

Wisconsin Medicaid

Methods of Implementation for Nursing Home Payment Rates

for July 1, 2020 through June 30, 2021

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1.00 Introduction & Rate-Setting Procedures

These Methods establish Wisconsin Medicaid rate-setting procedures for nursing facilities (NFs) and intermediate care facilities for individuals with intellectual disabilities (ICFs-IID) for the period of July 1, 2020 – June 30, 2021 unless subsequently modified by separate state plan amendment, legislative action or court order. The Methods provides for payments which are divided into five major cost centers: Direct Care; Support Services; Property Tax; Property; and Provider Incentives.

1.01 Definitions

Active Treatment - an ongoing, organized effort to help each resident attain his or her developmental capacity through the resident's regular participation, in accordance with an individualized plan, in a program of activities designed to enable the resident to attain the optimal physical, intellectual, social and vocational levels of functioning of which he or she is capable.

CPI – The Consumer Price Index for all Urban Consumers (United States City average).

Facility – The term facility is used throughout this document to generally refer to either a nursing facility (NF) or an intermediate care facility for individuals with intellectual disabilities (ICF-IID). When information more specific to each facility type is presented, the abbreviations NF and ICF-IID are used.

Fifty Bed Facilities - Unless granted an exception in writing from the Department, to be considered a facility of 50 or fewer beds the total sum of beds from all SNF and ICF-IID licenses on the same or contiguous properties must be 50 or fewer.

IMD – An institution for mental disease (IMD) is an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services as determined by the Department or CMS. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental disease.

Medicaid Days - General references to Medicaid days in this plan refer only to Medicaid fee-for-service (FFS) residents. Only residents eligible for the Medicaid FFS benefit will receive payment under any provision of this plan.

Self-Insurance - Self-insurance is a means where a provider, directly or indirectly or through a separate entity, trust or fund, undertakes the ultimate risk by assuming the actual liability for insurance costs. The creation of a separate entity, trust or fund for insurance purposes does not eliminate the provider's ultimate insurance risk or liability. Payment of insurance premiums to an insurance company, in the business of offering insurance to the general public, where such premiums are the final liability of the provider regardless of the actual cost incurred by the insurance company does not constitute self-insurance.

1.10 Cost Reporting

All certified NFs and ICFs-IID must submit a Medicaid Nursing Home Cost Report (F-01812) prepared in accordance with the instructions. Revenue and expenses are to be reported on the accrual basis of accounting except government facilities may use the cash method of accounting. A distinct part ICF-IID must submit a combined cost report.

Cost Reports must be signed by an officer of the facility as well as the paid preparer, if one was used. Supplementary information about the facility and any related parties or prior owners of the facility must be made available on request. Cost reports are due within five months of the close of a facility's cost reporting period. Supplemental information due dates will be set by regional facility auditors.

In general, a facility's cost reporting period shall be the provider's fiscal year ending in the calendar year prior to the effective date of the payment rates. For example, the provider's fiscal year ending in 2020 would be the base cost reporting period for rates effective 7/1/21, 10/1/21, 1/1/22, and 4/1/22. Payment rates may be based on alternative cost reporting periods at the discretion of the department.

1.20 Cost Allowability

Allowable costs are limited to those necessary and proper for patient care, appropriate for developing and maintaining the operation of the facility, and obtained by a reasonably prudent buyer. Costs may be limited when the department determines costs are excessive compared to prices paid by similar providers.

Not allowable costs include, but are not limited to:

- Forfeitures, civil money penalties, or other fines
- Bad debts, charity, or other courtesy allowances
- Legal fees are not allowable unless directly related to patient care
- Out-of-state travel expenses (including training, seminar, and convention fees), except to and from the facility's home office or within 100 miles of the Wisconsin border.
- Taxes or assessments on licensed beds
- Losses on investments
- Costs attributable to the care of residents aged 21-64 at an institute for mental disease.
- Accrued expenses not paid within 180 days of the end of the cost reporting period. (These disallowed expenses are not allowable on any subsequent cost report without a department-granted exception). This provision does not apply to property tax payments.

1.30 Penalties for Overdue Cost Reports, Supplemental Information and/or Licensed Bed Assessments

Payment rates will be reduced according to the following schedule if a provider does not submit cost reports, required supplementary information, or licensed bed assessment balances by the established due dates. Rates will be retroactively restored when the cost report, supplemental information, or licensed bed assessment balance is received.

Days Overdue	Rate Reduction
1-30	25%
31-60	50%
61-90	75%
90+	100%

1.40 Records Retention

Providers must retain financial records including cost reports and supporting items in sufficient detail to substantiate costs claimed for a period of five years. These records must be made available to the Department at a location within Wisconsin within a reasonable time upon request.

1.50 Related Parties

A “related party” or “related organization” is an individual or organization related to a facility by either common ownership or control.

“Related to the facility” means that the facility, to a significant extent, is associated or affiliated 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 in the institution or organization serving the facility.

“Control” exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

The existence of an immediate family relationship creates a rebuttable presumption of relatedness.

For costs incurred through a related party transaction, allowable expenses shall be limited to the lesser of:

- The expense incurred by the related party which furnished the goods or services, and
- The price of comparable goods or services that could be purchased elsewhere.

1.60 Restricted Use Beds

In order to receive restricted use status, facilities must request and receive Department approval in writing before the effective date. Approvals will be made at the Department’s discretion, and only in one of the following circumstances:

- The facility demonstrates a remodeling contract is in place which will cause the bed area to be out of service.
- The facility has documented life safety code violations, with an approved plan of correction.
- The facility transfers beds from another facility, with plans to build space for those beds.

Approval of restricted use status is for 12 months, and may be extended for an additional six months if the facility requests such in writing and is able to demonstrate that the remodeling or construction is still in progress. No restricted use bed approvals will be extended beyond 18 months unless space for the restricted use beds is not available at the facility and construction of the additional space is in progress.

In limited and exceptional circumstances, the Department will consider applications for extended restricted use status of beds for a period of up to five years. The facility would be required to identify a specific need for extended approval which cannot otherwise be met by the normal approval process. All extended approvals will be subject to an annual written status update; a formal, one-year written notice before removing the beds from restricted use status; and a 10% annual return of restricted use beds (i.e., de-licensing each year of 10% of the number of beds that were originally placed in restricted use status). Extended restricted use bed approval is solely at the Department’s discretion and is primarily intended to support long-range strategic planning and modernization, or facility remodeling efforts.

1.70 Rate Approval Process

Providers will receive a rate notification from their Medicaid Auditor including cost report adjustments and explanations. For initial rates, the provider will have a 30-day rate approval period to approve the rates or request changes. When cost report adjustments have already been agreed to and the only rate

change is due to CMI, the rate approval period will be 7 days. After the rate approval period, the auditor will submit the rates to ForwardHealth for payment.

If the provider wishes to contest the adjustments or rates, they must respond to the Medicaid Auditor within the rate approval period. If the provider is contesting an adjustment, they must either provide additional support for the amounts claimed, or let the Medicaid Auditor know that they will be providing such support within an agreed upon amount of time.

