

State of Wisconsin  
Department of Health Services  
Division of Medicaid Services  
*Methods of Implementation for Wisconsin Medicaid Nursing Home Payment Rates*  
For the Period July 1, 2017 through June 30, 2018

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## Section 1.000 Introduction

### 1.005 General Purpose

The purpose of the Wisconsin Medicaid *Methods of Implementation for Medicaid Nursing Home Payment Rates* is to ensure that nursing homes, including nursing facilities (NFs) and intermediate care facilities for individuals with intellectual disabilities (ICFs-IID), are paid appropriately for care provided to Medicaid residents in a cost-efficient fashion.

Wisconsin nursing homes participating in Wisconsin Medicaid are paid by a prospective rate-setting methodology as stipulated in s. 49.45(6m), Wis. Stats. This methodology must meet federal standards and is established in the *Methods* issued annually by the Wisconsin Department of Health Services, hereafter known as the Department. Within the Department, the Division of Medicaid Services (DMS) has primary responsibility for establishing nursing home payment rates.

The Department shall develop such administrative policies and procedures as are necessary and proper to implement the provisions outlined in the *Methods*. This information shall be communicated to the nursing home industry as necessary, such as through program memoranda, provider handbooks, and Medicaid Updates. Such policies and procedures are generally intended to apply to usual and customary situations and are not necessarily applicable to special situations and circumstances. Any questions regarding specific circumstances should be referred to the Department.

### 1.010 Further Information

For further information, contact:

Director  
Bureau of Long Term Care Financing  
Division of Medicaid Services  
P.O. Box 7851  
1 West Wilson Street  
Madison, WI 53703

Individual nursing homes should contact their district Medicaid auditor for specific questions on their payment rates.

### 1.100 Basis of the Nursing Home Payment Rates

Allowable payment levels are determined by the Department through examination of costs actually incurred by each nursing home in Wisconsin as described in these *Methods*, under the authority granted by, and requirements listed in, s.49.45(6m)(ag), Wis. Stats.

### 1.130 Authority and Interpretation of 2017-2018 *Methods*

These *Methods* will determine payment for services provided during the twelve-month time period of July 1, 2017, through June 30, 2018, unless otherwise modified by legislative action, or federal or court direction. A new rate period begins with services rendered on or after July 1, 2018.

### 1.131 Severability

The provisions of the *Methods of Implementation for the Medicaid Nursing Home Payment Rates* are to be considered separate and severable.

### 1.132 Effective Period of Payment Rates

Rates shall be implemented on or after July 1, 2017, unless otherwise specified. Rates issued after July 1, 2017, shall be approved retroactively to July 1, 2017. However, rates may be approved effective on a later date under the provisions of Section 4.000.

### 1.133 Authority of 2018-2019 *Methods*

Applicable nursing home payment rates for services rendered on or after July 1, 2018, will be governed by the provisions of a

separate, new 2018-2019 *Methods*, even if the 2018-2019 *Methods* are issued subsequent to July 1, 2018. Reimbursement rates established under one *Methods* will apply only to that reimbursement period.

#### 1.134 Recoupment of Overpayment

Upon a rate decrease for any purpose, any excess payments for previously provided services shall be recovered from the provider.

Large recoupments will be recovered as a set percentage of future remittances according to the schedule delineated in the ForwardHealth handbook, which is subject to change at any time. If a provider wishes, they may pay the entire amount of a recoupment as a check to the Department's fiscal agent to avoid adjustments to future remittances. In the event of a change of ownership or closure, the Department may also recover amounts due from the new owner or from other facilities owned by the same entity.

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.

#### 1.140 Litigation

The State has been or may be involved in litigation concerning the validity or application of provisions contained in this *Methods* or provisions of previous *Methods*. Medicaid payments resulting from entry of any court order may be rescinded or recouped, in whole or in part, by the Department if that court order is subsequently vacated, reversed or otherwise modified, or if the Department ultimately prevails in litigation. When recoupment occurs, recoupment will be made from all facilities affected by the issuance of the court order, whether or not such facilities were parties to the litigation. If any provision of this *Methods* is properly and legally modified or overturned, the remaining provisions of this *Methods* are still valid.

#### 1.160 Medicaid Participation Requirements

All nursing homes participating in the Medicaid program must meet established certification requirements, adopt a uniform accounting system, file a cost report, and disclose the financial and other information necessary for verification of the services provided and costs incurred. The Department will specify the time periods and forms used for those purposes.

#### 1.170 Cost and Survey Reporting Requirements

##### 1.171 Cost Reporting

All certified nursing home providers must annually submit a "Medicaid Nursing Home Cost Report" for the period of the home's fiscal year. Under special circumstances, the Department may require or allow a provider to submit a cost report for an alternative period of time. A standardized cost reporting form and related instruction booklet, which include detailed policies and instructions for cost reporting, are provided by the Department. This cost report and the related cost report instruction booklet along with policies adopted by the Department, are an integral and important part in determining payment rates. Additionally, the Department may require providers to submit supplemental information beyond that which is required in the cost report form. Supplemental information concerning related entities shall be made available on request. The intent of cost reporting is to identify the costs incurred by the nursing home provider to be used in the application of the Medicaid payment policies and methodology.

##### 1.172 Signature

If the cost report is prepared by a party other than the nursing home owner or a nursing home employee, it must be signed by both the preparer and the owner/employee.

##### 1.173 Timely Submission

The completed cost report is due to the Department within five months after the end of the cost reporting period unless the Department allows additional time. The due date of supplemental information, including responses to DMS questions, will depend on the complexity and need for the information being required. The Department shall establish and implement

policies to withhold payment to a provider, or decrease or freeze payment rates, if a provider does not submit cost reports and required supplemental information and responses to DMS questions by the due dates.

Failure to pay the Licensed Bed Assessment in a timely fashion will also cause the Department to withhold payment to a provider.

Facilities that do not meet the requirements of this section will have payment rates reduced according to the following schedule:

1. 25% for cost reports, supplemental information, and/or licensed bed assessments between 1 and 30 days overdue.
2. 50% for cost reports, supplemental information, and/or licensed bed assessments between 31 and 60 days overdue.
3. 75% for cost reports, supplemental information, and/or licensed bed assessments between 61 and 90 days overdue.
4. 100% for cost reports, supplemental information, and/or licensed bed assessments more than 90 days overdue.

The number of days overdue shall be measured from the original due date, without extension, of the cost report, supplemental information, and/or licensed bed assessment.

The rates will be retroactively restored once the cost report, supplemental information, and/or licensed bed assessment is received by the Department.

#### 1.174 Records Retention

Providers must retain all financial records, statistical records and worksheets to support their cost report and supplemental information for a period of five years. (Reference: DHS 105.02, Wis. Adm. Code). Records and worksheets must be accurate and in sufficient detail to substantiate the reported financial and statistical data. These records must be made available to the Department or the United States Department of Health and Human Services within a reasonable time from the date of request and at a location within Wisconsin unless alternative arrangements can be made. Failure to adequately support reported amounts may result in retroactive reductions of payment rates and recoveries of monies paid for services.

#### 1.175 Change of Ownership

Upon change of ownership of a nursing home operation, the prior owner is required to submit a cost report for the fiscal period prior to the ownership change unless the Department determines the cost report is not needed. The prior owner's failure to submit such a cost report may limit the new provider's payment rates. It is important that the new owner assure that the prior owner submits the cost report. Also see Sections 4.200 through 4.230.

#### 1.176 Combined Cost Report for Multiple Providers

A separate cost report is to be submitted by each separately certified nursing home provider. Nevertheless, the Department may allow or require two or more separately certified providers to submit a single combined cost report in the following circumstances:

1. Multiple Certified Nursing Homes. A combined cost report may be allowed or required for two or more separately certified nursing homes which are located on the same or contiguous property and which are fully owned by the same corporation, governmental unit or group of individuals.
2. Distinct Part ICFs-IID. A provider operating in conjunction with a distinct part ICF-IID provider, as defined in Section 1.311, shall be required to submit a combined cost report for both providers.
3. Distinct Part IMDs. A provider operating in conjunction with a distinct part institution for mental disease (distinct part IMD) provider, as defined in Section 1.312, shall submit a combined cost report. However, the Department may require separate cost reports depending on individual circumstances.

The Department shall not allow a combined cost report for a facility if the Department estimates that payment rates which are determined from such a report are likely to result in payments which are substantially in excess of the amount which would be

paid if separate cost reports were submitted. The Department shall not allow a combined cost report if a facility's rates cannot be readily or appropriately calculated based on such a report.

#### 1.200 Allowable Expenses

##### 1.210 Patient Care Related Expenses

Only expenses incurred by the nursing home related to nursing home patient care shall be allowable for payment. Expenses related to patient care include all necessary and proper expenses which are appropriate in developing and maintaining the operation of nursing home facilities and services. Necessary and proper expenses are usually expenses incurred by a reasonably prudent buyer which are common and accepted occurrences in the operation of a nursing home.

##### 1.215 Sanctions

Allowable expenses do not include forfeitures, civil money penalties or fines assessed under Wisconsin Statutes, Administrative Rules, Federal Regulations, or local ordinances.

##### 1.220 Bad Debts

Bad debts and charity and courtesy allowances applicable to any patient shall not be allowable expenses.

##### 1.230 Prudent Buyer

The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, but also seeks to economize by minimizing cost. Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicaid providers of services will also seek them.

The Department may employ various means for detecting and investigating situations in which costs seem excessive. These techniques may include, but are not limited to, comparing the prices paid by providers to the prices paid for similar items or services by comparable purchasers; spot-checking; and querying providers about direct and indirect discounts. In those cases where the Department notes that a provider pays substantially more than the going price for a supply or service in the absence of clear justification for the premium, the Department will exclude excess costs in determining allowable costs for payment rates.

##### 1.240 Approvals under the State's Resource Allocation Program: Long-Term Care

Unless otherwise specified in this *Methods*, payment shall not be provided for expenses related to capital projects or changes in service which were not approved or for which notice was not given (if required) under Section 1122 of the Social Security Act or Chapter 150, Wis. Stats.

The Department shall retroactively reverse or negate the effect of rate adjustments due to a Resource Allocation Program project if the facilities did not complete the projects.

##### 1.241 Workers Compensation

By Statute, nursing homes are required to provide Workers Compensation (WC) insurance for their employees. The Wisconsin Compensation Rating Bureau (WCRB) has the authority to establish rates for WC insurance. The allowed WC cost will be the lesser of the calculated amounts obtained from the WCRB WC policy for a given nursing home or allowable cost of a self-insurance plan.

WC expenses may need to be accrued on an estimated basis since subsequent audit may result in an adjustment to the Experience Modification Factor (EMF) resulting in additional costs or refunds for the cost reporting period. Allowed WC expense will be the amount accrued and paid within 75 days of the end of the cost report period. Any changes to previously estimated Workers Compensation amounts that result in additional costs or refunds shall be reported as an addition or reduction of WC expense in the cost reporting period that they become known.

#### 1.245 Legal and Other Professional Fees

Under the following circumstances, legal and other professional fees incurred by a provider are not related to patient care and are thus not allowable expenses:

1. The provider (or an organization of which a provider is a member) incurs the fees for the prosecution or defense or potential prosecution or defense of any administrative appeal or judicial suit which results from any reimbursement action taken by a state or federal agency administering Medicare or Medicaid programs.
2. The provider (or an organization of which a provider is a member) incurs the fees in an administrative appeal or judicial suit which results from any action by the state agency that administers licensing and certification requirements, unless the administrative law judge in the administrative appeal awards fees in a motion brought under Section 1.2455.
3. The provider incurs fees defending an owner or an employee in any personal matter or in any criminal investigation or prosecution.
4. The provider incurs the fees in any other remedial process pursued prior to the filing of an appeal under Chs. 50 or 227, Wis. Stats., or a judicial suit.
5. Other fees not related to patient care.

#### 1.2455 Award of Fees

The treatment of legal fees and other professional fees incurred in a provider's administrative appeal of any action by a state agency that administers licensing and certification requirements shall be as follows:

1. Upon resolution of any such appeal, the provider or the state agency may submit a motion for award of fees to the administrative law judge. The judge shall award fees if the judge determines that the moving party is the "prevailing party," unless the judge determines that the other party had a reasonable basis in law and fact for taking its position or that special circumstances exist that would make an award unjust. The judge shall determine the prevailing party and the amount of the award pursuant to ss. 227.485(4) and 814.245(5), Stats., except that the amount of the award shall not include any fees associated with preparing, submitting or litigating the motion for fees. The judge's decision is not subject to judicial review.
2. If the fees are awarded to the provider under this section, the amount awarded will be treated as an allowable expense in the cost report year or years in which the fees were incurred, to the extent the amount does not exceed the Administrative and General cost center maximum limitation under Section 3.210 of the *Methods*. If the fees are awarded to the Department in its role as state licensing or certification agency, the amount awarded will be deducted from the provider's otherwise allowable costs in the Administrative and General cost center for the cost report year or years in which the fees were incurred.
3. Section 227.485, Stats., is intended to allow an administrative law judge to award costs associated with a hearing to the prevailing party in the proceeding, upon motion of that party, but it only allows such awards for individuals, small non-profit corporations, or small businesses. Providers who are individuals, small non-profit corporations or small businesses, and who pursue costs under s. 227.485, Stats., shall not be entitled to, in addition, pursue costs under the provisions of this state plan.

#### 1.246 Accruals of Paid Time Off

The Department will not recognize the accruals of expenses for paid time off. It will recognize only the cost of paid time off (e.g. vacations, sick leave, etc.) which has been paid during the cost reporting period.

#### 1.248 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. If not separately identified, investment income will be treated according to Section 1.270 and/or Section 3.526. Any proceeds from these policies will be offset against the claims paid during the cost reporting period of receipt.

For purposes of implementing this section and payment plan, the terms self-insurance and self-funded are synonymous. Self-insurance is a means where a provider, either directly or indirectly or through a separate entity, trust or fund, undertakes the ultimate risk by assuming the actual liability for insurance costs as defined in this section. 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. Property insurance expense may include only premiums paid to a non-related insurance company where the provider retains interest in no portion of that premium. Allowable costs resulting from the liability assumed by a provider under any property insurance plan (either through self-funding or deductible) will be reported and reimbursed under Section 3.500 or Section 2.200.

