fewer beds, re-appraisals shall be conducted if the total renovation cost is $75,000 or more.
b. For facilities that have more than 60 beds, re-appraisal shall be conducted if the total renovation cost is $150,000.

6. Facilities Protection Period:

a. Rate Protection - Until July 1, 2002, no NF shall receive a rate under the new methodology that is less than their rate that was set in July 1, 1999 unless a facility's resident acuity changes. However, NFs may receive increases in rates as a result of the new methodology as the Medicaid budget allows.
b. Case Mix - Until July I, 2000, no facility will receive an average case-mix weight lower than the casemix weight used for the January I, 1999 rate setting. After July I, 2000, the facility shall receive the casemix weight as calculated by RUGs III from data extracted from MOS 3.0 information.
c. Effective January 1, 2003, county owned hospital-based nursing facilities shall not receive a rate that is less than the rate that was in effect on June 30, 2002.

7. Case-mix Rate Adjustments. Rates will be recomputed quarterly based on revisions in the case mix assessment classification that affects the Nursing Services components.

8. Case-mix rate adjustment will be recomputed should a provider or the department find an error.