When an auditor changes a cost report adjustment/rate as a result of additional support provided, they will allow the provider or provider's accounting firm a minimum of 7 calendar days from their response to review changes made. (Depending on when the auditor responds, this could be within the original rate approval period or could extend the rate approval period.)

If a provider disagrees with the determinations made by their Medicaid Auditor, they may request an administrative review by writing to:

Nursing Home Rate Setting & Policy Section Chief
P.O. Box 7851
1 West Wilson Street
Madison, WI 53703

Providers also have the ability to contest a final rate-setting action of the Department by requesting an administrative hearing within 15 days of a new rate being uploaded to ForwardHealth. Whether or not an administrative review is filed does not have any bearing on the right to an administrative hearing. An administrative hearing may be obtained by sending a brief and plain statement of every matter or issue contested to:

Department of Administration
Division of Hearing and Appeals
P.O. Box 7875
Madison, WI 53707-7875

1.71 Material Adjustments

After final rates are set, only adjustments and/or corrections of errors which have a combined net material impact on rates will be corrected. "Material" is defined as the combined net increase or decrease being equal to or greater than \$0.50 per patient day for the non-DD in-house rate.

A provider must deliver written notice of errors to the Department within 150 days of the date of the first rate approval letter in order for any corrected rates to take effect on the original effective date of the rates in error. If a provider notifies the Department of an error after 150 days from the first rate approval letter, any resulting rate increase will occur on the first of the month following the month in which the error was noticed. The provider will be limited to only one such retroactive adjustment per rate effective period in order to correct errors in reported data.

1.72 Circumstances Necessitating a Rate Recalculation

A change of ownership will not result in a rate recalculation for the current payment rate year. The new owner will be paid the rate the former owner would have been paid if no change of ownership had occurred. For the following rate year, the Department may permit rates to be based on the new owner's costs if a cost report can be submitted that covers a period of at least six months. This provision does not exclude the prior owner from submitting a cost report if the Department so requires. If the prior

owner's cost report is needed, but not submitted, the new owner's rates for the payment rate year will default to the facility's June 30th rate of the prior payment rate year, less a reduction of up to 25% if the Department deems appropriate.

Providers may request or the Department may require a rate recalculation following a certification and/or licensure change (such as from SNF to ICF-IID or IMD and vice versa). Rate recalculations requested by providers will be granted at the discretion of the Department.

New facilities will receive an interim rate during the start-up period, which consists of the initial twelve months from the date of facility licensure. During the start-up period, a facility's minimum patient days for the property and property tax allowances will be 50% occupancy of licensed beds. Actual patient days will be used if greater than the minimum. If an existing licensed facility becomes certified for Medicaid after the start-up period, the facility must provide a cost report covering at least six months for rates to be established.

Replacement facilities, or facilities that have replaced at least 25% of their licensed bed capacity or 50 beds, may request a property payment allowance adjustment based on a cost report covering at least 6 months of new property costs following the licensure of the replacement area. The adjusted property payment allowance will be effective as of the date of licensure. No phase-in or start-up provisions will apply to property payment allowances for facilities receiving adjustments for replacement facilities.

Facilities experiencing a significant increase or decrease in licensed bed counts may request, or the department may require rates to be reestablished. Facilities decreasing licensed bed capacity over a period of time longer than six months may have rates retrospectively established for the phasedown period based on a six month or longer cost report. Facilities undergoing a major phasedown, significant bed reduction, or closing may request negotiated rates.

The Department may modify the above start-up period and cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or accurate cost reporting.

1.80 Recoupment of Overpayment

Upon a rate decrease for any purpose, any excess payments for previously provided services shall be recovered. Large recoupments will be recovered as a set percentage of future remittances according to the ForwardHealth Provider Handbook. The Department may choose to recover amounts due from new owners of facilities or from facilities owned by the same individuals if the situation warrants. Providers may request repayment arrangements that differ from the fiscal agent's regular schedule for reasons of financial hardship. Such requests should be addressed to the Nursing Home Policy and Rate Setting Section Chief, who will grant such requests in limited and exceptional circumstances at the sole discretion of the Department.

2.00 Direct Care

2.10 Direct Care Allowance Calculation

The rate calculation will use Resource Utilization Groups (RUGs) for payment of Medicaid FFS Non-DD residents. The DD rate will be used for residents in ICFs-IID and for residents that require specialized services in nursing facilities. The case mix index is determined using the RUGs 48 grouper with index maximization for residents at the medical care levels. In addition to the RUGs group, all residents must

meet the minimum definition for Limited Nursing Care in DHS 132.13. In other words, residents must have a “nursing home level of care.” For information on the process for establishing the need for nursing care with ForwardHealth, please see the Provider Handbook.

Direct care allowances will be calculated separately for facilities certified as ICF-IID (or distinct part ICF-IID) and nursing facilities, as the targets and case mix weights for direct care services may differ. Separate direct care allowances will be calculated for each of the following rate classes: non-DD in-house residents, developmentally disabled (DD) residents, non-DD bedhold residents, and DD bedhold residents.

The facility’s actual allowable direct care nursing service expenses for staff wages, fringe benefits, purchased services and supplies shall be inflated or deflated from the cost reporting period to the reimbursement period using the weights in Section 2.50. The sum of these inflated expenses is divided by total patient days to yield per day inflated expenses.

The direct care allowance calculation uses two case mix indices (CMI). The All-Resident CMI represents acuity of all residents during the cost reporting period. The Medicaid FFS Non-DD CMI represents the acuity for Medicaid FFS Non-DD residents during the reimbursement quarter starting six months after the end of the picture quarter, and is updated quarterly.

Facilities that have beds for rate setting of fifty beds or less will have a 20% increase in their case mix indices. Facilities certified as ICF-IIDs either in whole or in part are not eligible for this increase.

The Inflation Adjusted Nursing Services Expense per patient day is divided by the All Resident CMI to produce the Case-Mix-Neutral Nursing Services Expense per patient day.

The Nursing Services Target is the product of Nursing Services Base (table below) and the Labor Region Factor.

The Case-Mix-Neutral Nursing Services Allowance is the lesser of the facility’s Case-Mix-Neutral Nursing Services Expense per patient day or the Nursing Services Target.

The Case-Mix-Neutral Other Supplies and Services Allowance is equal to the Other Direct Care Supplies and Services Base (table below).

The Direct Care Allowance for each rate class is determined by multiplying the sum of the Case-Mix-Neutral Nursing Services Allowance and Case-Mix-Neutral Other Supplies and Services Allowance by the adjusted Medicaid FFS Non-DD case mix index.

	NFs	ICFs-IID
Nursing Services Base	\$93.24	\$75.22
Other Direct Care Supplies and Services Base	\$15.24	\$15.78

2.20 Direct Care Nursing Services

Direct Care Nursing Services shall include wages, fringe benefits, and purchased service expenses for registered nurses, nurse practitioners, licensed practical nurses, qualified intellectual disabilities personnel, certified nursing assistants, feeding assistants, nurse aide training and nurse aide training supplies. To be included as direct care, certified nursing assistants must be listed on the registry (unless

they have enrolled but not yet completed the required instructional program) and feeding assistants must have completed the state training program. Nursing personnel who provide inservice training are included. The expenses and hours for direct care nursing services not meeting the above requirements should be included in the cost center that most represents the task performed other than direct care.