#### 1.249 Provider Assessments or Provider Specific Taxes

Reimbursable expenses under these *Methods* will not include any cost attributable to taxes or assessments on licensed beds imposed by the State solely with respect to nursing homes or ICFs-IID.

#### 1.250 Costs from Related Parties and Related Organizations

##### 1.251 Allowable Related Party Costs

A nursing home may incur expenses for services, facilities and supplies furnished by organizations related to the nursing home by common ownership or control. In lieu of such expenses incurred by the nursing home, allowable expenses for payment may include the expenses incurred by the related organization for the furnished items. Allowable expenses must not exceed the lesser of:

1. The expense incurred by the related organization for the services, facilities or supplies which the related party furnished to the nursing home, or
2. The price of comparable services, facilities or supplies that could be purchased elsewhere.

The purpose of this principle is to avoid the payment of a profit factor to the nursing home through the related organization, and also to avoid payment of artificially inflated expenses which may be generated from less than “arm’s length” bargaining.

##### 1.252 Definitions for Related Parties

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

“Related to the nursing home” means that the nursing home, 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 nursing home and in the institution or organization serving the nursing home.

“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.

“Immediate family relationships” include husband/wife, natural parent, child, sibling, adoptive child and adoptive parent, step-parent, step-child, step-sibling, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent and grandchild.

#### 1.253 Determination of Relatedness

In determining whether a nursing home is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create a rebuttable presumption of relatedness.

1. "Related by Common Ownership." A determination as to whether an individual(s) or organization possesses significant ownership or equity in the nursing home organization and the supplying organization, so as to consider the organizations related by common ownership, should be made on the basis of the facts and circumstances in each case. This principle applies whether the nursing home or the supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (for example, a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).
2. "Related by Control." The term "control" includes any kind of control which is exercisable, regardless of legal enforceability. It is the reality of the control which is decisive, not its form or mode of its exercise. The facts and circumstances in each case must be examined to ascertain whether legal or effective control does exist. Since a determination reached in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same.
3. "Exception." An exception is provided to the general rule applicable to related organizations. The exception is intended to cover situations where large quantities of goods and services are furnished to the general public and only incidentally are furnished to a nursing home by a related organization. The exception applies if the provider demonstrates to the satisfaction of the Department that the following criteria are met:
  - a. The supplying organization is a bona fide separate organization.
  - b. A substantial part of the supplying organization's business activity as engaged with the nursing home is transacted with other organizations not related to the nursing home and the supplier by common ownership or control AND there is an open, competitive market for the type of services, supplies or facilities furnished by the organization.
  - c. The services, supplies or facilities are those which commonly are obtained by nursing homes from other organizations and are not a basic element of patient care ordinarily furnished directly to patients in nursing home operations.
  - d. The charge to the nursing home is in line with the charge for such services, supplies or facilities in the open, competitive market, and no more than the charge made by the organization, under comparable circumstances, to other customers for such services, supplies or facilities.

If all the above conditions are met, the charge by the related supplier to the nursing home for such services, supplies or facilities shall be an allowed expense for payment.

#### 1.254 Documentation

The nursing home must make available to the Department adequate documentation to support the costs incurred by the related organization, including access to the related organization's books and records concerning supplies and services furnished to the nursing home. Such documentation must include an identification of the organization's total costs, and the basis of allocation of direct and indirect costs to the nursing home and to other entities served.

#### 1.255 Medicare Influence

Generally, the Department will refer to the Medicare Program's guidelines and interpretations when examining payment issues arising out of costs to related organizations.



#### 1.260 Employee Compensation

Any form of compensation which is included in the payment rate must be reasonable and necessary. "Reasonable" means that the compensation should not exceed what would be paid by other nursing homes or the home in question for similar services. "Necessary" means that the services are required and commonly performed in other nursing homes.

#### 1.265 Out-of-State Travel

Out-of-state travel and related travel expenses shall not be allowed, except for travel expenses to and from the nursing home's home office. This provision shall not apply to travel within 100 miles of the Wisconsin border or to home office personnel with one or more nursing homes located outside the State of Wisconsin. Travel expenses shall include but not be limited to meals, lodging, transportation, and all training, seminar and convention fees associated with the out-of-state trip.

#### 1.266 Definition of Investment Income

Investment income consists of the aggregate net amount from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss is not allowable.

#### 1.270 Interest Expense on Working Capital Debt

Working capital loans are debts entered into by a provider to finance current operations until current cash flow allows payment of the debt. Such debts may carryover from a recent fiscal year to the current fiscal year. Only interest expense on operating working capital loans which are related to patient care shall be allowed to be included in the calculation of the administration and general allowance. The Department shall determine allowable expense and shall include the following adjustments.

1. Revenues from any invested funds shall be offset against working capital interest expense; such revenues remaining after the offset may be offset under Department policy in determining the property allowance per Section 3.500.
  - a. Investment income earned by any home office, other corporate entity or organization, foundation or related party that has a purpose of furthering the goals and objectives of the nursing home or its related organizations, shall be offset against the nursing home's allowable interest expense. Long term interest expense and working capital interest expense shall be offset by investment income from all sources (including home office, other corporate entities or organizations, foundations and related parties). Offsets from these entities shall be applied after offsets to interest expense at the home office, other corporate entities or organizations, foundations and related parties are made. Offsets to the nursing home shall be allocated based on the home office or foundation acceptable allocation basis. The investment income offset shall first be applied to working capital interest expense and then to long term interest expense.
  - b. Investment income generated to meet specific financial reserve requirements of the Office of Commissioner of Insurance or other regulatory agencies will be exempt from the income offset requirement.
2. Interest expense on borrowed funds which are not used for operating the nursing home shall not be allowable.
3. Interest on debts to acquire plant assets, which is not reimbursed under the property allowance in Section 3.500, shall not be allowed as interest in the administrative component.

#### 1.281 Therapy and Beauty and Barber Shop Spaces

Dietary and environmental services, fuel and utility, property tax, and property expenses which are indirectly allocated to therapy services and beauty and barber services, on the basis of the building area which those services use, shall be generally allowed in the calculation of the payment rate. If gross therapy revenues (physical, occupational, and speech) are less than \$100,000 for the applicable cost reporting period, then space allocations will not be made. If gross therapy revenues (physical therapy, occupational therapy, and speech therapy) generated in nursing home therapy space attributable to non-nursing home residents equal 2% or more of total gross therapy revenues and/or if the nursing facility (or a related party as defined in Section 1.252) bills Medicare Part B for therapy generated in the nursing facility therapy space and the Medicare Part B revenues equal 10% or more of the total therapy revenues, then space allocations shall be made on a square footage basis. If the nursing home is subject to an allocation under the Medicare Part B criterion, then the non-nursing home resident

allocation will be made if there are any non-nursing home resident therapy revenues. These qualifying criteria are based on the facility's cost reporting period for the payment rates.

#### 1.290 Institutions for Mental Disease and Mentally Ill Nursing Home Residents

Sections 1.291 through 1.294 describe limitations on payments to institutions for mental disease and nursing homes for the care of mentally ill residents, as required by 1987 Act 399.

#### 1.291 Limitation on Payment

Operating, capital and ancillary costs attributable to the care of 21 through 64 year old residents of an institution for mental disease are not allowable costs, except that costs for 21 year old residents are allowable if the resident resided in the institution for mental disease immediately prior to turning 21.

#### 1.292 Limitation on Institute for Mental Diseases (IMD) Patient Days

This section applies to IMDs and facilities declared to be at risk of being IMDs which agree to receive a permanent limitation on payments, pursuant to s. 46.266(1)(am), Wis. Stats. For these facilities, costs attributable to Medicaid patient days in excess of the patient day cap are not allowable costs. The patient day cap is determined as follows:

Patient day cap =  $365 \times [A + (B - C)]$ , where

- A = The number of Medicaid eligible residents of the facility on the date that it is declared an IMD or the date that it is declared at risk of being an IMD.
- B = The total licensed beds in the facility on the date that the facility agrees to receive the permanent limitation on payments.
- C = The total residents of the facility on the date that it is declared an IMD or the date that it is declared at risk of being an IMD.

The patient day cap may be increased by 365 patient days for each resident who was not eligible for Medicaid on the date the facility was declared an IMD or at risk of being an IMD, but who becomes eligible at a later date.

#### 1.294 Cap on Mentally Ill Nursing Home Residents

Pursuant to s.49.45(6j), Wis. Stats., the number of mentally ill Medicaid recipients in a nursing home determined by the Department to be at risk of being an IMD may not exceed the average population of mentally ill Medicaid recipients age 21 through 64 (excluding persons under 22 who were receiving Medicaid services in the facility prior to July 1, 1988, and continuously thereafter) in the nursing home during the period from January 1, 1987, through June 30, 1988. Costs attributable to mentally ill residents of the facility in excess of the average population are not allowable costs.

#### 1.300 General Definitions

##### 1.301 Active Treatment

Active treatment for developmentally disabled and mentally ill nursing home residents means 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.

##### 1.302 Base Cost Reporting Period

Payment rates shall be based upon information from cost reports for the provider's fiscal year ending in the calendar year prior to effective date of the payment rates per Section 1.132, except that the property tax allowance shall be based on the cost reporting periods described under Section 3.400. Payment rates may be based on alternative cost reporting periods acceptable to the Department, whenever allowed under the provisions of Section 4.000 of this *Methods*.

Expenses included in a reporting period are to be on the accrual basis of accounting, except where otherwise noted. For reimbursement purposes, the accrued expense must be paid within 180 days following the end of the reporting period. An expense disallowed under this section in any cost report period may not be claimed on a subsequent cost report. Specific

exceptions to the 180 day rule may be granted by the Department for documented contractual arrangements such as receivership, property tax installment payments, and pension contributions; or expenses relating to audit of another provider group if the audit settlement indicates acceptance of these costs in writing. Note Section 1.248 for pending claims for self-insurance costs.

For 2017-2018 rates, the facilities' 2016 cost reports will be used to calculate payment rates. Exceptions to this may be for facilities in a start-up or phase-down period per Sections 4.300, 4.400, 4.500 and 4.600.

#### 1.304 Definition of Significant Changes in Licensed Bed Capacity

Unless otherwise stated in this *Methods*, a significant increase or decrease in licensed bed capacity is defined as the lesser of: (1) a change that is greater than or equal to 25.0% of the previously unrestricted use licensed beds or (2) 50 beds or (3) a change in licensure to 50 or fewer beds or (4) an increase in licensure to more than 50 beds. Restricted use beds are not used in this calculation.

#### 1.305 New Facilities

A new facility is defined as a nursing home newly beginning operation and not previously licensed as a nursing home. A change in ownership does not constitute a new facility. An existing operation, which becomes certified for the Medicaid Program, shall not be considered a new facility.

#### 1.306 Replacement Beds and Facilities

A replacement is defined as the licensure and certification by a Medicaid provider of beds to take the place of beds closed or de-licensed by the same or a related provider. Total replacement means all beds under a provider's certification were replaced. The resulting licensed bed capacity of the provider may be considered a significant increase or decrease in licensed beds if the criteria of Section 1.304 are met.

#### 1.307 Fifty-bed Facilities.

Unless prior approval has been received by the Department, to be considered a facility of 50 or fewer beds the total beds from all Skilled Nursing Facility (SNF) and ICF-IID licenses for facilities on the same or contiguous properties must be 50 or fewer.

#### 1.308 Fringe Benefits

The term "fringe benefits" refers to general fringe benefits for staff as defined in detail by the Department in the Medicaid nursing home cost report form. Significant, unique benefits, as defined in the cost report form, are to be included as a salary or wage expense under this *Methods* and not as a fringe benefit expense. For facilities with special salary and wage payments to employees, such as bonuses, the Department shall classify such payments as salaries instead of fringe benefits. The cost of employee meals as a fringe benefit will be the cost per meal in Section 5.450 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.

#### 1.309 Average Licensed Beds

The term "average licensed beds" means the average of the number of licensed beds of the facility on the last day of each month of the period for which the average is being determined. An average for a one-month period shall be the average of the daily number of licensed beds.

#### 1.310 Significant Licensed Bed Days

A significant number of licensed bed days is the lesser of 4500 licensed bed days or 25.0% of the annualized bed days of the provider.

#### 1.311 Distinct Part ICF-IID

A distinct part ICF-IID is a specific segment of a licensed NF facility which has been certified by the Department as a distinct part intermediate care facility for intellectual disabilities.

#### 1.312 Institution for Mental Disease (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 the federal Center for Medicare/Medicaid Services. 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.

#### 1.313 Restricted Use Beds

Restricted use beds are beds that exceed a nursing home's normal bed capacity, or are not in use due to remodeling. Restricted use bed status requires Department approval. Nursing home facilities must request and receive Department approval in writing before the effective date of restricted use status. The Department shall be afforded 30 days to approve any written request. Approvals will be made at the Department's discretion, and only under one of the following conditions:

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

Approval of restricted use status is for 12 months, upon receipt and approval of the original request. Approval may be extended for an additional six months if the facility makes the request in writing and is able to demonstrate that the remodeling or construction project is 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. Restricted use beds will be returned to active status on the date the Department's approval expires.

In limited and exceptional circumstances, the Department will consider applications for 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 (delivered by the provider to the Department); a formal, one-year written notice delivered by the provider to the Department before removing the beds from restricted use status; and a 10% annual return of restricted use beds to the Department (i. e., de-licensing each year of 10% of the number of beds that were originally placed in restricted use status, at the time of the initial request). 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.

#### 1.314 Reimbursement Period

The reimbursement period is the twelve- month period from July 1, 2017 through June 30, 2018.

#### 1.315 Patient Day

For cost reporting purposes, a patient day means a day when any resident, regardless of pay source and who has been admitted as a nursing home resident, is present at the midnight census. This includes the day of admission but not the day of discharge.

If the day of admission and discharge are the same it will be considered one patient day.

Bed hold days will be considered a patient day when they are billable (Medicaid bed hold days must meet the billable criteria identified in Section 1.500.) For cost allocation purposes, all bed hold days will be assigned Non-DD or DD bed hold case mix values as specified in Section 5.420.