2.21 Labor Factors

For each labor region, the labor factor is a three-year, rolling average of the factors from the most recent cost period and the two immediately preceding cost periods.

Labor Region	Labor Factor	Counties
Rural Wisconsin	0.955	Adams, Ashland, Barron, Bayfield, Buffalo, Burnett, Clark, Crawford, Door, Florence, Forest, Grant, Green Lake, Iron, Jackson, Jefferson, Juneau, Lafayette, Langlade, Manitowoc, Marinette, Marquette, Menominee, Monroe, Oneida, Pepin, Polk, Portage, Price, Rusk, Sawyer, Shawano, Taylor, Trempealeau, Vilas, Vernon, Walworth, Washburn, Waupaca, Waushara, Wood
Minneapolis	1.185	Dunn, Pierce, Saint Croix
Duluth/Superior	1.051	Douglas
Eau Claire	0.969	Chippewa, Eau Claire
La Crosse	1.050	La Crosse
Wausau	1.033	Marathon, Lincoln
Madison	1.057	Columbia, Dane, Dodge, Green, Iowa, Janesville, Richland, Rock, Sauk
Racine	0.962	Racine
Kenosha	1.028	Kenosha
Green Bay	0.952	Brown, Kewaunee, Oconto
Sheboygan	1.033	Sheboygan
Milwaukee	1.053	Milwaukee, Ozaukee, Washington, Waukesha
Appleton	1.001	Calumet, Outagamie
Oshkosh	1.009	Winnebago
Fond Du Lac	0.985	Fond du Lac

2.22 Fringe Benefits

Fringe benefits for staff are allocated to the same cost center as their wage category during the rate calculation. Unique fringe benefits (those provided to only a few employees) shall be reported as a salary or wage expense and not as a general fringe benefit. Bonuses that are associated with hours worked shall be reported in the same cost center as the employee's associated wages. The cost of employee meals as a fringe benefit will be \$4.25 times the allowable employee meals, less the employee meal revenue. The net cost for employee meals shall not be less than zero.

Medical services (such as vaccinations and wellness screenings) provided to ongoing employees of the provider may be classified as fringe benefits. Medical services provided to applicants (such as pre-employment physicals or drug screenings) will be treated as a recruitment expense in the Support Services cost center.

2.23 Worker's Compensation

The allowed worker's compensation cost will be the lesser of the calculated amounts obtained from the Wisconsin Compensation Rating Bureau policy or allowable cost of a self-insurance plan. Expenses may need to be accrued on an estimated basis since subsequent audit may result in additional costs or refunds for the cost reporting period. Allowed expense will be the amount accrued and paid within 75 days of the end of the cost report period. Any changes to previously estimated amounts that result in additional costs or refunds shall be reported as an addition or reduction of worker's compensation expense in the cost reporting period that they become known.

2.24 Self-Insurance Costs

The allowable expense for self-insurance plans is the actual claims paid during the cost reporting period. At the facility's option, accrual of pending claims may be made to the extent that such claims are paid within 75 days of the close of the cost reporting period. Such accrued claims may not be expensed in the following year's cost report. If a facility's self-insurance fund is managed by an independent (non-related) trustee, the fee paid to the trustee may be included in allowable self-insurance costs. If actuarial determinations are performed by an independent (non-related, non-employee) actuary, the fee paid to the actuary may be included in allowable self-insurance costs. Allowable self-insurance costs may also include the premium costs of re-insurance ("stop-loss") policies purchased from an unrelated company and any costs to administer the self-insurance plan. Allowable costs shall then be reduced for investment income. In order for investment income to remain in the self-insurance allowable cost determination, it must be separately identified and accounted for as related to the self-insurance plan. Any proceeds from these policies will be offset against the claims paid during the cost reporting period of receipt.

2.25 Inservice Training

The expense of providing inservice training for any of the above personnel shall be included in the calculation of the direct care allowance. Expenses relating to Nurse Aide Training and Competency Evaluation Programs (NAT/CEP) mandated by OBRA shall not be included as separate reimbursement is provided.

2.30 Direct Care - Other Supplies and Services

Direct Care – Other Supplies Services shall include expenses for ward clerks, non-billable physician time, non-billable lab, radiology, pharmacy, PT/OT/Speech, Dental, psychiatric and respiratory services, active treatment, volunteer coordinators, social service personnel, recreation personnel, religious services and other special care personnel, as well as their supplies, including purchased laundry-diapers and underpads, catheter and irrigation supplies, and other medical supplies. Non-billable services generally include those types of services which are provided to the facility as a whole instead of to an individual resident and/or which are not billable separately to the Medicaid Program per DHS 107, Wis. Adm. Code.

Direct Care – Other Supplies Services shall also include expenses to provide certain over-the-counter drugs ordered by a physician. For information on what drugs are considered over-the-counter, please reference the Covered Over-the-Counter Drugs data table available on the Forward Health Portal. Costs for any such over-the-counter drugs are considered to be reimbursed in the facility's daily rate and not to be billed or paid for separately. The allowable expenses may include the average wholesale price of the drugs and any pharmacy dispensing costs. Pharmacy dispensing costs shall not exceed 50% of the pharmacy's average wholesale price of the drug.

2.31 Supplies and Equipment

Durable Medical Equipment (DME) and Disposable Medical Supplies (DMS) reasonably associated with resident's personal living needs in normal and routine facility operations are to be provided to Medicaid members without charge to the patient, the patient's family, or other interested persons. Costs for any such items are considered to be reimbursed in the facility's daily rate and not to be billed or paid for separately. See the Forward Health Provider Handbook for lists of covered items.

If a Medicaid member specifically requests a brand of a non-durable item which the facility does not routinely supply and for which there is no equivalent or close substitute brand routinely supplied, then the recipient will be expected to pay the actual cost of that item out of personal funds, after being informed in advance that there will be a charge for the item. However, if the non-durable item was ordered by a physician, the member cannot be charged. DHS 107.09(2)(b), Wis. Adm. Code.

Information regarding DME is contained in DHS 107.24, Wis. Adm. Code, and in the DME Provider Handbook.

2.40 Case Mix Indices (CMI)

CMIs are established using the information available on claims and MDS assessments by the "as of date." Medicaid residents receiving special payment as ventilator-dependent will not be included in either the All Resident or the Medicaid CMI.

A resident will be included in the Medicaid FFS Non-DD CMI for a quarter if there is both a payment for a Medicaid day and a RUGable MDS dated on or prior to the last day of that quarter. If a Medicaid FFS resident does not have an acceptable RUGable MDS, they will be assigned the average CMI for all other Medicaid FFS Non-DD residents. Eligible patient days from the admission date, but preceding the assessment date, shall be assigned the RUGable MDS established on the assessment date.