#### 1.317 Medicaid Days

General references to Medicaid days in this plan refer only to Medicaid fee-for-service (Medicaid FFS) residents. Medicaid days for the exceptional Medicare/Medicaid utilization incentive in Sections 3.651 and a total replacement facility in section 4.920(1) shall include days of care for Medicaid FFS, Family Care- Medicaid, Medicaid residents paid for by other states and residents funded by other Medicaid programs such as PACE, and Partnership in the determination of the Medicare/Medicaid percentage. Only residents eligible for the Medicaid FFS benefit will receive payment under any provision of this plan.

## 1.500 Bed Hold Days

Hospital bed hold days and therapeutic bed hold leave days, including bed hold days for residents approved for payment under Section 4.691, will be paid at a 0.25 RUG classification rate for qualifying nursing facilities and at the DD Bedhold rate for qualifying ICFs-IID. A maximum of 15 consecutive days is payable for each hospitalization leave. In order to qualify to bill for bed hold, facilities must meet occupancy criteria below. (Reference: DHS 107.09(3)(j), Wis. Adm. Code).

### 1.510 Bed Hold Occupancy Requirements

Hospital and/or therapeutic bed hold leave can be billed if the certified provider's occupancy level is 94.0% or greater occupancy rate during the calendar month prior to the bed hold leave days. If this test is met, then the subsequent month's bed hold days may be billed. For purposes of this calculation, licensed bed-days shall not include any restricted use beds and chargeable bed hold days shall be included as one full patient day. Homes in start-up must meet bed hold occupancy provisions. Bed hold cannot be billed to Medicaid for residents receiving Medicare Part A nursing home services. Bed hold cannot be billed to Medicaid for residents receiving services in a traumatic brain injury unit.

Any facility pursuing a phase-down of resident population due to a licensed bed reduction or a phase-out may be exempted from the above occupancy requirements. The Department must approve the phase-down or phase-out and its expected time period in writing and in advance before such exemption shall be allowed.

### 1.511 Combined Occupancy Test for Multiple Providers

A provider, at its option, may combine the occupancy calculation under Section 1.510 for two or more separately certified facilities if the facilities are located on the same or contiguous property and are fully owned by the same corporation, governmental unit or group of individuals. The election to combine or separate facilities for the occupancy can differ from one month to the next month. Distinct part facilities may also utilize this occupancy test.

### 1.530 Excludable Licensed Beds

Licensed beds may be reduced for (a) certain code violations, and (b) renovations, in order to calculate the occupancy for bed hold billings. The occupancy calculation for bed hold billings must include all beds except for those specifically noted below. Any beds designated by the facility as "seclusion," isolation," "restraint" or similar or related terminology shall be included in the occupancy calculation. Excluded beds must meet one of the following criteria:

1. For code violations, excluded beds must be out-of-use due to life safety code violations cited by the Department. The Department must be notified of such beds.
2. For renovation, licensed beds must be out-of-use due to renovation projects. The excluded beds and the expected time period of the exclusion must be prior approved by the Department.
3. Restricted Use Beds. Restricted use beds are defined in Section 1.313.

### 1.550 No Charge to Resident and Third Party

No resident or third party may be charged for covered but unreimbursed bed hold or therapeutic bed hold leave days provided to a Medicaid recipient. Beds held for the following leaves are deemed to be Medicaid-covered services, even when a certified provider does not meet the above occupancy requirements:

- All hospital leaves of absence up through 15 days per hospitalization.
- All leaves for therapeutic visits.
- All leaves for therapeutic rehabilitative programs meeting the criteria under DHS 107.09(3)(j), Wis. Adm. Code.

## 1.600 Resource Allocation Program Rates as a Maximum

The per patient day property allowance stated in an application to the state's resource allocation program under Chapter 150, Wis. Stats., is the maximum allowable payment that may be granted by the Department for applications not involving the addition of beds for the first full year following completion of the project. In an application for approval of additional beds, the per patient day rate(s) stated in an application to the State's resource allocation program under Chapter 150, Wis. Stats., is

the maximum allowable reimbursement that may be granted by the Department for the twelve months following licensure of the additional beds. If the *Methods* generates per patient day rates or per patient day property allowance that are less than those stated in the application, the Department shall use the lower rate(s) or allowance.

This section does not apply to ICFs-IID certified after June 30, 1988.

Resource Allocation Program maximums shall be applied for the first full year following completion of a project or the time period specified in the RAP approval.

#### 1.700 Rate Approval Process

Providers will receive a rate notification from their District Medicaid Auditor along with any adjustments made to the submitted cost report. In standard circumstances, 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 District 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 District Medicaid Auditor know that they will be providing such support within a reasonable period 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 District Medicaid Auditor, they may request an administrative review by writing to:

Nursing Home Policy & Rate Setting 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

#### 1.900 Medicare Billing

Facilities must bill Medicare for covered services and supplies. Facilities that bill Medicare for applicable Part B services must be dually-certified facilities, and must bill Medicare for Medicare-covered services or supplies prior to billing Medicaid. Providers are expected to bill the Medicare Part B program for any services or supplies for residents covered by that program. Should a provider not exhaust Medicare Part B sources of revenue, then the Department may offset that amount or an estimate of that amount which could be billed to Medicare Part B. This policy applies to facilities which do not bill Medicare at all or do not exhaust Medicare to the extent available for applicable Medicare third-party liability.

## Section 2.000 Payment Rate Allowances Described

This *Methods* provides for payments which are divided into five major cost centers: Direct Care; Support Services; Property Tax; Property; and Provider Incentives. Section 2.000 describes the types of services and costs generally covered by each cost center. The calculation of the payment allowances is described in Section 3.000.

### 2.100 Direct Care Allowance

The direct care allowance shall reimburse for allowable facility expenses related to the provision of the following purchased and/or provided services and supplies, (which include, but are not limited to, staff wages, fringe benefits, and purchased services costs) up to maximums in Section 3.100.

#### 2.110 Direct Care Nursing Services

Direct Care Nursing Services shall include all Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, QMRP-Nursing, Certified Nursing Assistants, Feeding Assistants, Nurse Aide Training and Nurse Aide Training Supplies. Certified Nursing Assistant duties primarily involve skills that are taught in the instructional programs certified under Chapter DHS 129.05, Wis. Admin. Rules. Certified Nursing assistants are listed on the registry established under Chapter DHS 129.10, Wis. Admin. Rules, unless they have enrolled but not yet completed the required instructional program.

Feeding Assistants carry out limited tasks normally performed by nursing assistants. The salary expenses for feeding assistants may be allowed as direct care if they have completed a specified training program adopted by the State and passed a standardized written competency quiz and a skills demonstration to include hand washing. The salary expenses and hours for feeding assistants not meeting the above requirements and all other single task employees should be included in the cost center that most represents the task performed other than direct care.

#### 2.120 Other Direct Care Supplies and Services

Direct Care Supplies and Other Services shall include Ward Clerks, Non Billable – Physician, Active Treatment, Volunteer Coordinator, Social Service Personnel, Recreation Personnel, Religious Services and other special care, QMRP-Other, Purchased Laundry-Diaper, Diapers and Underpads, Catheter and Irrigation Supplies, Other Medical Supplies, Non Billable – Lab, Non Billable –X-Ray, Non Billable – Pharmacy, Non Billable – PT, Non Billable – OT, Non Billable – Speech, Non Billable – Dental, Non Billable – Psychiatric Services, Non Billable – Respiratory Services, Non Billable – Physician Supplies, QMRP-Nursing Supplies, QMRP-Other Supplies, Active Treatment Supplies, Volunteer Coordinator Supplies, Social Service Supplies, Recreation Supplies, Religious Services Supplies and other special care 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 Supplies and Other Services shall also include nonprescription charges approved by the Department to provide certain over-the-counter drugs, ordered by a physician. 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.

#### 2.130 Exclusions

The cost of non-covered services identified in DHS 107, Wis. Adm. Code or Department policies shall not be reimbursed.

Expenses for the time to perform overhead activities related to billable therapy evaluations, procedures and modalities are not to be included in the rate calculation and are not to be considered in the cost report category of "non-billable expenses." Activities such as end-of-the-day clean-up time, transportation time, consultation and required paper reports are considered to be overhead activities.

Any nursing personnel, quality assurance personnel and/or therapy consultants who do not provide direct, hands-on patient care shall be considered administrative and general expenses. Personnel who provide in-service training are exempted from this provision: see Section 2.135.

## 2.135 In-service Training

The expense of providing in-service 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 in the daily rate; separate reimbursement is provided for the direct expenses incurred by a nursing facility for NAT/CEP that is required before an aide can be entered on the Nurse Aide Registry.

Section 5.100 of this *Methods* contains further guidelines on, and a list of, supplies which are intended to be included under this provision.

## 2.140 Medicaid Fee-For-Service Non-DD Quarterly Case Mix Indices (CMI).

Medicaid payment rates are adjusted periodically to reflect changes in the case mix of that nursing home's Medicaid FFS Non-DD residents. This Medicaid case mix is established using the information available for the Medicaid residents during the calendar quarter, i.e. January 1 through March 31, April 1 through June 30, July 1 through September 30, and October 1 through December 31. The analysis is limited to the information available in the MDS data system and the Medicaid billing system by a specific date. This date is referenced by the "as of date". These dates are specified in Section 5.422.

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, rather than the Non-DD bed hold CMI specified in Section 5.420. Non-DD bed hold residents are included in the All-Resident 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, rather than the Non-DD bed hold CMI specified in Section 5.420.

A resident will be considered a Medicaid FFS resident if they were in the facility or the facility listed them as on "bed hold" during the quarter and Medicaid paid for that day by the "as of date", i.e., the date when the billing data was extracted for the CMI calculation. An actual payment amount for that person must be recorded. If the amount due is less than the patient liability, the resident is excluded from the Medicaid FFS Non-DD CMI for that quarter. If the claim was paid after the "as of date" for any reason, including retroactive eligibility or claims processing errors by the facility or the fiscal agent, the resident is excluded from the Medicaid FFS Non-DD CMI for that picture quarter.

Providers are required to complete MDS assessments for each resident. The assessment for each resident that is RUG-able, dated on or before the last day of the quarter, and correctly included in the WI MDS database by the "as of date" will determine the case mix grouping for that resident for that quarter. New admissions will not be included in the CMI unless they have received a RUG-able MDS assessment on or before the last day of the quarter. Re-entries will be included in the CMI with their last valid RUG classification from their prior stay, if they were discharged "with return expected" and actually returned the facility, if there is no more recent valid RUG classification. A RUG-able MDS assessment includes Admission Assessments, Annual Assessments, Quarterly Review Assessments, Medicare Assessments, Significant Change in Status MDS, and Significant Correction to Prior Comprehensive MDS Assessments.

The average quarterly CMI for the facility shall include all valid RUGS scores, which may include multiple distinct RUGS scores for an individual resident, subject to the limitations described above.

Medicaid residents receiving payment under Section 4.691 will not be included in the Medicaid FFS Non-DD CMI.

## 2.145 All-Resident Case Mix Indices for the Cost Reporting Period

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 specified in Section 5.420. 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.



A resident will be included in the All-Resident Non-DD CMI for a quarter only if the most recent MDS record dated is within the quarter and is a not a discharge tracking record. Only MDS records present in the MDS database on the applicable “as-of” date in Section 5.421 will be used in this tabulation. If a resident does not have a “RUG-able” MDS, they will be assigned the average CMI for all other Non-DD residents in that quarter. The average RUGS CMI for any picture date is based on the RUGS scoring system in use on that date.

Residents receiving payment under Section 4.691 will not be included in the All-Resident Non-DD CMI.

## 2.200 Support Services Allowances

### 2.210 Dietary and Environmental Services

The support services allowance recognizes the allowable expenses to provide dietary and environmental services up to amounts payable under Section 3.200. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

#### 2.211 Dietary Service Expenses

Dietary service expenses are those expenses directly related to the provision of meals to residents of the facility, including dietary supplements and dietician consultants.

#### 2.212 Environmental Service Expenses

The support services allowance recognizes environmental service expenses related to the provision of maintenance, housekeeping, laundry and security services. Also included are expenses related to residents’ personal laundry services, excluding personal dry cleaning services. Residents are not to be charged for the laundering of gowns.

### 2.250 Administrative and General Services

The support services allowance recognizes the allowable expenses for administrative, central office services and management services contract fees. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

#### 2.251 Administrative Service Expenses

Administrative service expenses include those expenses related to the operation’s overall management and administration, and other allowable expenses which cannot be appropriately recognized/reimbursed in other payment allowances or service areas. Expenses for the provision of general administrative, clerical, financial, accounting, purchasing, data processing, medical records and similar services are usually considered administrative 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. (In-service training, see 2.135) (Legal expenses, see 1.245) (Interest expense, see 1.270)

#### 2.252 Central Office Costs

Administrative expenses allocated to the nursing home from centralized administrative units of a nursing home chain organization, multi-entity or governmental agencies 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.

#### 2.253 Management Service Contract Fees

Management service contract fees shall be recognized among administrative service expenses, but may be adjusted by the Department for unreasonable or unnecessary levels of service, compensation, or duplicative services. Fees resulting from a percentage of cost or revenue arrangement will be disallowed by the Department, in whole or in part, according to the policy

established by the Department. If actual management costs can be documented, those costs (subject to Medicaid allowability) may be substituted for the amount reported up to the amount actually paid.

#### 2.254 Nursing Home Appraisals

The cost of Department-required nursing home property appraisals conducted by a Department-approved contractor shall be recognized among administrative service expenses.

#### 2.260 Fuel and Other Utility Expense

The support services allowance recognizes the allowable facility expenses related to the provision of electricity, water and sewer services, and heating fuel including fuel oil, natural gas, LP gas, coal and other heating fuels.

#### 2.400 Property Tax Allowance

##### 2.410 Tax-Paying Facilities

The property tax allowance shall be a per patient per day amount for allowable property tax expense. Allowable property tax expense shall exclude any state property tax credit and any special assessments for capital improvements, such as sewers, water mains and pavements. Whenever exemptions to property tax are legally available, the provider shall be expected to pursue such exemptions. If the provider does not pursue available exemptions, the expenses incurred for property tax shall not be allowed.