Medicaid FFS Non-DD bed hold residents during a quarter are included in the Medicaid FFS Non-DD in-house CMI. The CMI applied to these bed hold residents is the Non-DD in-house CMI obtained by treating these residents as if they were in-house residents during the quarter. Non-DD bedhold residents are also included in the All-Resident CMI.

The average quarterly CMI for the facility shall include all valid RUGs scores, which may include multiple distinct RUGs scores for an individual resident.

A resident will be included in the All-Resident CMI only if the most recent MDS record is dated within the cost reporting period and is not a discharge tracking record. If a resident does not have a RUGable MDS, they will be assigned the average CMI for all other Non-DD residents in that quarter.

For cost allocation purposes, resident acuity during the cost reporting period is based upon the distribution of patient days by rate class provided in the cost report. For all rate classes other than Non-DD, the case mix index is weighted according to the weights in Section 2.42. Reported Non-DD patient days are assigned a facility-specific case mix weight equal to the average RUGs CMI for all Non-DD residents during each quarter falling within the cost reporting period.

2.41 Review and Correction of Case Mix Indices

The department will provide summary information supporting the basis of the CMIs to the provider. The facility may request resident level data. The facility may request corrections if they meet the material adjustment standard and are based on the data available. Any information exchanged under this process will be considered protected health information.

If the Medicaid FFS non-DD CMI for any quarter is based on five residents or less, the facility may request or the Department may require an alternate reporting period.

2.42 Case Mix Weights

Level of Care	Case Mix Weight
DD	1.94
DD Bedhold	1.07
Ventilator	3.89

RUG	Case Mix Weight
BA1	0.53
BA2	0.58
BB1	0.75
BB2	0.81
CA1	0.65
CA2	0.73
CB1	0.85
CB2	0.95
CC1	0.96
CC2	1.08
CD1	1.15
CD2	1.29
CE1	1.25
CE2	1.39
ES1	2.22
ES2	2.23
ES3	3.00
HB1	1.22
HB2	1.55
HC1	1.23
HC2	1.57
HD1	1.33
HD2	1.69
HE1	1.47
HE2	1.88
LB1	0.95
LB2	1.21
LC1	1.02
LC2	1.30
LD1	1.21
LD2	1.54
LE1	1.26
LE2	1.61
PA1	0.45

PA2	0.49
PB1	0.65
PB2	0.70
PC1	0.85
PC2	0.91
PD1	1.06
PD2	1.15
PE1	1.17
PE2	1.25
RAA	0.82
RAB	1.10
RAC	1.36
RAD	1.58
RAE	1.65
Non-DD Bedhold	0.25

2.43 Source of the RUGs Case Mix Weights from Various Reporting Periods

Reporting Period	Picture Quarter	Available Data Used, as of
Jan 2018 – Mar 2018	Jan 2018 – Mar 2018	June 30, 2020
Apr 2018 – Jun 2018	Apr 2018 – Jun 2018	June 30, 2020
Jul 2018 – Sep 2018	Jul 2018 – Sep 2018	June 30, 2020
Oct 2018 – Dec 2018	Oct 2018 – Dec 2018	June 30, 2020
Jan 2019 – Mar 2019	Jan 2019 – Mar 2019	June 30, 2020
Apr 2019 – Jun 2019	Apr 2019 – Jun 2019	June 30, 2020
Jul 2019 – Sep 2019	Jul 2019 – Sep 2019	June 30, 2020
Oct 2019 – Dec 2019	Oct 2019 – Dec 2019	June 30, 2020

2.44 Source of the Reimbursement Period Case Mix Index

Picture Quarter	Available Data Used, as of	Rate Effective Date
Oct - Dec 2019	June 30, 2020	July 1, 2020
Jan - Mar 2020	Aug 31, 2020	Oct 1, 2020
Apr - Jun 2020	Nov 30, 2020	Jan 1, 2021
Jul - Sep 2020	Feb 28, 2021	Apr 1, 2021

2.50 Cost Report Inflation and Deflation Factors

The inflation factors used to adjust expenses from cost reports to the reimbursement period are listed below according to the ending month of the cost reporting period. The Department may establish alternate factors for periods not listed.

	January February March 2019	April May June 2019	July August September 2019	October November December 2019
Wages	8.1%	7.0%	5.9%	4.9%
Fringe Benefits	7.3%	6.6%	6.1%	5.5%
Supplies/OTC Drugs	4.5%	4.0%	3.5%	3.0%
Purchased Services	6.4%	5.7%	5.0%	4.4%

3.00 Support Services

3.10 Support Services Allowance Calculation

The support services allowance is a priced allowance as follows:

NFs: \$50.61	ICFs-IID: \$50.79
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3.20 Support Services Allowance Description

The support services allowance covers allowable expenses for dietary, maintenance, housekeeping, laundry, security, transportation, administrative service, and fuel and utilities expenses. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services and other allowable expenses which cannot be appropriately recognized in other cost centers.

Expenses for the provision of general administrative, clerical, financial, accounting, purchasing, data processing, medical records and similar services are usually considered administrative service expenses. Also included are allowable expenses for non-medical transportation, telephone, office supplies, training fees, license fees, insurance (except property, mortgage and general employee benefit insurance), working capital interest expense, amortized financing acquisition costs and other similar expenses.

3.21 Home Office Cost Allocations

Administrative expenses allocated to the nursing facility from centralized administrative units shall be recognized among administrative service expenses, including the centralized unit's allocated overhead expenses such as maintenance, utilities and depreciation. Salaries and fringe benefits for any nursing personnel, quality assurance personnel, and therapy consultants who report to a centralized administrative unit, but do not provide direct hands-on patient care shall be included as central office costs. Expenses may be adjusted by the Department for unreasonable or unnecessary expenses or duplicative services.

3.22 Management Service Contract Fees

Management service contract fees shall be recognized among administrative service expenses, but may be adjusted for unreasonable or unnecessary levels of service, compensation, or duplicative services.

3.23 Legal and Other Professional Fees

Legal and other professional fees incurred by a provider that are not directly related to patient care are not allowable.

Legal and other professional fees awarded to a provider as a result of an administrative appeal of any licensing/certification action by a state agency shall be allowed.

3.30 Cost Report Inflation and Deflation Factors

The inflation factors used to adjust expenses from cost reports to the reimbursement period are listed below according to the ending month of the cost reporting period. The Department may establish alternate factors for periods not listed.

	January February March 2018	April May June 2018	July August September 2018	October November December 2018
Support Service Expenses	6.1%	5.3%	4.6%	4.0%

4.00 Property

4.10 Property Payment Allowance Calculation

The property payment allowance will be a per patient day amount based on the equalized value of the nursing facility; target amounts established by the Department, and the nursing facility's allowable property-related expenses. If needed, the expenses and patient days reported shall be adjusted to a 365-day period. This allowance is intended to provide payment for ownership and/or rental of land, land improvements, buildings, fixed and movable equipment and any other long-term, physical assets.

Annualized allowable property expenses will be limited to 15% of the equalized value of the facility.

The property target is 7.5% of equalized value.

When the facility's allowable property-related expenses are greater than the target, the property payment allowance will be the target amount plus the cost share value (20% or 40%) times the amount by which allowable expenses exceed the target.

Nursing facilities licensed as NF only that have beds for rate setting of 50 beds or less will have a cost share value of 40%. All other facilities will have a cost share value of 20%.

4.11 Maximum Decrease

A facility's payable property allowance will not be reduced by more than \$3.50 per patient day from the allowance in effect for the prior rate year. If the prior rate year's allowance was based on "start-up" occupancy provisions for newly-licensed or expanded facilities, the \$3.50 maximum reduction is measured from the allowance which would have resulted from applying the Methods without those provisions on the last day of the prior rate year.

4.20 Equalized Value

The equalized value will be derived from the values determined by an independent appraisal contractor using the CoreLogic Building Valuation System (BVS). The values established by such contract will be indexed, if necessary, to the current rate year. The equalized value will be the Depreciated Replacement Cost (DRC) from the BVS valuation after adjustment for square footage allocations and the per bed maximum on equalized value.

The values derived from the BVS valuation will be adjusted to exclude the value of areas not related to skilled nursing facility patient care. To the extent possible, this adjustment will be based on the square footage used in the BVS valuation.

The Undepreciated Replacement Cost (URC) arrived at under the BVS valuation will be limited to not exceed \$75,900 times the beds for rate setting. Where this maximum is exceeded, the equalized value will be adjusted proportionately.

Equalized value (EV) = (URC after adjustment for square footage and per bed limits / URC after adjustment for square footage but before per bed limits) * DRC after adjustment for square footage

4.30 Therapy Spaces

If gross therapy billings (exclusive of contractual adjustments) for physical, occupational, and speech therapy services provided are greater than or equal to \$100,000 for the cost reporting period, square

footage space allocations may be made. Gross therapy billings include total amounts billed for all therapy services provided at the facility for residents and non-residents, by the facility directly, by a related party or by a contracted therapy services provider.

If Medicare Part B billings for services provided at the facility are greater than or equal to 10% of total billings for therapy services provided, square footage space allocations shall be made to the skilled nursing facility, based on the proportion of Part B billings to total billings.

If total therapy gross billings attributable to non-nursing facility residents equals 2% or more of total billings, or if the nursing facility is subject to an allocation under the Medicare Part B criterion (above), a space allocation will be made based on the proportion of therapy services billed for non-nursing facility residents to total therapy services billings.

4.40 Changes of Ownership

If a facility changes ownership, the new owner's costs will be reported in the following cost reporting period.

The asset value of nursing facilities acquired at a total cost of less than \$101 shall be allowed at the lesser of fair market value or net book value of the owner last participating in the Medicaid program.

For facilities acquired at a price in excess of \$101; the new owner's allowed costs will be the lesser of the purchase price or maximum allowed costs. The maximum allowed cost is the seller's annual asset acquisition costs by year(s) of acquisition times the lesser of one-half of the percentage increase, measured over the same period of time, in the Consumer Price Index (CPI) for All Urban Consumers (United States city average) or the Dodge Construction Index (DCI) applied from the year(s) of acquisition to the date of the sale. The year(s) of acquisition is/are the year(s) the assets were purchased or constructed by the seller.

If either the seller or the buyer cannot support the individual assets acquired, the historic asset acquisition cost(s) and/or the date(s) of asset acquisition, the following procedure will be followed to impute the maximum allowed costs:

1. The ending balance of the total capitalized historical cost of all depreciable assets, from the last available fiscal year cost report of the seller will be the base value.
2. The ending balance of accumulated depreciation of all depreciable assets, from the same cost reporting period, will be divided by the reported depreciation expense (annualized, if necessary) to impute average years of ownership.
3. The lesser percentage of CPI or DCI will be determined based on the imputed average years of ownership and applied to the base value of all assets acquired to calculate an initial maximum.
4. This initial maximum will be compared to 108% of the equalized value and the lesser value will be allowed as the maximum value related to all assets.

Where no cost report information is available, the maximum allowable value will be 108% of the equalized value.

If more than one nursing facility is purchased at the same time, the purchase price of all property related assets will be allocated proportionately to all purchased assets based upon an independent uniform appraisal method chosen by the purchasing provider.

The merger or the consolidation of a corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership. In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, constitutes change of ownership.

The costs of acquiring the rights to licensed beds from another provider are non-reimbursable.

If a facility's valuation is limited by a change of ownership to maximum allowed costs, the associated depreciation, amortization, and interest expenses will be limited by the ratio of allowed value to reported value.

4.41 Inadequate Documentation

If the provider, buyer, or seller is unable or unwilling to provide adequate documentation of acquisition cost, acquisition date or other data relevant to the property-related expenses, or does not comply with property documentation requests, secondary sources of information, such as income and property tax records will be used. The source chosen may result in the lowest value or the lowest property payment allowance.

4.50 Allowable Property-Related Expenses

Allowable property-related expenses include property and mortgage insurance, amortization of construction-related costs, amortization of bond discount and premium, interest on plant asset loans, depreciation, and lease and rental expenses.

4.51 Property Insurance

Allowable property insurance expense will be the accrual-based expense from the base cost reporting period. This expense will be subject to allocations for revenue-producing areas and non-nursing facility areas. Allowable property insurance expense includes mortgage insurance required by the lender.

4.52 Amortization

Amortization of bond discounts and premiums are to be considered an element of interest expense. Letter of credit fees related to a letter of credit used only as collateral for obtaining long term financing shall be allowed.

4.53 Interest Expense

Interest expense on debt incurred for acquisition of land, land improvements, buildings, leasehold improvements, and fixed and movable equipment related to nursing facility patient care shall be allowed subject to the limitations that follow.

The order for cost finding adjustments for interest expense is;

1. Reclassification of expenses; only debt for asset purchases are reimbursed.
2. CPI limitation, applied if associated asset purchases are limited by a CPI factor for allowed value.
3. Allocations to non-nursing home areas.
4. 110% of Equalized Value limit for total loan balances.

4.53(a) Recognizable Debt Balances

Interest expense will not be allowed on the portion of debt balances which were disallowed or not allocated to the SNF due to a change in ownership.

Interest expense will only be recognized for allowable assets purchased in the same cost report period of loan acquisition or the following two cost report periods. Assets purchased in the second and third cost report periods may increase the maximum allowable financing.

Maximum allowable financing may not exceed 110% of Equalized Value.

4.53(b) Systematic Reduction of Debt

Allowable interest expense may not exceed the amount which would have been incurred under a systematic reduction of debt which has payments of interest and principal that are uniform over the total length of debt and a length not exceeding the remaining useful life of the longest lived asset acquired with debt proceeds.

If a facility does not make at least annual principal payments, the allowable interest expense will be limited by an amortization schedule calculation. The amortization schedule will be prepared for the period of the longest-lived asset acquired by the debt and use the interest rate as stated in the debt contract.

4.53(c) Refinancing Expenses

Refinancing fees and amounts borrowed for working capital will not be recognized as property costs.

The allowable interest expense for refinancing arrangements may not exceed the amount which would have been allowed on the recognizable debt balance, excluding financing fees, had the refinancing not occurred.