##### 2.420 Tax-Exempt Facilities

The property tax allowance for tax-exempt facilities may include a per patient per day amount for the cost of needed municipal services. Includable municipal services will be limited to those services which are financed through the municipality's property tax and which are provided by the municipality to property taxpayers without levying a special fee for the service. A tax-exempt facility may be paying a municipal service fee to the municipality for the services or may provide the service and incur the cost in their own operation.

#### 2.500 Property Payment Allowance

The property payment allowance will be a per patient day amount based upon the value of a facility's buildings as estimated by a commercial estimator, target amounts based on service factors established by the Department, and the nursing home's allowable property-related expenses. The estimation will conform to guidelines determined by the Department. This allowance covers, in whole or in part, the nursing home's expenses related to ownership and/or rental of the land, land improvements, buildings, fixed and movable equipment, and other physical assets.

#### 2.700 Provider Incentives

##### 2.710 Exceptional Medicaid/Medicare Utilization Incentive

Nursing homes, other than those operated by a governmental entity, with exceptional Medicaid/Medicare utilization, described in Section 3.651, may receive the payment incentive. A non-profit corporation operating a facility, which in turn is controlled exclusively by a municipality, will be viewed as a government entity. The primary source of ownership information is the owner identified on the operating license issued by the Department. Ownership status is determined as of the last day of the cost report. If a governmental facility changes ownership status, it will not be eligible for this incentive until such time that the change in ownership status has been reflected on the cost report used to set the rate for the applicable rate year.

##### 2.720 Private Room Incentive

Nursing homes may be eligible to receive a Basic Private Room Incentive (BPRI), or a Replacement Private Room Incentive (RPRI). To determine eligibility, nursing homes must meet licensed bed and patient day requirements. To receive an incentive, nursing homes must submit an affidavit to the department stating that during the reimbursement year they will not

charge Medicaid residents the surcharge for private rooms allowed under DHS 107.09(4)(k) as of the date the incentive would be effective. The affidavit must be received prior to the effective date of the incentive unless the Department approves an alternate cost reporting period under Section 1.302. A private room is a room licensed for single occupancy.

1. The Basic Private Room Incentive (BPRI) is for nursing homes which meet both the exceptional Medicaid/Medicare utilization, see Section 2.710, and have an extraordinary number of private rooms equal to the private room percentage (PRP) listed in Section 3.653(a), may receive a payment incentive. This Basic Private Room Incentive is based on the percentage of private rooms to total licensed beds. Licensed bed and private room requirements are listed in Section 3.653(a).
2. The Replacement Private Room Incentive (RPRI) is for facilities replacing 100% of the patient rooms subsequent to July 1, 2000, and will be effective the first day of service in the replacement facility or July 1, 2017, whichever is later. The replacement facility must meet the exceptional Medicaid/Medicare utilization in Section 2.710 and the private room percentage (PRP) listed in Section 3.653(b). If a facility does not replace 100% of the patient rooms they may still qualify for the BPRI.

#### 2.740 Medicaid Access Incentive

The Medicaid access incentive is provided to facilitate access to nursing home care for all Medicaid recipients. The incentive will vary based on the facility's certification.

#### 2.750 Bariatric Equipment Incentive

Due to their weight, bariatric nursing home residents require specialized moveable equipment, specifically beds and mattresses, commodes, wheelchairs and lifts. This incentive will allow nursing homes to recover the cost of specialized moveable equipment more rapidly to reflect the special equipment needs for this population

The equipment must be identified on the vendors' invoice or catalog description as bariatric equipment. It is the responsibility of the facility to provide the documentation to make this determination.

Other identifying factors that would make the item allowable:

- Lifts weight maximums identified as 400 lbs. or more
- Beds weight maximums identified as 500 lbs. or more and extra wide (40" or greater)
- Mattresses identified to fit the bariatric bed only
- Commodes weight maximums identified as 600 lbs. or more and extra wide
- Wheelchairs weight maximums identified as 450 lbs. or more

No options or attachments to the above units will be allowed for the incentive. (i.e. trapeze, special padding, special head or foot boards, etc.)

The incentive will cover acquisitions of specialized bariatric moveable equipment during the base cost reporting period. Equipment leases will not be included in the incentive payment.

Lease purchase agreements will not be considered purchases for this incentive. To be included in this incentive, the actual final purchase amount after the lease purchase agreement (if any) will be subject to capitalization policies limitations of \$1,000 or more for a single item or \$2,000 for multiple purchases.

In special situations such as short period cost reports or where the same cost report is used for multiple payment periods, the calculation may be adjusted to accurately reflect the incentive payment and not duplicate the incentive.

#### 2.760 Behavioral/Cognitive Impairment Incentives

The Behavioral/Cognitive Impairment Incentives will provide additional reimbursement for costs associated with the care of patients with specific cognitive or behavioral difficulties.

## 2.800 Specialized Psychiatric Rehabilitative Services

Specialized psychiatric rehabilitative services (SPRS) are those services as determined by the comprehensive assessment and the (SPRS) care plan, to prevent avoidable physical and mental deterioration and to assist clients in obtaining or maintaining their highest practicable level of functional and psycho-social well-being.

SPRS shall include:

1. The client's regular participation, in accordance with their SPRS care plan, in professionally developed and supervised activities, experiences and therapies.
2. Activities, experiences and therapies that reduce the resident's psychiatric and behavioral symptoms, improve the level of independent functioning, and achieve a functional level that permits reduction in the need for intensive mental health services.

To qualify for the supplemental payment the nursing home 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 nursing home believes that specialized rehabilitative services are no longer required, they must request a resident review from the PASRR contractor. 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.

## **Section 3.000 Calculation of Payment Allowances**

### **3.001 Introduction**

The payment allowance calculations are described in this section. For the payment system, the calculations of the allowances are on a per patient day basis.

### **3.040 Beds for Rate Setting**

The beds for rate setting will be the licensed beds on the last day of the base cost reporting period in section 1.302. Beds in restricted use status during the cost report period may be excluded from beds for rate setting if they are in restricted use at the end of cost reporting period.

### **3.100 Direct Care Allowance**

Both the rate calculation and any blended rate for payment will use Resource Utilization Groups (RUGs) for payment of Medicaid FFS Non-DD residents during the reimbursement period. The DD rate classes will continue to be used for residents in ICFs-IID and for residents that require specialized services in nursing facilities. The RUGs case mix index is determined using the RUGs 48 grouper as pertinent with index maximization for residents at the medical care levels. In addition to the RUGs group, all residents at the medical levels of care must meet the minimum definition for Limited Nursing Care (ICF2) in DHS 132.13 to be eligible for nursing home payments.

Separate direct care allowances will be calculated for facilities certified as ICF-IID (or the distinct part ICF-IID of a combined operation) and for facilities certified as nursing facilities. The targets and case mix weights for direct care services may differ for nursing facilities and ICFs-IID.

### **3.110 Payment Rate Classes**

The Medicaid FFS payment allowance for direct care will be computed for each of the following rate classes:

- a. Non-DD in-house residents
- b. Developmentally disabled (DD) residents
- c. Non-DD bed-hold residents
- d. DD bed-hold residents

### **3.115 Patient Days**

Patient days are defined in Section 1.315.

### **3.118 ICFs-IID**

A facility which has a distinct part certified as ICF-IID shall submit a combined cost report under Section 1.176. Separate sets of direct care allowances shall be calculated for the ICF-IID distinct part and the NF distinct part which are covered by the combined cost report.

### **3.120 Method of Computation of Direct Care Allowance**

### **3.121 Inflation-Adjusted Nursing Services Expense (IANSE)**

The facility's actual allowable direct care nursing service expenses for staff wages, fringe benefits, purchased services and supplies shall be inflated/deflated from the cost reporting period to the reimbursement period using the inflation factors in Section 5.310. Dividing the sum of these inflated expenses by total patient days yields per day inflated expenses.

### 3.122 Case Mix Indices

The direct care allowance calculation uses two case mix indices (CMI) values for the facility. These CMI's relate to resident acuity during the cost reporting period and anticipated during the reimbursement period. One CMI is associated with the all-resident population, while the other relates only to the Medicaid FFS resident population (or a portion of that population).

The All-Resident CMI (ALLRESCMI), defined in Section 2.145, represents resident acuity during the cost reporting period and reflected in the Inflation Adjusted Expense for direct care nursing services from Section 3.121.

The Medicaid Fee-For-Service Non-DD CMI (T19FFSCMI), defined in Section 2.140, represents the anticipated acuity for Medicaid FFS Non-DD residents during the reimbursement quarter starting six months after the Picture Quarter.

T19FFSCMI will be calculated quarterly, once for each of the quarters indicated in Section 5.422. The resulting rates from each calculation will become effective according to the Rate Effective Dates in Section 5.422.

Facilities that have beds for rate setting of fifty beds or less (Sections 1.307 and 3.040) and are certified only as a nursing facility will have a 20% increase in their case mix indices for Non-DD patient days only. Facilities that are certified as ICF-IID facilities either in whole or in part are not eligible to have its case mix index adjusted under this section.

### 3.123 Case-Mix-Neutral Nursing Services Expense (CMNNSE)

The Inflation Adjusted Nursing Services Expense in Section 3.121 is divided by the ALLRESCMI to produce an inflated nursing services expense per patient day adjusted to an average case mix of 1.000.

### 3.124 Case-Mix-Neutral Nursing Services Allowance (CMNNSA)

The Case-Mix-Neutral Nursing Services Allowance is the lesser of the facility's Case-Mix-Neutral Expense or the Nursing Services Target as follows:

1. The Case-Mix-Neutral Expense (CMNE) per patient day is defined in Section 3.123.
2. The Nursing Services Target (NST) is the product of Nursing Services Base (NSB) in Section 5.430 and the Labor Factor (LF) in Section 5.410.
3. The Case-Mix-Neutral Nursing Service Allowance (CMNNSA) is determined as follows:

If CMNE is greater than or equal to NST, then CMNNSA = NST.

If CMNE is less than NST, then CMNNSA = CMNE.

### 3.126 Case-Mix-Neutral Other Supplies and Services Allowance

The Case-Mix-Neutral Other Supplies and Services Allowance is equal to the Other Direct Care Supplies and Services Base (ODCSSB) in Section 5.430.

### 3.128 Direct Care Allowance Adjustments for Changes in Medicaid Case Mix

The Medicaid FFS Non-DD CMI (T19FFSCMI) will be recalculated according to the schedule in Section 5.422.

### 3.129 Direct Care Allowances by Rate Class

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 case mix associated with the rate class. The case mix index for each Medicaid FFS rate class is determined as follows:

1. For the DD in-house rate class, the case mix index is equal to the CMI in Section 5.420.
2. For DD bed hold, the case mix index is equal to the DD3 in-house CMI.
3. For the Non-DD in-house rate class, the case mix index is T19FFSCMI in Section 3.122.
4. For Non-DD bed hold, the RUGs bed hold CMI shown in Section 5.420.

The following formula summarizes the Direct Care Allowance calculation for a specific rate class:

$$DCA_j = [ \min( IANSE / ALLRESCMI, NSB \times LF ) + ODCSSB ] \times CMI_j, \text{ where,}$$

$DCA_j$  = Direct Care Allowance for rate class j  
 $IANSE$  = Inflation-Adjusted Nursing Services Expense from Section 3.121  
 $ALLRESCMI$  = All-Resident Case Mix Index from Section 3.122  
 $NSB$  = Nursing Services Base from Section 5.430 (SNF or ICF-IID, as appropriate)  
 $LF$  = Labor Factor from Section 5.410  
 $ODCSSB$  = Other Direct Care Supplies and Services Base from Section 5.430 (SNF or ICF-IID)  
 $CMI_j$  = Rate cell case mix index for Medicaid FFS rate class j

### 3.130 Payment for Specialized Psychiatric Rehabilitation Services

Facilities that provide Specialized Psychiatric Rehabilitation Services per Section 2.800 can provide the Department with adequate documentation of services provided to residents each month. The facilities will receive payment separately from the rate per Section 5.950.

### 3.150 Review and Correction of the Case Mix Indices

The Department will calculate the case mix indices in section 3.122 from information in the MDS data base, Medicaid paid claims information, the base cost report and supplemental cost reports. The department will provide summary information supporting the basis of the CMIs to the provider. The facility may request resident level data from the calculation of the CMIs. The facility may request corrections supported by resident level data for the period. Any correction will result in a recalculation of the RUGs CMI and the behavioral/cognitive impairment access and improvement scores for the period. The Department may apply the material adjustment standard in section 4.120 to corrections in the CMI. Allowable corrections to the CMI are only accepted by the "Date Available" listed in Section 5.422. See section 2.140 for further limitations. Any information exchanged with the Department and the facility under this process will be considered protected medical information.

If the T19FFSCMI is for any quarter based on five residents or less, the facility may request or the Department may require, an alternate reporting period to calculate the T19FFSCMI.

### 3.200 Support Services Allowance

#### 3.210 Method of Calculation

The support services allowance shall be paid in the amount provided under section 5.510.

#### 3.211 On-Site Water and Sewer Plants

For facilities which have on-site water and sewer plants, costs associated with maintaining such operations will be included in the support services payment allowance.

#### 3.212 Seasonal Cost Variations

If a facility's base cost report is not for a twelve-month period, the heating fuel and utility expense shall be adjusted for seasonal cost variations. Whenever possible, a twelve-month period for heating fuel and utility expense should be used with such expenses adjusted to the time period covered by the patient day count. If twelve months cannot be acquired, then heating fuel expenses should be adjusted to a twelve-month period based on heating degree days.

### 3.400 Property Tax Allowance

#### 3.410 Tax-Paying Facilities

Allowable property tax expense shall be based on the tax due for payment by the provider (or the lessor of the building) in the calendar year in which the payment rate year begins. For example, a July 2017 payment rate will include the amount of the December 2016 property tax bill increased by the inflation factor in Section 5.700 to adjust payment and expense to the payment rate year. Alternative cost reporting may be allowed under provisions in Section 4.000.