4.54 Depreciation

Depreciation expense must be calculated under a straight-line method over a useful life determined by the American Hospital Association guidelines, subject to the minimums below. Depreciation options available for income tax purposes, such as the Asset Depreciation Range System or the Additional First-Year Depreciation, may not be used. A composite useful life may be used for a class or group of assets.

For the initial construction of buildings, including fixed equipment and land improvements, the minimum useful life must be 35 years from the earlier of the date of initial licensure or the date of initial occupancy. A minimum useful life of 20 years will be applied to purchased facilities. A minimum useful life of 5 years will be applied to purchase of used moveable equipment. Remodeling of existing licensed facilities will be depreciated according to American Hospital Association guidelines for each of the individual components of the project.

Amortization of costs related to acquiring financing (i.e., bond issuance costs, bond placement fees, letter of credit fees, finder's fees, credit checks, origination fees, appraisal fees, feasibility studies, and loan application fees) are not considered property-related expenses but are allowable amortizable expenses under the support services cost center. Write off of the entire unamortized discount (premium) and unamortized fees associated with refinanced debt will be allowed as of the date of refinancing as recognized for cost reporting purposes.

4.55 Lease Expense

Leased facilities will be subject to a lease maximum. The property costs recognized will be the lower of actual payments made as required under the lease contract or the lease maximum. Lease expenses determined under the capitalized lease method will not be recognized.

Facilities leased for the first time will have their lease maximums determined by reference to the current owners' years of acquisition of the facility's fixed assets. If a facility is unable to provide adequate support of the dates of asset acquisition, average years of ownership may be imputed as they would be under a change of ownership Reference. The allowable property costs included in rates on the last day of the prior cost report period will be multiplied by the ratio below:

- If the current owner constructed the facility: Original costs adjusted by one-half CPI divided by original costs.
- If the current owner purchased the facility: Purchase price and capital additions adjusted by one-half CPI divided by the allowable purchase price plus capital additions in prior cost report period.

Facilities leased in previous cost report periods will have their lease maximums increased by one-half of the percentage change in the CPI.

New or replacement facilities will have a lease maximum of the lessor's allowable depreciation and interest for the new building, with the lessor's loan balance being limited to 110% of Equalized Value.

An unrelated party sale and lease back transaction will have a lease maximum determined by applying one-half the increase in the CPI from the year of the sale to the allowed reimbursable property expenses in the year before the sale for the assets that are now leased.

Lease maximums will not apply to depreciation, interest, lease and rental or other property costs on assets acquired after lease inception, such as the purchase or leasing of new equipment or leasehold improvements. The costs of acquiring existing leasehold rights are not allowable.

5.00 Property Tax

5.10 Property Tax Allowance Calculation

Allowable property tax expense is the tax due in the calendar year in which the rate year begins. For example, the 7/1/20 rate calculation will include the amount of the 2019 property tax bill increased by the inflation factor in Section 5.40.

Allowable property tax expense shall be net of any state property tax credit and any special assessments for capital improvements or additional fees or interest. Whenever exemptions to property tax are legally available, the provider is expected to pursue such exemptions or the expenses incurred shall not be allowed.

5.20 Tax-Exempt Facilities

The property tax allowance for tax-exempt providers includes municipal service fees or payments in lieu of property taxes made subject to an agreement with a taxing authority, as long as these fees are not intended for capital expenditures or utilities and otherwise mirror property taxes that would be charged a similarly situated for-profit provider.

5.30 Property Tax Changes

The property tax allowance shall not be adjusted to recognize a change in tax status upon a change of ownership until it is reported in the normal cost report period.

The provider may request the property tax allowance for a new facility or expanded facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective January 1 of the year payment is due.

5.40 Property Tax Inflation Factor

Property tax inflation factor	0.7%
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6.00 Provider Incentives

6.10 Exceptional Medicaid/Medicare Utilization Incentive (EMMUI)

Nursing facilities with exceptional Medicaid/Medicare utilization not operated by a governmental entity may receive the Exceptional Medicaid/Medicare Utilization Incentive (EMMUI). The primary source of ownership information is the owner identified on the operating license issued by the Department as of the last day of the cost report period. If a governmental nursing facility changes ownership, it will not be eligible for this incentive until the change in ownership is reflected on the cost report period.

The incentive is calculated according to the Medicaid/Medicare percentage, which is the facility's FFS and Managed Care Medicaid patient days plus Medicare patient days divided by the facility's total patient days. The incentive will vary based on facility size and whether the facility is located within the city limits of the City of Milwaukee.

Min %	Max %	Incentive >50 Beds	Incentive <50 Beds	Milwaukee City Limits
95%	100%	\$2.70	\$4.20	\$4.60
90%	94.9%	\$2.45	\$3.65	\$4.00
85%	89.9%	\$2.20	\$3.10	\$3.40
80%	84.9%	\$1.90	\$2.50	\$2.75
75%	79.9%	\$1.70	\$2.00	\$2.20
70%	74.9%	\$1.50	\$1.50	\$1.65

6.20 Private Room Incentive

Nursing facilities may receive a Private Room Incentive (PRI) by signing a cost report affidavit stating the facility will not charge Medicaid residents a surcharge for private rooms as allowed under DHS 107.09(4)(k) for the entire rate year. The affidavit must be received prior to the effective date of the incentive unless the Department approves otherwise.

The amount of the incentive is determined using the excess of the percentage of licensed beds in private rooms over the percentage of cost report patient days associated with non-Medicaid residents. This excess, if greater than zero, is divided by the percentage of cost report patient days associated with Medicaid residents and the result is multiplied by \$1.50 per patient day.

For the purposes of calculating this incentive, Medicaid resident patient days include Medicaid Fee-For-Service, Medicaid Managed Care and Medicaid Hospice days.

6.40 Innovative Area Incentive

Nursing facilities may be eligible for the Innovative Area Incentive by requesting Department approval for improvement of the physical environment and the quality of resident life through renovation or replacement of the building. The facility must improve the physical plant and operations in which nursing care is provided in a manner that will not increase the overall cost to the Medicaid program. For details, please request an application packet from the Section Chief for Nursing Home Policy & Rate Setting.

Nursing facilities that have received approvals for the incentive will continue to receive the incentive according to the terms of their approval letter.

6.50 Bariatric Equipment Incentive

The bariatric equipment incentive covers specialized bariatric moveable equipment purchases during the cost report period. Lease purchase agreements will not be considered for this incentive. The incentive is calculated by the cost of the purchases in the cost reporting period divided by the total patient days to get the acquisition cost per day. The incentive is equal to 50% of the acquisition cost per day. The bariatric equipment must meet all normal cost reporting capitalization requirements. No options or attachments to the bariatric units will be allowed for the incentive. In situations of a short period cost report or where the same cost report is used for multiple payment periods, the calculation will only be allowed in one rate year as to not duplicate the incentive.