#### 3.420 Tax-Exempt Facilities

The property tax allowance for tax-exempt providers may include the cost of needed municipal services. For municipal service fees, the expense shall be the expense for municipal services provided to the facility in the calendar year prior to the beginning of the payment rate year as appropriately accrued to that period. The operating expense will be inflated/deflated to the common period by the dietary and environmental services inflation factor. Alternative cost reporting may be allowed under Section 4.000. The payment rate will include the inflated amount increased by the inflation factor in Section 5.700 to adjust payment and expense to the payment rate year. For operating expenses incurred by the facility, the expense will be from the cost reporting period used for other payment allowances.

### 3.500 Property Payment Allowance

#### 3.510 General

The property payment allowance will be a per patient day amount based on: the equalized value of the nursing home; target amounts based on service factors established by the Department; and the nursing home's allowable property-related expenses.

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. The asset value of nursing homes 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. Depreciation life shall be at the greater of 20 years or balance of 35 years from date of construction. The minimum estimated useful life of used movable equipment will be 5 years. This life will be applied to the composite value of the acquired equipment.

#### 3.520 Allowable Property-Related Expenses

Allowable property-related expenses include: depreciation, interest on plant asset loans, amortization of construction-related costs, amortization of bond discount and premium, lease and rental expenses, and property and mortgage insurance. These costs must be reported in accordance with generally accepted accounting principles (GAAP) and must be necessary for providing nursing home patient care. Costs associated with property that is not necessary for providing nursing home patient care are non-allowable. This includes property held for future expansion or investment. Purchase, lease or rental of equipment associated with Negative Pressure Wound Therapy (Wound Vac therapy) or procedures will not be considered allowable costs.

The cost reports for the base cost reporting periods and alternative cost reporting periods, as defined in Sections 1.302 and 4.000, will be the source for the information used to determine allowable property-related expenses.

Allowable costs will be adjusted to reflect any limitation on the revaluation of capital assets or lease limitations required under Sections 3.522 or 3.523.

#### 3.521 Maximum on Allowable Property-Related Expenses

Annual allowable property-related expenses will be limited to 15% of the equalized value of the facility.

#### 3.522 Changes of Ownership

If a facility changes ownership on or after October 1, 1985, a change in valuation will be allowed the new owner of the facility. The new owner's valuation will be the lesser of the purchase price or maximum valuation. The maximum valuation is calculated by multiplying the sellers 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 of the facility.

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 allowable value related to capital assets:

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 DPI described in the first paragraph of this Section 3.522 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; and
4. This initial maximum will be compared to 108% of the equalized value described in Section 3.531 below and the lesser value allowed as the maximum allowable value related to all assets.

Where no cost report information is available, the maximum allowable value will be 108% of the equalized value from Section 3.531.

If more than one nursing home 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.

This section does not apply to changes of ownership pursuant to an enforceable agreement entered into prior to October 1, 1985.

The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new 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, as permitted by applicable State law, constitutes change of ownership.

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

#### 3.522(a) Expenses Associated with Change of Ownership Limited by Section 3.522

If a facility's valuation is limited under Section 3.522 the associated depreciation, amortization, and interest expenses will also be limited. Reported depreciation, interest and amortization expenses will be multiplied by the ratio of the above maximum to the actual purchase price to determine allowable expense. If the valuation of assets of the new owner is not limited to the maximum in Section 3.522, actual costs will be allowed subject to Section 3.520.

#### 3.523 Lease and Rental Expense

1. Lease Maximum determination for ongoing leases. If a facility was leased prior to the current cost reporting period, the maximum allowable lease expense for the current cost report period, will be limited to the lower of the actual lease payments or the total of the allowable lease expenses from the previous year's cost reporting period multiplied by one-half of the percentage change (as measured over the same period of time) in the Consumer Price Index for all Urban Consumers (United States City average).
2. Lease Maximum determination for previously owned but never leased. If a facility is leased during the current cost reporting period but was not previously leased, the allowable maximum lease expense will be determined by reference to the current owners' year(s) of acquisition of the facility's fixed assets to the current cost reporting period. The year(s) of acquisition is/are the year(s) the facility was purchased or constructed by the owner. The lease maximum will be determined by: a) If the facility is still owned by the original provider that constructed the facility- divide the original

cost(s) of construction/acquisition adjusted by one-half of the Consumer Price Index, by the original costs(s) of construction/acquisition; or b) If the facility was previously purchased – divide the allowable purchase price adjusted by one-half of the Consumer Price Index plus capital additions, by the allowable purchase price plus capital additions from the cost report used for rate setting prior to the lease (per Section 3.522). This ratio will then be applied to the allowable property expenses, related to the assets now leased, and that were included in rates effective June 30, 2017, to determine the maximum allowable property expense subject to number 5 below and Section 3.523(a). The lower of actual or calculated maximum lease expense shall be used for determining the property reimbursement under Section 3.530.

3. Lease Maximum determination for new or replacement facilities. For new or replacement facilities that began operation in the cost report used for 2017-2018 rate setting, the lease expense reimbursed is the lower of actual or the lease maximum allowable for 2016-2017, subject to all other cost standards and formula limitations. The lease maximum will be the lessor's allowable depreciation and interest for the new building, with the lessor's loan balance being limited to 110% of Equalized Value.

In subsequent years, Section 3.523 (1) applies for determining the lease maximum.

4. Lease determination for a sale and lease back. For purposes of this section, an unrelated party sale and lease back transaction will be limited by the percentage increase that would be applied if the facility had been leased prior to the base cost reporting period. The lease maximum shall be determined by applying one-half the increase in the CPI from the year of the sale to the allowed reimbursable property expenses for the assets that are now leased from the year before the sale.
5. General provisions of allowable lease determinations. This limitation will only apply to lease expense and other capital costs as of the date of lease inception. It will not apply to depreciation, interest, lease and rental or other property costs on assets, whether the lessee or lessor acquired the assets after lease inception, such as the purchase or leasing of new equipment or leasehold improvements.

If a facility is unable to provide adequate support of the dates of asset acquisition, the procedure under Section 3.522 for imputing average years of ownership may be applied.

Lease expense includes the actual payments required under the lease contract. Lease expenses determined under the capitalized lease method of Financial Accounting Standards Board Statement ASC 840-30 will not be recognized.

The costs of acquiring existing leasehold rights are not allowable.

3.523(a) For leases existing prior to the cost report used for 2017-2018 rates, the limit calculated under this section will be increased for depreciation and interest expenses incurred by a lessor for leasehold improvements completed on or after July 1, 2017. The amount of increase will be calculated as if the lessee had made the improvements. This increase will be allowed only after a written agreement by the lessor has been received by the Department guaranteeing access to all records relating to the claimed expenses.

### 3.525 Depreciation and Amortization

1. Amortized Administrative & General (A&G) expenses. Amortization of the costs related to acquiring financing (i.e., bond issuance costs, bond placement fees, and letter of credit fees) is not considered property-related expenses but are allowable expenses under the administrative and general component. Financing fees include such items as, but not limited to, finder's fees, credit checks, origination fees, appraisal fees, feasibility studies, and loan application fees. Amortization of such fees is allowable in A & G. 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.
2. Amortized property expenses. 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 (bonds, mortgages, etc.) shall be allowed as property.
3. Depreciation expense. Depreciation expense must be calculated under a straight-line method over a useful life. Useful lives will be determined by reference to the useful lives guidelines published by the American Hospital Association.

### 3.525(a) Minimum Useful Life for Plant Assets

Depreciation for either the initial construction of buildings or building additions (including fixed equipment and land improvements) must be based on a minimum useful life of 35 years from the earlier of: 1) the date of initial licensure of the facility as a nursing home or other health care facility, or 2) the date of initial occupancy. Remodeling projects of existing licensed facilities will be depreciated according to American Hospital Association (AHA) guidelines for each of the individual components of the project. A minimum estimated useful life of 20 years will be applied to facilities purchased after July 1, 1988. New movable equipment will be depreciated according to AHA guidelines. The minimum estimated useful life for purchases of used movable equipment will be 5 years. This life will be applied to the composite value of the purchased equipment.

### 3.525(b) Expenses Directly Related to Establishing Units for Services to Ventilator Dependent Residents

A facility's additional expenses for depreciation and interest directly related to establishing a unit for ventilator dependent residents may be exempted from the limitations and maximums under Sections 3.500. "Directly related" means that the costs have been incurred solely as a result of creating this unit and that the equipment acquired or remodeling performed benefits only this unit. Prior approval by the Department of the remodeling project or equipment acquisition is required. This adjustment is only available for projects completed after July 1, 1993.

### 3.526 Interest Expense

Generally, interest expense on loans for acquisition of nursing home plant assets and equipment is an allowable property-related expense. Interest expense must be reasonable and necessary to be considered allowable. "Necessary" means that the interest is incurred on a loan necessary to satisfy a financial need and for a purpose reasonably related to nursing home resident care. Allowable interest expense on debt incurred for the acquisition of land, land improvements, buildings, leasehold improvements, and fixed and movable equipment related to nursing home patient care is a property-related expense.

### 3.526(a) Basis for Allowable Interest Expense

Allowable interest expense is based on:

1. Proper accrual under Section 1.302;
2. Recognizable debt balances under Section 3.526(b);
3. A "systematic reduction of debt" under Section 3.526(c);
4. Financing terms that would be incurred by a "prudent buyer" at the time a debt is created; and
5. The net amount remaining after investment income is offset.

### 3.526(b) Recognizable Debt Balances

Interest expense will be allowed only on debts which:

- First, are for the acquisition of the plant assets listed in Section 3.526 that are directly related to nursing home patient care;
- Second, have been limited or allocated, if necessary, under Section 3.522;
- Third, are for original asset acquisition or for allowable assets purchased in the second and third cost report year after a loan has been taken out. The costs incurred subsequent to the original loan will be added to the assets purchased during the first year of the loan to determine maximum financing allowable. The recognized debt balance of the loan will be adjusted in each of the two subsequent cost reports when the additional asset costs are recognized; and
- Fourth, do not exceed 110% of Equalized Value per Section 3.531(b).

### 3.526(c) Systematic Reduction of Debt

Allowable interest expense may not exceed the amount which would have been incurred under a systematic reduction of debt. The calculation of this limitation varies based on whether a facility makes at least annual principal payments or deposits to a segregated interest-bearing account.

If a facility makes at least annual principal payments or deposits to a segregated, interest-bearing account which will result in repayment of the debt at maturity, a systematic reduction of debt means a debt which has:

1. Payments of interest and principal which are uniform over the total length of debt; and
2. A length not exceeding the lesser of forty (40) years or the remaining useful life of the longest lived asset acquired with debt proceeds.

Allowable interest expense is predicated upon required systematic reduction of debt.

If a facility does not make at least annual principal payments or deposits, a systematic reduction of debt will be determined by the Department through:

1. An amortization schedule for a period of thirty (30) years from the date of asset acquisition;
2. Applying the interest rate as stated in the debt contract;
3. For debt contracts entered into prior to July 1, 1990, assuming a principal reduction schedule beginning July 1, 1990, and ending thirty (30) years from the original loan date; and
4. Reducing the calculated interest expense by any investment income on segregated funds.

### 3.526(d) Interest Expense Related to Refinancing of Debt

The recognizable debt balance following refinancing will be determined as:

#### Long Term Debt

1. The remaining balance of the original debt as determined under Sections 3.526(b) and 3.526(c); plus
2. The cost of assets acquired in the year of refinancing and then adjusted the following two fiscal years for additional assets acquired; plus

#### Separate short term Working Capital

1. The financing fees related to the refinancing

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.

Systematic reduction of debt under Section 3.526(c) is required for refinancing arrangements.

### 3.526(e) Reduction for Investment Income

The allowable interest expense after applying Sections 1.270 and 3.526(a)1 through 4 will be reduced by the amount of any investment income of the facility or related entities, including foundations, home offices, etc. per Section 1.270 to the extent the total property related expenses exceed 6% of equalized value. Investment income offset will not include income from donor-restricted funds provided that there is separate accounting for such funds, that the funds are used for their intended purpose, and there is no future benefit to the donor, grantor, or endower. Reserves needed by Continuing Care Retirement Centers to offset lifetime contracts can be calculated by their actuaries if lifetime contracts do not require residents to apply for Medicaid if the resident's funds are exhausted.

### 3.527 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 for non-nursing home areas. Allowable property insurance expense includes mortgage insurance required by the lender.

### 3.528 Inadequate Documentation

Where the provider, or in the case of changes of ownership, the buyer or seller of a nursing home, is unable or unwilling to provide adequate documentation of acquisition cost, acquisition date or other data relevant to the property-related expenses, or if the provider does not comply with property documentation requests by the Department or the contractor under Section 3.531, the Department will determine the values, dates and data through use of secondary sources of information, such as income and property tax records, and may use the source which results in the lowest value or the lowest property payment allowance.

### 3.530 Calculation of Property Allowance

#### 3.531 Equalized Value

The equalized value will be derived from the values determined by an independent contractor under contract with the Department, using CoreLogic Building Valuation System (BVS). Any 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 under Sections 3.531(a) and (b). These values will not be modified by any sales price; by a market appraisal by a certified appraiser on behalf of the facility; or by the assessed value on the property tax rolls.

The total value of the facility will be the sum of the values determined for the separate sections of the facility.

A facility's equalized value shall be based upon the values determined above, including adjustments, unless the facility does not render payment under Section 4.697 within a reasonable time period. In such instance, the facility's property allowance will be reduced by applying 50% of the facility's June 30, 2017, DRC and Undepreciated Replacement Cost (URC) under Section 3.531(b) or by 50% of the facility's June 30, 2017, property allowance, whichever is lower. This reduction applies to both the interim rate granted, if any, and the final rate. Upon facility payment of the appraisal cost, this reduction will be restored on a retroactive basis to the effective date of the reduction, and the facility property allowance will be calculated as determined by the provisions of the *Methods*.