Allowable purchases for the incentive:

- Lifts identified for 400 lbs. or more
- Beds identified for 500 lbs. or more and 40" or greater in width
- Mattresses identified to fit the bariatric bed only
- Commodes identified for 600 lbs. or more and extra wide
- Wheelchairs identified for 450 lbs. or more

6.60 Behavioral/Cognitive Impairment (Beh/CI) Incentives

The Behavioral/Cognitive Impairment Incentives (Beh/CI) provides additional reimbursement for costs associated with the care of patients with specific behavioral or cognitive difficulties. The incentives are calculated by applying two scores for each resident, an Access Score and an Improvement score. The score values are defined by the MDS elements listed below and acuity categories ranging from 0 to 5 based on psychiatric and related diagnosis codes under the International Classification of Diseases, as organized via decision rules promulgated under the Chronic Illness and Disability Payment System (CDPS). The Beh/CI scores are based on index values aggregated at the facility level, calculated using data from Title 19 FFS Non-DD residents present on the last day of the second quarter of the fiscal year that also had a RUGable MDS assessment on or prior to that date. The scores are only calculated for individuals when they have both a RUGable MDS assessment and a CDPS score greater than zero. Non-RUGable MDS assessments or MDS assessments that do not coincide with a CDPS score greater than zero are excluded and treated as a break in stay for the purposes of the incentive.

- a) Beh/CI Access Incentive: The incentive is determined by multiplying the Beh/CI Access Score by the Beh/CI Access Base Rate of \$6.05. The Access Score for each resident is calculated by subtracting 1.00 from the higher of the resident's first two available MDS Behavioral Scores and

setting any negative results to zero. The first and second MDS behavioral scores are defined as the resident's first and second scores after whichever of the following Starter Events occurred most recently:

- Admission to the facility;
- A change in the POP ID;
- A break in stay of more than 30 days;
- October 1, 2010.

b) Beh/CI Improvement Incentive: The incentive is determined by multiplying the Improvement Score by the Beh/CI Improvement Base Rate of \$0.65. The Improvement Score for each resident is calculated using the six most recent RUGable MDS Behavioral Scores since the Starter Event determined for the Beh/CI Access Incentive. If fewer than six RUGable MDS Behavior Scores exist, all available scores are used. First, an Improvement Baseline is set. If the Starter Event occurred far enough in the past that the resident has more than six available MDS Behavioral Scores, the Improvement Baseline is set to the fifth most recent MDS Behavioral Score. If six or fewer MDS Behavioral Scores are available, the Improvement Baseline is set to the greater of the two earliest available MDS Behavioral Scores. Next, the Improvement Score is determined by a) calculating the change from the Improvement Baseline to the average of the MDS Behavioral Scores that remain after excluding the two earliest MDS Behavioral Scores; b) setting negative results to zero; and c) multiplying the calculated change by a CDPS factor ranging from zero to five. The CDPS factor is the CDPS score that the individual had on the date of the MDS Behavioral Score used for the BEHCI Access Incentive.

MDS Variable Item Number	Item Title	Coded Score	Behavioral Score Weight
E0900	Wandering Presence & Frequency	1	.4
		2	.8
		3	1.2
E01000A	Wandering Impact	1	1.5
E01000B	Wandering Impact	1	1.5
E0200A	Behavior: Physical Directed Toward Others	1	.6
		2	1.2
		3	1.8
E0200B	Behavior: Verbal Directed Toward Others	1	.6
		2	1.2
		3	1.8
E0200C	Behavior: Other Symptoms	1	.6
		2	1.2
		3	1.8
E0500A 1 1.5 .6	Behavior: Risk of Physical Injury	1	1.5
E0500B	Behavior: Interferes with Care	1	.75
E0500C	Behavior: Interferes with Activities	1	1.5
E0600A	Behavior: Others at Risk	1	1.5

E0600B	Behavior: Intrudes on Others	1	.75
E0600C	Behavior: Disrupts Care	1	.75
E0800	Behavior: Rejects Care	1	.6
		2	1.2
		3	1.8
D0300	Severity: Resident Mood Interview	15 or greater	1.5
D0600	Severity: Staff Assessment of Mood	15 or greater	1.5
G0110E	Locomotion: Resident Movement	0	1.0
		1	.75
		2	.75

6.70 Medicaid Access Incentive (MAI)

The Medicaid access incentive is provided to all facilities to facilitate access to nursing facility care for Medicaid recipients. Facilities certified as a nursing facility will receive an incentive of \$9.65. Facilities certified as an Intermediate Care Facilities for Intellectual Disabilities (ICF-IID) will receive an incentive of \$33.24. Distinct part ICF-IIDs will have separate rates reflecting the separate incentives.

7.00 Other Payment Calculations

7.01 Ventilator Dependent Residents

A rate of \$610 per patient day shall be paid in lieu of the normal daily rate for any facility treating a resident who has received prior authorization for ventilator-dependent care. Bedhold days for these residents, if qualifying, will pay at the applicable bedhold rate. The costs of exceptional supplies related to care of ventilator-dependent residents are included in the above rate and cannot be billed separately. Facilities must receive approval of their ventilator program from the Division of Quality Assurance in order to treat residents and receive payment under this section.

7.02 Traumatic Brain Injury Residents

Facilities providing treatment for residents that have suffered a traumatic brain injury and received prior authorization for rehabilitative care may receive a negotiated rate in lieu of the facility's daily rate. Allowable cost principles and formula maximums may be applied to rate calculations. If occupancy of the unit drops below 50% for the reimbursement period, allowable costs will be proportionately reduced to reflect costs associated with unoccupied head injury unit beds. Facilities must receive approval of their traumatic brain injury program from the Division of Quality Assurance in order to treat residents and receive payment under this section.

7.03 Isolation Rate

Subject to prior authorization and the requirements of DHS 132.51(2)(b), a facility providing an isolation room may receive an add-on of the difference between the facility's semi-private and private-room rates, limited to \$35 per day.

7.04 Appraisal Payments

Facilities are responsible for paying the Department's selected appraisal contractor for approved appraisals used for rate-setting purposes. The rate charged by the contractor will be determined by the state procurement process. Facilities will be reimbursed these costs through supplemental payments when the Department has received verification that the contractor has received the facility's payment.

7.10 State and Tribal Owned or Operated Facilities

The rate for State and Tribal-owned nursing facilities will be the Medicare payment rate effective during the reimbursement period, based on the Medicaid case mix of the facility.

The payment rate for state and tribal-owned or operated ICFs-IID will be based on the actual allowable cost during the reimbursement period. Interim rates may be established. A cost reconciliation will be conducted at the end of each state and tribal-owned or operated ICF-IID's fiscal year. In no case shall the total Medicaid payment exceed the Medicare Upper Limit. (For information on the Medicare upper limit, see section 7.30.)

Maximums and limitations shall not be applied in determining payments to state-and tribal operated facilities. The amount of the final payment shall be based upon the actual and allowable costs in the cost reporting period plus the Medicaid Access Incentive. Actual and allowable capital expenses for the cost reporting period shall be used to calculate the final property allowance. The facilities shall be subject to all cost reporting requirements.