#### 3.531(a) Allocation for Areas Not Related to Routine Services

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

#### 3.531(b) Maximum on Equalized Value

The Undepreciated Replacement Cost (URC) arrived at under the BVS valuation system shall not exceed the value in Section 5.821 times the beds for rate setting (Section 3.040) for allowances calculated under this *Methods*. Where this maximum is exceeded, the equalized value will be adjusted proportionately. This calculation can be expressed as follows:

$$\begin{aligned}\text{For: BVS URC} &= \text{The BVS Undepreciated Replacement Cost after} \\ &\quad \text{Section 3.531(a) square footage adjustments;} \\ \text{BVS DRC} &= \text{The BVS Depreciated Replacement Cost after} \\ &\quad \text{Section 3.531(a) square footage adjustments} \\ \text{URC} &= \text{Allowable Undepreciated Replacement Cost} \\ &\quad \text{(the lesser of BVS URC or the equalized value in Section 5.820)}\end{aligned}$$

Then allowable Equalized Value (EV) is calculated as:

$$\text{EV} = (\text{BVS DRC/BVS URC}) \times \text{URC}$$

### 3.532 Property Allowance Calculation

A target amount (T1) will be calculated for each facility by multiplying the equalized value from Section 3.531 by a service factor described in Section 5.810.

When the facility's allowable property-related expenses are equal to or greater than the target amount (T1), the property payment allowance will be the target amount (T1) plus the cost share value in Section 5.830 times the amount by which allowable expenses under Section 3.521 exceed the target (T1)

This calculation can be expressed:

For: E = Allowable property-related expenses up to Section 3.521 maximum;

T1 = The service factor in Section 5.810;

PA = Total property payment allowance;

C = Cost Share Value described in Section 5.830; and

Where E is less than T1:

$$PA = E$$

Then:

Where E is greater than or equal to T1:

$$PA = (T1 + C * (E - T1))$$

Nursing facilities that have a licensed bed capacity of 50 beds or less (Section 1.307), after adjustments in Section 3.000, will have a cost share as described in Section 5.830(b). Facilities that are certified as ICFs-IID, either in whole or in part, will have a cost share as described in Section 5.830(a).

### 3.534 Per Patient Day Property Payment Allowance

To calculate the per patient day property payment allowance, the property allowance (Section 3.532) is divided by the patient days in Section 1.315. If needed, the expenses shall be adjusted to the length of time covered by the patient days.

For calculating the per patient day property payment allowance for newly-licensed facilities and facilities with significant licensed bed increases, the patient day provisions of Sections 4.320 and 4.420 will apply.

### 3.537 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 on June 30, 2017. An exception to this maximum decrease is made if the June 30, 2016, allowance is subject to adjustment after June 30, 2017, for the lapsing of the "start-up" occupancy provisions for newly-licensed or expanded facilities. In these cases, the \$3.50 maximum reduction is measured from the allowance which would have resulted from applying the *Methods* in effect on June 30, 2017.

### 3.600 Provider Incentives

#### 3.651 Exceptional Medicaid/Medicare Utilization Incentive (EMMUI)

MM% = the facility's Medicaid patient days plus Medicare patient days divided by the facility's total patient days under Section 1.315. The MM% must be greater than or equal to 70.0% in order to receive the EMMUI. The incentive will vary based on the MM% and the beds for rate setting of the facility. A separate incentive is available for facilities located within the city limits of the City of Milwaukee. Payment for the EMMUI supplement will be determined per the table in Section 5.920.

### 3.653 Private Room Incentive

#### 1. Basic Private Room Incentive (BPRI)

A basic private room incentive will be determined using the following formula:

$$\text{BPRI} = \text{PRP} \times \text{BBA}$$

where PRP = Private rooms divided by total licensed beds on the last day of the cost report used for the rate calculation. PRP must be greater than or equal to 15% **AND** the facility's Medicaid patient days plus Medicare patient days divided by the facility's total patient days under Section 1.315 must be greater than or equal to 65% in order to receive the BPRI

and BBA = The basic base allowance in Section 5.930

#### 2. Replacement Private Room Incentive (RPRI)

A replacement private room incentive will be determined using the following formula:

$$\text{RPRI} = \text{PRP} \times \text{RBA}$$

where PRP = Private rooms divided by total licensed beds on the last day of the cost report used for the rate calculation. PRP must be greater than or equal to 90% **AND** the MM% from Section 3.651 must be greater than or equal to 65.0% in order to receive the RPRI.

and RBA = The replacement base allowance in Section 5.930

A facility may receive only one private room incentive.

### 3.654 Medicaid Access Incentive

Facilities certified as skilled nursing facilities (SNF) will receive the incentive in 5.941. Facilities certified as Intermediate Care Facilities for Intellectual Disabilities (ICFs-IID) will receive the incentive in 5.942. Distinct part ICFs-IID as defined in Section 1.311 will have separate rates reflecting the separate incentives in Sections 5.941 and 5.942.

### 3.655 Property Incentive for Innovative Projects

Facilities may request Departmental approval for a special rate adjustment to allow for improvement of both the physical environment and the quality of resident life, through either renovation or replacement of the nursing home building. The goal of these projects is to improve the physical plant and facility in which nursing care is provided *and* to do so in a manner which will not increase overall costs to the Medicaid program. Requests will be made by application, reviewed by Department staff, and approved by the Department at its sole discretion. Priority approval will be given to requests involving highest levels of demonstrated benefit to the quality of nursing home care and most favorable impact on overall Medicaid costs. Facilities that have received approval for an incentive for innovative projects under the *Methods* prior to 7/1/12 will continue to receive the incentive as described in the *Methods* in effect when that request was approved. See Section 4.920.

Approvals for innovative projects, under both Section 3.655 and Section 4.920, are not transferable to parties other than the nursing home owner receiving the approval, or to projects other than the one approved. The property incentive rate add-on will be available to successive owners if the nursing home operation is sold after the project is approved, providing the project was completed as approved before the sale.

The Department will generate an application packet to assess proposed projects. Application packets and approvals will be accepted, and approved, on a quarterly basis. The Department will manage the number of approvals, taking into account the potential for short-term cost increases and budget constraints.

General criteria for consideration during the approval process will include, but not be limited to, the following:

- The facility will clearly demonstrate the improvement in the quality of care and resident life it expects to achieve. The project application will indicate details of how the living environment will be enhanced through specific aspects of the physical environment such as:
  - Large % of private rooms per DQA license
  - Single loaded corridors-patient rooms on one side, exterior open on the other
  - Small household settings including inviting common areas
  - Access to the outdoors and outdoor views
  - Personalized space-enhanced dining, bathing and activity programs
  - Access for family and community involvement
  - Design features to enhance relationship between residents and staff
- Resident-centered design elements intended to improve care outcomes for residents with behavioral and cognitive impairment challenges, including dementia-related needs, will significantly enhance the likelihood of project approval, assuming other program requirements are fully satisfied
- The facility will demonstrate the cost savings to the Department that will, at a minimum, equal the additional rate adjustment that is implemented. The facility will demonstrate the total financial impact of the innovative project will not increase overall Medicaid costs.
- The timeframe over which these savings will be achieved will be explicitly identified in advance. A financial template will be supplied by the Department for this purpose.
- All requests will include the return of a number of licensed nursing home beds to the Department, and this number will be specified during the application process. Licensed beds must be returned to the Department as the project is completed. Other than Phase-down period rates under option 1 any enhancement to the rate formula approved under this section is effective when the costs of the project are recognized in the Title XIX rates.
- All options include construction or renovation of existing space to create innovative and improved physical living area.
- All requests will be related to one of the four allowable options described below, the option must be specified during the application process, and it may not change, once approved.
- Construction may not begin before the approval date.

Additional details will be specified in the application packet. Selection criteria will also be included in the application packet, to ensure fair and equitable implementation of the selection process. Four distinct options will be presented to interested parties. The program options are as follows:

1. Nursing Home Downsizing Program: The facility plans to reduce its current census by 15% or more, reduce licensed beds, along with replacement or renovation of the facility and implementation of quality of care improvements across the whole facility. The time period of the reduction will be specified in the application and be subject to approval by the Department. Medicaid payment levels will be frozen during the approved phasedown period. After the phase-down period is complete, Medicaid rates will be re-established using a cost report that is based on the post phase-down cost structure. The cost of the increased reimbursement rate will not exceed documented savings to the Department. The facility will demonstrate that the total financial impact of the innovative project will not increase overall Medicaid costs
2. Replacement Facility Program: The facility plans to replace its current facility, or partially replace its facility, reduce licensed beds, *and also* implement quality of care improvements across the entire facility. Medicaid payment, once the new construction is complete and reflected in the current Medicaid rates, would increase the un-depreciated replacement cost (URC) in the property component of the rate from \$75,900 to \$135,000. In the case of partial facility replacement, the URC on the non-replaced beds would not change. The period to which the increased URC would apply will be proposed by the facility in their application, and be subject to approval by the Department. The cost of the increased reimbursement rate will not exceed documented savings to the Department. The facility will demonstrate that the total financial impact of the innovative project will not increase overall Medicaid costs.
3. Small Replacement Facility/Renovation Program-60 beds: The facility plans to replace, or renovate its current facility, reduce licensed beds resulting in a facility with a licensed bed capacity of between 51 and 60 beds, and also implement quality of care improvements across the entire facility. Medicaid payment, once the new construction is complete and reflected in the current Medicaid rates, would increase the un-depreciated replacement cost (URC) in the property component of the rate from \$75,900 to \$135,000. In the case of a partial facility replacement, the URC



on the non-replaced beds would not change. In cases of renovation, rather than replacement, the facility must demonstrate the expenditures were significant to justify the increased URC. The Medicaid rate could also include an add-on to the rate of up to \$5 per Medicaid patient day. The amount of the add-on, and the period requested for both the add-on and the increased URC would be specified in the application and be subject to approval by the Department. The cost of the increased reimbursement rate will not exceed documented savings to the Department. The facility will demonstrate that the total financial impact of the innovative project will not increase overall Medicaid costs.

4. Small Replacement Facility/Renovation Program-50 beds: The facility plans to replace, or renovate its current facility, reduce licensed beds resulting in a facility with a licensed bed capacity of 50 beds or less, and also implement quality of care improvements across the entire facility. Medicaid payment, once the new construction is complete and reflected in the current rates, would increase the un-depreciated replacement cost (URC) in the property component of the rate from \$75,900 to \$135,000. In the case of a partial facility replacement, the URC on the non-replaced beds would not change. In cases of renovation, rather than replacement, the facility must demonstrate the expenditures were significant to justify the increased URC. The Medicaid rate could also include an add-on to the rate of up to \$10 per Medicaid patient day. The amount of the add-on, and the period requested for both the add-on and the increased URC would be specified in the application and be subject to approval by the Department. The cost of the increased reimbursement rate will not exceed documented savings to the Department. The facility will demonstrate that the total financial impact of the innovative project will not increase overall Medicaid costs.

### 3.656 Bariatric Equipment Incentive

The cost of acquisitions of bariatric moveable equipment during the base cost reporting period in section 2.750 divided by total patient days shall equal the bariatric equipment acquisitions cost per day. The facility will receive an incentive equal to 50% of the cost of the bariatric equipment acquisitions per day.

In special situations such as short period cost reports or where the same cost report is used for multiple payment periods, the calculation may be adjusted to accurately reflect the incentive payment and not duplicate the incentive.

### 3.657 Behavioral/Cognitive Impairment (BEHCI) Access and Improvement Incentives

The funding available for the SFY2018 BEHCI Incentive will be distributed as two incentives.

To calculate the BEHCI Access and Improvement Incentives the Department will apply two scores, an Access Score and an Improvement Score, to each resident based on values defined by:

- The MDS elements listed in section 5.971; and
- Acuity categories ranging from 0 to 5 based upon psychiatric and related diagnosis codes under the International Classification of Diseases, version 9 (ICD-9), as organized via decision rules promulgated under the nationally-recognized Chronic Illness and Disability Payment System (CDPS).

The BEHCI Access and Improvement Scores are based on index values aggregated at the facility level, calculated using data available for Title 19 FFS Non-DD residents present in the facility on the last day of the second quarter of the fiscal year (December 31, 2016) that also had a RUGable MDS assessment on or prior to that date. The BEHCI Access and Improvement 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 BEHCI Incentive. Only MDS Assessments completed since October 1, 2010 are included in the BEHCI Incentive calculations.

#### BEHCI Access Incentive

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 PopID;
- A break in stay of more than 30 days;
- October 1, 2010.

The BEHCI Access Incentive is determined by multiplying the BEHCI Access Score by the BEHCI Access Base Rate in Section 5.460.

### BEHCI Improvement Incentive

The Improvement Score for each resident is calculated using the six most recent RUGable MDS Behavioral Scores since the Starter Event determined for the BEHCI 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.

The BEHCI Improvement Incentive is calculated by multiplying the Improvement Score by the BEHCI Improvement Base Rate in Section 5.460.

### 3.700 Final Rate Determination

A facility's rate shall be the sum of the payment allowances resulting from sections 3.100, 3.200, 3.400, 3.500, and 3.600.

### 3.775 Special Allowances for Facilities Operated by Local Units of Government

In recognition of the unique nature of nursing homes operated by local units of government, local government-operated homes are eligible to apply for supplemental funding. Government-operated facilities will be consistent with the definitions used in Section 2.710.

#### A. Supplemental Payments for Local Units of Government

1. In order to participate in the supplement, the home must have on file with the Department and/or submit the following materials:
  - a. A cost report as required in Section 1.170.
  - b. A prospective supplemental award application form.
  - c. An affidavit signed by the executive officer of the local unit of government or by his or her designee, certifying the amount of local government expenditures eligible for FFP under 42 CFR 433.51(b), for the purpose of meeting the cost of nursing home care and services.
2. Supplemental funds awarded to facilities will be made in lump sum payment(s). Total supplemental funding shall not exceed \$39,100,000. The Department shall reduce the supplemental funding to the local units of government if it determines that the aggregate payments to nursing homes under these *Methods* would exceed the Medicare upper limit calculated in Section 3.780.
3. The following methodology will be used to distribute funds under this Section:
  - a. The Medicaid deficit and payment calculations will be determined by using the Medicaid patient days from the 2016 cost report. Based upon the 2016 cost report and the rates established under the *Methods* and any other revenue including gifts or management fees associated with Medicaid residents, the Department will determine the following Medicaid deficits for July 1, 2017 through June 30, 2018: Medicaid costs (DD vs. Non-DD) for each facility are allocated from the all-resident allowable cost. The allocation basis reflects the proportion of patient days related to Medicaid residents, weighted by the relative acuity of these residents. The acuity basis used to weight patient days is the same basis underlying the Medicaid rates for the period:
    - 1) The Projected Direct Care Operating Deficit (DCOD).
    - 2) The Projected Overall Operating Deficit (OAOB).
    - 3) The Eligible Direct Care Deficit (EDCD) (Equal to the lesser of the DCOB or the OAOB).

- 4) The projected non-direct care deficit (Equal to the OAOD less the EDCD).

The Department will issue a report to each applicant facility detailing its DCOD and OAOD.

- b. The Department will distribute, \$39,100,000 or the aggregate OAOD, whichever is less, in supplemental funding as follows: If there are insufficient funds to reimburse facilities *OAOD*, then the distribution shall be made as follows

- 1) Each facility shall receive a maximum payment equal to the facility's EDCD.

If there are insufficient funds, to reimburse all facilities' EDCD, an EDCD per Medicaid day will be calculated by dividing the \$39,100,000 by total Medicaid days for all facilities with a factoring of the limits of individual facility's EDCD. This per day amount will then be paid for each Medicaid day up to the amount of the facility's Medicaid EDCD.

- 2) If additional funds remain after payment of the EDCD, the remaining funds shall be divided by the Medicaid patient days with a factoring of the limits of individual facility's projected non-direct care deficit to determine a non-direct care loss per Medicaid day. Each facility will receive their non-direct care deficit per Medicaid day, not to exceed their non-direct care deficit.
- 3) The nursing home will receive payments only based on Medicaid patient days.
- 4) If a governmental facility is sold during the effective period of this plan, the deficits per Section 3.775A.3.a. and patient days will be prorated based on the number of calendar days the facility was licensed as a governmental facility. 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 2016 cost report days.

**B. Non-State Government Nursing Facility and ICF-IID Operating Deficit Reduction (ODR) Program**

The Department will claim Federal Financial Participation (FFP) based on public funds expended for nursing home care for Medicaid residents under 42 CFR 433.51(b). All references to Medicaid in this Section relate only to services provided to Medicaid residents.

**Background**

Wisconsin pays non-state government facilities a daily rate for Medicaid services under the nursing home reimbursement provisions of the State Medicaid Plan. In most cases, the cost of providing Medicaid services exceeds the daily payment rate. This deficit is absorbed by the local government and is eligible for federal matching up to any remaining room to the Medicare Upper Limit (UL) applicable to non-state government nursing facilities (or ICF-IID), not to exceed the cost of providing services to Medicaid residents. A claim for these matching funds is made by the state based upon cost reports filed by the nursing facility. Since these local government facilities serve non-Medicaid residents as well as Medicaid residents and the filed cost report reflects costs for all residents combined, a cost allocation must be made between Medicaid and non-Medicaid residents. In addition, since some facilities provide Medicaid services to both developmentally disabled (DD) residents as well as adult disabled and elderly residents (Non-DD), which have separate aggregate Medicare ULs, a cost allocation also needs to be made between Medicaid DD and Medicaid Non-DD residents.

It is necessary to use the Medicaid cost report instead of the Medicare cost report for several reasons.

- Not all facilities participate in the Medicare program. Use of the Medicaid cost report provides a consistent platform for cost finding, allocations and final settlement.
- Some facilities that participate in Medicare certify only a distinct part of the facility. Utilizing the Medicaid cost report provides a comprehensive instrument for the entire operation.

There will be three separate calculations; an interim payment calculation; an interim settlement and a final settlement. Each calculation will use the most recent cost information available, the most recent Medicaid utilization information available and the most recent Medicaid payment information available.

Step 1 below, the cost report and audit step, provides a cross reference to the Medicaid cost report and a summary of the audit process. Step 2 describes how the Medicaid operating deficit is calculated. Subsequent Steps describe how the interim payment, interim settlement and final settlement are calculated and the information sources for each.

#### Step 1. Computation of Allowable Cost using Medicaid Cost Reports

The following methodology is used to determine allowable cost from Wisconsin Medicaid cost reports:

In each of the following cost centers, allocations are made that adjust the expense to the Nursing Home utilization net of all revenue offsets. Audited allowable costs are Wisconsin Medicaid allowable as defined by our State Plan (using Medicare principles as a guide and applying further restrictions). Only audited cost report values are used in the final settlement calculations.

Wisconsin Medicaid Cost Report Schedules used for the Operating Deficit Reduction:

- Patient Days: Schedule 6 = all patient days reported by pay source for the cost report period.
- Direct Care: Schedules 20-24A = nursing wages and other professional wages (therapy etc.) and supplies.
- Support Services: Schedules 25-26, 29-32 = dietary, maintenance, housekeeping, laundry, security, transportation, fuel and utilities, administration, working capital interest, liability insurance, and amortized fees.
- Fringe Benefits: Schedule 28 = allocated to direct care and support cost centers based on wages.
- Property: Schedules 31-35 = property insurance, long term interest, amortized points/letter of credit fees, depreciation (straight line per AHA), and lease expense.

In summary, we are claiming the difference between allowable Medicaid expenses before formula limitations (limited to the Medicare UL) and the total Medicaid revenues received (as accrued) for that same time period. Allocations of ICF-IID expenses and revenues are determined as stated in Step 2 below.

Formula Limitations:

- Direct care targets as adjusted for case mix indexes
- Support care targets (priced cost center)
- Property limitations based on assessed value

Medicaid Revenues:

- Accrued Medicaid rate revenue for the same time period as expenditures
- Supplemental payments
- Appeals revenue of Medicaid rates
- Any other one time Medicaid rate adjustment revenue
- Miscellaneous revenues are already offset to Medicaid expense

#### Step 2. Calculation of the Medicaid Operating Deficit

For a specified period, the Medicaid operating deficit is calculated as the Medicaid allowable cost less the Medicaid revenue.

a. Fee for service Medicaid costs (DD vs. Non-DD) for each facility are allocated from the all-resident allowable cost obtained in Step 1 for the cost report containing the specified period. The allocation basis reflects the proportion of patient days related to Medicaid residents, weighed by the relative acuity of these residents. RUG case mix indices are applied directly to weight cost report patient days to allocate direct care costs to Medicaid residents. Other reported costs will be allocated to Medicaid in proportion to unweighted patient days. The RUG acuity for reported patient days (all residents or Medicaid residents) is computed as the average RUG case mix index of

residents for each calendar quarter falling in the reporting period. Costs associated with Medicaid managed care residents are imputed using the ratio of Managed Care daily rates compared to the fee for service daily rates.

b. Medicaid revenue will include all payments for nursing home services provided to Medicaid residents, including patient liability revenue, rate payment revenue, supplemental payments, nursing home appeals awards and any other financial transactions, for services provided during the specified period.

### Step 3. The Medicare Upper Limit

The SFY16 Medicare Upper Limit (UL) per patient day is computed at the time the SFY16 rate formula is determined. The UL per patient day (ppd) is available by quarter by facility by DD versus Non-DD resident classification. We apply the UL ppd to actual MMIS accrued patient days by quarter by facility (DD vs. Non-DD) to obtain each period's applicable UL for Medicaid payments accrued in that quarter.

### Step 4. Interim Payment Calculation

Interim payments will be calculated quarterly in the first month of the quarter, and will be claimed in three equal installments at the end of each month of each quarter in SFY 2018. The interim payment calculation employs the same methodology as the final settlement, except estimates are used where actual values are not yet available. Specifically,

- a. For each facility, Medicaid patient days are projected based on the last completed quarter and adjusted for any known changes, such as a planned closure or downsizing.
- b. For each facility, Medicaid costs (DD vs. Non-DD) are estimated from the Medicaid cost ppd (using the allocation method from Step 2a above) for the most recent audited cost report, inflated to the current cost reporting period using the Medicare SNF Total Market Basket index with the 2004 based weights, and multiplied by projected Medicaid patient day estimates from item 4a above.
- c. For each facility, Medicaid payments (DD vs. Non-DD) for services incurred are based upon projected patient days (from item 4a above) multiplied by the Medicaid payment rate from the last quarter adjusted for any pending Medicaid rate schedule changes.
- d. The Medicaid operating deficit will be the Medicaid costs from Step 4b less the Medicaid payments in Step 4c.
- e. The UL (DD vs. Non-DD) is obtained by multiplying the facility-level UL ppd by projected Medicaid patient days from item 4a above. The room to the UL is equal to the UL minus Medicaid revenue from item Step 4c.
- f. The interim payment will be the lower of the aggregate Medicaid operating deficit in Step 4d or the aggregate room to the Medicaid UL in Step 4e.

### Step 5. Interim Settlement Calculation

An interim settlement will be calculated when the nursing homes submit their cost reports for each reporting period. The interim calculation in Step 4 will be updated using each facility's cost report with initial audit adjustments and reclassifications; actual patient days and acuity data from the cost report and MMIS; actual Medicaid rate payments, supplemental payments, appeals payments and other financial transactions from the cost report and MMIS and the UL.

If the interim settlement calculation indicates that there was a material overpayment, or underpayment is indicated for the reporting period, then the ODR claim will be adjusted to reflect the interim settlement calculation.

### Step 6. Final Settlement

- a. For facilities with cost reports based on a calendar year, there will be two separate final settlements for the state fiscal year of 2017-2018. The period of July 2017 to December 2017 will be finally settled around January 2019 when cost reports for calendar year 2017 have been fully reviewed and audited. The period of January

2018 to June 2018 (in conjunction with the July 2018 to December 2018 period) will be finally settled around January 2020 when cost reports for calendar year 2017 have been fully reviewed and audited. For facilities with state fiscal year cost reports, there will be a single final settlement for state fiscal year 2018, around January 2020 when the cost reports for SFY2018 have been fully reviewed and audited.

- b. Medicaid costs (DD vs. Non-DD) for each facility for the respective period are allocated from all-resident costs from the applicable audited cost report using the method described in Step 2a above.
- c. Medicaid revenues (DD vs. Non-DD) for each facility are obtained retrospectively from MMIS claim records. These revenues include daily rate payments and other non-rate payments, including supplemental payments and appeals payments, accrued throughout the respective period.
- d. For each period, for each facility and for DD vs. Non-DD, the Medicaid deficit is computed as the Medicaid cost (from Step 6b) minus the Medicaid revenue (from Step 6c). Negative deficits are set to zero. Deficits are summed separately for DD and Non-DD.
- e. For each period and for DD vs. Non-DD, the room to the UL is computed as the UL minus the sum of facility Medicaid revenue.
- f. For each period and for DD vs. Non-DD, the amount subject to federal matching is the lesser of the total deficits and the room to the UL.

### 3.780 Calculation of Medicare Upper Limit

The upper limit is applied in aggregate to each of six categories of skilled nursing facilities (SNFs) and intermediate care facilities for individuals with intellectual disabilities (ICF-IID):

- 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
- 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. This general rule was applied as follows to each category.

- NFs: Medicare pays for skilled nursing facility care under a prospective payment system (SNF PPS) with daily rates published in the Federal Register at the beginning of each Federal fiscal year. These rates vary by facility location, by resident resource utilization group (RUG) classification and cover a specified set of covered Medicare services. The estimated amounts Medicare would pay for Medicaid services within each of the three 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 does not apply to ICFs-IID and the RUG classification system is not applied to ICF-IID residents, we use aggregate allowable costs for the Medicare Upper Limit for ICFs-IID.

Note also that the calculations of SFY2018 Medicaid payments and upper limit values are based upon information that is available at the time the State Plan is filed with CMS. That is, the calculations are prospective in nature and actual Medicaid payments may vary from estimates due to differences in actual 2016 cost report data (used to set actual SFY2018 rates) and expected 2016 cost report data (projected from 2015 cost reports and used to estimate SFY2018 Medicaid rates) and differences in actual SFY2018 Medicaid patient days and expected patient days, among other items.

### 3.790 Purchased Relocation Services

Payment for relocation services may be paid as a lump sum, in addition to the daily payment rate, if all of the requirements listed below are met.

- The relocation plan(s) must be ordered by the Department.

- The Department must approve the contractor performing the services.
- Only services such as assessment of the resident for alternate placements, preparing contracts for community-based services and developing the community-based care provided by and paid to an outside contractor are allowable. All staff costs are allowable in the *Methods* and are not eligible for the lump sum payment.
- The amount allowed must meet all Departmental contracting limits.

The Department will pay the Medicaid portion of the allowed Purchased Relocation Services. The percentage of residents that were Medicaid during the month prior to the relocation order will be used as the Medicaid portion. The Department may, at their sole discretion, pay 100% of the allowed Purchased Relocation Services if the request is made prior to contract signature and it is shown to be in the Departments best interest.

Example: The Nursing Home receives a relocation order from the Department on July 15. They hire Apex Relocation Services to relocate all 100 residents in the next 60 days for a cost of \$15,000. The Department approves the contract with Apex and the contract amount of \$15,000. During June, 75 of the 100 residents were paid through Medicaid. Therefore, \$11,250 (\$15,000\* 75%) will be paid to The Nursing Home as a lump sum.

If this section does not apply, the relocation services will be included in the cost report and paid accordingly.

### 3.800 Separately Billable Ancillary Items

#### 3.801 Medical Transportation

Medical transportation may be separately billed by a nursing home provider as an ancillary. Billings may not exceed \$10 per day for a resident when a ride is provided plus \$1.00 per mile. Medical Transportation is transportation provided by a nursing home to permit a recipient to obtain health treatment or care if the treatment or care is prescribed by a physician as medically necessary and is performed at a physician's office, clinic, or other recognized medical treatment center. Such transportation may be provided in the nursing home's own controlled equipment and by its staff, or by other carriers, such as bus or taxi. The Department shall retain its authority under s. 49.45(10), Wis. Stats., to modify this paragraph.

#### 3.802 Oxygen

A nursing home may bill for oxygen and oxygen generators at a daily rate as described in the Medicaid Update series. The nursing home must use the claim form approved by the Department for oxygen billing. The nursing home will be subject to maximum fees for these services. Prior authorization is required for more than 30 days' rental of an oxygen concentrator for a resident. Ancillaries mentioned in this section cannot be paid as part of the rate but can be billed by the facilities.