7.20 Supplemental Payments for Facilities Operated by Local Units of Government

Total supplemental payment funding of \$39,100,000 will be made unless it is determined that aggregate payments would exceed the Medicare upper limit, or if additional supplemental funding is authorized by state statute. (For information on the Medicare upper limit, see section 7.30.)

In order to participate in the supplemental payment program, each NF must have on file a cost report, a prospective supplemental award application form, and a signed affidavit certifying the amount of local government expenditures eligible for FFP under 42 CFR 433.51(b).

Supplemental payments will be awarded based on the following calculated Medicaid deficits from the audited cost reports used for rate-setting.

- The Projected Direct Care Operating Deficit (DCOD).
- The Projected Overall Operating Deficit (OAOD).
- The Eligible Direct Care Deficit (EDCD) (Equal to the lesser of the DCOD or the OAOD).
- The projected non-direct care deficit (Equal to the OAOD less the EDCCD).

If funding is sufficient, each facility will receive their OAOD. If funds are not sufficient, each facility will receive their EDCCD and remaining funds will be distributed according to facility's non-direct care deficit per Medicaid day. If funds are not sufficient to distribute each facility's EDCCD, facilities will receive payments for each Medicaid patient day up to the amount of their EDCCD.

If a governmental facility is sold during the effective period of this plan, deficits and patient days will be prorated based on the number of calendar days the facility was licensed as a governmental facility during the cost reporting period. If the facility was sold prior to the effective period of this plan, there shall be no award under this provision. If an existing facility is purchased by a local unit of government during the effective period of this plan, there will be no award because the purchasing local unit of government had no days during the cost reporting period.

7.30 Calculation of Medicare Upper Limit

The Medicare upper limit (MUL) is applied in aggregate to each of six categories of NFs and ICF-IIDs: NFs owned or operated by the state, non-state government-owned NFs, privately-owned NFs, ICF-IID owned or operated by the state, non-state government-owned ICF-IID, and privately-owned ICF-IID.

Medicaid payments to any category may not exceed a reasonable estimate of the amount that would be paid for the services furnished by the facilities under Medicare payment principles. The estimated amounts Medicare would pay for Medicaid services within each of the NF categories are the aggregate payments that would be applicable to Medicaid residents according to their RUG classification under the SNF PPS. Since the SNF PPS system and the RUG classification system does not apply to ICFs-IID, aggregate allowable costs are used to determine the Medicare Upper Limit for ICFs-IID.

7.40 Specialized Psychiatric Rehabilitative Services (SPRS)

A \$9 per patient day payment is available to skilled nursing facilities that provide SPRS to residents determined to have a mental illness by a Level II PASRR screen. A Level II PASRR screen that indicates that nursing facility placement is appropriate and that SPRS is needed is required every two years to maintain eligibility for the supplemental payment.

To qualify for the supplemental payment, the nursing facility must prepare a SPRS care plan that defines measurable goals and objectives for the client's specialized psychiatric rehabilitative services. The SPRS care plan must be reviewed and updated at least annually or as needed to appropriately reflect change in the client's need for mental health services. If the facility believes that specialized rehabilitative services are no longer required, they must request a resident review from the PASRR contractor.

7.50 Medical Transportation

Medical transportation is separately billable and reimbursed at \$10 per day plus \$1.00 per mile. Medical Transportation is transportation provided by a nursing facility to permit a recipient to obtain healthcare if prescribed by a physician as medically necessary. Such transportation may be provided in the facility's own controlled equipment and by its staff, or by other carriers, such as bus or taxi.

7.60 Out-of-State Nursing Facilities

Wisconsin Medicaid recipients may receive care in a NF located outside the State of Wisconsin if the facility is certified in the Medicaid program of the other state.

Payment for temporary coverage will be at a standard payment rate for the month of admission and for a maximum of three full calendar months after the admission date. The Department will establish the rate based on the approximate average payment rate for a comparable level of care as paid to Wisconsin nursing facilities.

A payment rate more specific to the out-of-state facility may be established if either the facility or the Department determines the standard rate is inappropriate for the resident or if the resident stays longer than the temporary rate period. In determining a different rate, the Department may consider Medicaid rates being paid to the facility by their home state; payment for similar services in Wisconsin; available information on the cost of the facility's operation; and any specialized services or unique treatment regimens.

Ancillary items may be separately reimbursed to the out-of-state facility according to the usual procedures.

7.70 Purchased Relocation Services

A lump sum payment may be paid in addition to the daily payment rate if a relocation plan is ordered by the Department, the Department approves the contractor, and the allowed amount meets all Departmental contracting limits. Staff costs otherwise allowable are not to be included in the lump sum payment.

The Department will pay the Medicaid portion of the purchased relocation services, as determined by the percentage of residents receiving FFS Medicaid in the month prior to the relocation order. The Department may pay 100% of the purchased relocation services if it is in their best interest.

7.80 Payment for Services Provided During Temporary Evacuation

If a facility is evacuated due to a natural or man-made disaster, pursuant to a declaration by the Governor or approval by the Department Secretary of a state of emergency, the Department shall provide payment for extraordinary expenses that occurred on or after the first day of the base cost reporting period and associated with the temporary evacuation.

Extraordinary expenses include the Medicaid share of payments for direct expenses or purchased services for temporary accommodations and emergency repairs to the nursing home, including costs associated with the evacuated residents incurred by other service providers in providing care, treatment, housing and housing-related services for the evacuated residents. Payment for extraordinary expenses is not subject to the formula maximums but is net of insurance and third party payments.

The Department may establish an interim payment for extraordinary expenses, subject to reconciliation with a retrospective settlement.

Payment for extraordinary expenses is contingent upon the facility pursuing all possible sources of revenue, including third party insurance for resident services, property insurance, business interruption insurance and litigation for damages from responsible parties. Payment may be recouped in part or in full if the facility does not make a good faith effort to pursue all possible sources of revenue for extraordinary expenses or if the facility successfully recovers funds.

7.90 Bedhold

Hospital bed hold days and therapeutic bed hold leave days, including bed hold days for residents approved for ventilator-dependent payment, will be paid at a 0.25 RUG classification rate for qualifying nursing facilities and at the DD Bedhold rate for qualifying ICFs-IID. Bed hold cannot be billed for residents approved for traumatic brain injury stays, or for residents receiving Medicare Part A nursing facility services. A maximum of 15 consecutive days is covered for each hospitalization leave.

In order to qualify to bill for bed hold, the provider's occupancy level must be 94.0% or greater during the calendar month prior to the bed hold days. For purposes of this calculation, licensed bed-days shall not include any restricted use beds or beds out of service due to code violations or for isolation, seclusion, or restraint purposes. Chargeable bed hold days in the prior month shall be included as occupied patient days in the calculation.

Facilities pursuing a closure or licensed bed reduction may receive an exemption from the occupancy requirements if approved in advance by the Department. A provider operating two or more separately certified facilities on contiguous property with common ownership, including distinct part facilities, may elect to combine the occupancy tests or maintain separate occupancy tests on a month-by-month basis.

No resident or third party may be charged for covered but unreimbursed bed hold days provided to a Medicaid recipient, even if a provider does not meet the occupancy requirements to bill for them.