#### 3.803 Reimbursement Manner

The costs of services and materials billed separately by the nursing home are not included in the calculation of the daily payment rate of the nursing home. These costs shall be reimbursed in the following manner:

1. Claims shall be submitted under the nursing home's National Provider Identifier (NPI)
2. The items shall either have been prescribed in writing by the attending physician or the physician's entry in the medical records or nursing charts shall make the need for the items obvious
3. The amounts billed shall reflect the fact that the nursing home has taken advantage of the benefits associated with quantity purchasing
4. Reimbursement for questionable materials and services shall be decided by the Department
5. The amount charged for transportation may not include the cost of the facility's staff time and shall be for an actual mileage amount
6. Reimbursement will be limited to the amounts set per sections 3.801 and 3.802.

### 3.900 Reimbursement of State-and-Tribal-Owned or Operated Facilities

#### 3.910 General

The payment rate for State and Tribal-owned nursing facilities will be the Medicare PPS payment 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 Intermediate Care Facility for Intellectual Disabilities (ICF-IID) facility's fiscal year. If payment at the interim rates does not exceed the Medicare upper limit, then the facility will be reimbursed the difference. If the payments at the interim rates are above the Medicare upper limit, then the difference will be recovered. However, in no case shall the total Medicaid payment exceed the Medicare Upper Limit.

#### 3.9231 Direct Care, Support Services and Property Tax

The maximums and limitations in Sections 3.100 through Section 3.400 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 in Section 3.654.

#### 3.9232 Capital Costs

Actual and allowable capital expenses for the cost reporting period shall be used to calculate the final property allowance. The property allowance shall be subject to reconciliation under Section 3.980.

#### 3.950 Reporting Limitations

The facilities shall be subject to all cost reporting requirements. The costs of teaching and vocational counseling services rendered to residents under age 22 as part of an active treatment plan are only allowable in facilities licensed as ICFs-IID. The facilities will maintain adequate records so that audits of costs may be conducted to determine payable costs.



## **Section 4.000 Special Payment Rate Adjustments and Recalculations**

### **4.100 Retroactive Rate Adjustments**

#### **4.110 Retroactivity**

The Department has the authority to retroactively adjust the daily rate in such circumstances as audit adjustments, errors in reporting, errors in calculations, implementation of administrative formula provisions, and implementation of rules enacted under s. 49.45(10), Wis. Stats.

#### **4.115 Administrative Reviews and Appeals**

Sections 4.110 through 4.150 do not apply to administrative reviews or appeals under Section 1.700. The time limits within which administrative reviews or appeals must be filed are determined under the relevant section, rule, and guidelines.

#### **4.120 Material Adjustments**

Only audit adjustments and/or corrections of errors which have a combined net material impact on rates and payments for services will be incorporated into the rates. "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, inhouse rate. The materiality test will be applied separately each time payment rates are recalculated for the correction of errors or audit adjustments with the newly-adjusted rates being compared to the rates being corrected or adjusted.

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.

If errors are found by the Department, increased corrected rates will be effective on the first of the month following the month in which the error was found and decreased corrected rates will be effective on the original effective date of the rates being corrected. If such errors are found coincident to a notice from the provider of some other errors, then corrections for the findings of the Department shall be incorporated with and allowed to be retroactively effective in conjunction with the corrections resulting from the notice from the provider.

### **4.200 Change of Ownership**

#### **4.210 No Rate Change for New Owner**

There shall be no payment rate recalculation due to the change of ownership of a facility or operation which occurs during the payment rate year described in Section 1.130. The new provider will be paid the rate which the former owner was paid or would have been paid if no change of ownership had occurred, unless other provisions of this Section 4.000 allow adjustments to the payment rate. If the change of ownership occurred prior to the payment rate year, July 1 payment rates shall be determined based on a cost reporting period allowed under Section 1.302.

#### **4.220 Prior Owner's Cost Report Required**

The cost report for the period during which the facility was operated by the previous owner is still required and must be submitted to the Department unless the Department determines the cost report is not needed. The new owner should assure the prior owner's cost report is submitted. In those rare instances where it may be impossible to obtain the prior owner's cost report, the Department may determine it is not needed if the cost reporting period for the new owner allowable under Section 1.302 covers a period of at least six months. If the prior owner's cost report is needed, but not submitted, the new provider's rates for the payment rate year specified in Section 1.130 will default to the facility's June 30th rate of the prior payment rate year, exclusive of any amounts for ancillary add-ons and special allowances for local government operated facilities. The Department may reduce those rates by no more than 25.0% if deemed appropriate.

#### 4.230 Property Tax

The property tax allowance shall not be adjusted to recognize a change in tax status upon a change of ownership.

#### 4.300 Payment Rates for New Facilities

##### 4.301 General

Payment rates for a new facility will be established under the rate calculation provisions of Section 3.000. The rate computation will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates. The Department will establish interim rates until rates can be finalized under this section. New facilities are defined in Section 1.305. The Department may deny approval of any rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the new facility. Allowable costs will be deflated and inflated as appropriate with the indices in Section 5.300 and the provisions of the current *Methods* applied. The property allowance shall be calculated under the provisions of Section 3.500.

The provisions of Sections 4.300 through 4.360 shall not apply to the full or partial conversion of an NF to ICF-IID certification.

##### 4.310 Start-Up Period

The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the facility was licensed. A facility certified for the Medicaid Program after this twelve-month period shall be considered to have completed its start-up period.

##### 4.320 Payment Rates During the Start-Up Period

Payment rates for the start-up period shall be retrospectively established based on one or more cost reports for the start-up period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the date of certification for Medicaid, and (2) end on, or within the five calendar months after, the end date of the start-up period. The payment rates shall not be effective earlier than the certification date and shall lapse not later than at the end of the start-up period.

The minimum patient days for the property tax allowance (Section 3.400), and the property allowance (Section 3.500) shall be the greater of patient days at 50.0% occupancy of average licensed beds or patient days during the cost reporting period.

##### 4.330 Payment Rates After the Start-Up Period

After completion of the start-up period, rates for a new facility shall be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting periods used under Section 4.320.

##### 4.332 Modified Cost Report Period

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 reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.212.

##### 4.335 July 1 Payment Rates

A base cost reporting period shall be designated by the Department for establishing a new facility's payment rates for July 1 of the reimbursement period described in Section 1.314. If the start-up period includes the July 1 date, then the July payment rates shall be established under the retrospective provisions for the start-up period. If the cost reporting fiscal year specified in Section 1.302 begins before or during the start-up period, then the Department may designate a more current base cost reporting period for July rates.

##### 4.350 Inflationary Adjustment of Expenses

Cost data from any cost reporting period described above will be inflated or deflated to the reimbursement period described in Section 1.314.

#### 4.360 Property Tax Allowance

The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for a new 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 on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the dietary and environmental services allowance in the January 1 payment rate.

#### 4.400 Payment Rates for Significant Increases in Licensed Beds

##### 4.401 General

The Department may require or a provider may request the payment rate to be reestablished under the provisions of Section 3.000 when a provider significantly increases its unrestricted use licensed beds. The rate computations will consist of two phases: (1) retrospective rates for the start-up period, and (2) post start-up period adjusted rates.

The Department may establish interim rates until rates can be finalized under this section. A significant increase in licensed beds is defined in Section 1.304. Restricted use beds are not used in this calculation. The Department may deny approving any adjusted rates if any required Chapter 150 approval was not obtained. The Chapter 150 rate maximum per Section 1.600 shall apply, if applicable, to the expanded facility. The property allowance shall be recalculated under the provisions of Section 3.500.

The provisions of Sections 4.400 through 4.460 shall not apply to the full or partial conversion of an NF to ICF-IID certification.

##### 4.410 Start-Up Period

The start-up period shall be the twelve-month period beginning on the first of the month following the month in which the new beds were licensed.

##### 4.420 Payment Rates During the Start-Up Period

Application of this section is optional. Payment rates for the start-up period may be retrospectively established based on one or more cost reports for the start-up period for any or all applicable payment allowances. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the start-up period, and (2) end on, or within the five calendar months after, the end date of the start-up period. The adjusted payment rates shall be effective as of the date of amended licensure.

##### 4.430 Payment Rates After the Start-Up Period

After completion of the start-up period, rates for a significantly expanded provider may be reestablished based on at least a six-month cost report which will begin after the end of the start-up period or after the end of the cost reporting period used in Section 4.420.

##### 4.432 Modified Cost Report Period

The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.273.

##### 4.435 July 1 Payment Rates

A base cost reporting period shall be designated by the Department for establishing an expanded facility's payment rates for July 1 of the reimbursement period described in Section 1.314. If the start-up period includes the July 1 date, July payment rates may be established under the retrospective provisions for the start-up period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the start-up period, the Department may designate a more current base cost reporting period for July 1 rates.

#### 4.460 Property Tax Allowance

The property tax allowance shall be based on the provisions of Section 3.400. Nevertheless, the provider may request the property tax allowance for an 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 on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is received by the Department. The adjustment shall only consider current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the dietary and environmental services allowance in the January 1 payment rate.

#### 4.500 Payment Rates for Significant Decreases in Licensed Beds

##### 4.501 General

A provider may plan to significantly decrease its number of unrestricted use licensed beds. The Department may require or the provider may request payment rates to be reestablished. If the provider makes the request, the provider must notify the Department in writing prior to the effective date of the reestablished rates and must relinquish the future use of a significant number of licensed beds. Any future use of the relinquished beds must be approved, if required, under Chapter 150, Wis. Stats. The Department may deny rate adjustments under this section if it determines the provider's decrease is not desirable or appropriate.

If the reduction involves an extended and major phase-down, the provider may elect to have rates established under the provisions of Section 4.560 below. If Section 4.560 is not applied, the rate computation will consist of two phases: (1) retrospective rates for the phase-down period, and (2) post phase-down adjusted rates. A significant decrease is defined in Section 1.304. The property allowance shall be recalculated, subject to the targets, maximums and ratios described in Section 3.500.

The provisions of Sections 4.500 through 4.560 shall not apply to the full or partial conversion of an NF to ICF-IID certification or the transfer of restricted use beds.

##### 4.510 Phase-Down Period

The phase-down period is that time period during which the resident population may be reduced and during which licensed beds are being reduced to the objective bed capacity. The provider shall submit a written plan for the phase-down acceptable to the Department. The plan must specify the objective licensed bed capacity, the expected date by which any phase-down of the resident population is to begin, the amount of the phase-down, and the expected date by which the license will be amended to the objective capacity. The Department shall establish the beginning and ending dates of the phase-down period which may be modified as needed during the phase-down.

##### 4.520 Payment Rates During the Phase-Down Period

Application of this section is optional. Payment rates for the phase-down period shall be retrospectively established under Section 3.000 based on one or more cost reports. No retrospective adjustment shall be available if the phase-down period is less than six months. The cost reporting period(s) shall: (1) begin on, or within the five calendar months before or the five calendar months after, the starting date of the phase-down period, and (2) end on, or within the five calendar months after, the effective date of the amended license at the objective capacity. The retrospective payment rates shall not be effective earlier than the beginning date of the cost reporting period and shall lapse at the end of the reporting period.

##### 4.530 Payment Rates After the Phase-Down Period

After a provider's license is amended to the objective licensed bed capacity, payment rates may be reestablished based on at least a six-month cost report acceptable to the Department which will begin after the end of the phase-down period or after the end of the cost reporting period used under Section 4.520. Section 4.530 may be applied to the significantly decreased provider which does not receive a retrospective adjustment under Section 4.520.

#### 4.532 Modified Cost Report Period

The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or reliable cost reporting. Whenever possible, fuel and utility expense should cover a twelve-month period pursuant to Section 3.273.

#### 4.535 July 1 Payment Rates

A base cost reporting period shall be designated by the Department for establishing the decreased facility's payment rates for July 1 of the reimbursement period described in Section 1.314. If the phase-down period includes the July 1 date, then the July 1 payment rates may be established under the retrospective provisions for the phase-down period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the phase-down period, then the Department may designate a more current base cost reporting period for July 1 rates.

#### 4.550 Inflationary Adjustment of Expenses

Cost data from any cost reporting periods described above will be inflated or deflated to the reimbursement period described in Section 1.314.

#### 4.560 Major Phase-Down

A major phase-down is: (1) a significant reduction in unrestricted use licensed beds, and (2) a reduction of resident population by 15.0% or more. The determination of the extent of the reduction of resident population shall be based on the average daily resident census, including each bed hold day as one full day, during the cost reporting period which would have been used for establishing payment rates in the first month of the phase-down period if no phase-down rate adjustment had been pursued. Payment rates for such a provider shall be negotiated between the Department and the provider. Rates for some or all related facilities under common control of a parent entity may be affected. The provisions of Section 3.000 need not be applied for determining such rates.

#### 4.580 Facility Closings

A provider may choose to phase out its nursing home operation. In such cases, the provider may request, or the Department may require, an adjustment to payment rates for the period of the phase-out. The Department may deny rate adjustments under this section if it determines the provider's phase-out is not desirable or appropriate. Payment rates for such a provider shall be negotiated between the Department and the provider. The provisions of Section 3.000 need not be applied for determining such rates.

#### 4.600 Change in Facility Certification or Licensure

##### 4.601 General

If a provider changes its certification, including certification in whole or in part as an ICF-IID or licensure level, the Department may require, or the facility may request, payment rates to be reestablished under Section 3.000. Only the direct care allowance under Section 3.100 and the final rates under Section 3.700 will be recalculated, based on a cost reporting period for patient days and for direct care wages, purchased services and supply expenses. In lieu of reporting new supply expenses, previously allowed supply expenses may be used in the recalculation if acceptable to the Department. The rate computations will consist of two phases: (1) retrospective rates for the changeover period, and (2) post changeover period adjusted rates. The Department may establish interim rates until rates are finalized. The Department may deny reestablishing payment rates if any required Chapter 150 approval was not received. The Chapter 150 rate maximum, per Section 1.600, shall apply, if applicable, to the facility.

##### 4.610 Changeover Period

The changeover period shall be at least a six-month period but no more than a twelve-month period beginning on the first of the month following the month in which the change was effective.

#### 4.620 Payment Rates During Changeover Period

Application of this section is optional, and if it is not applied, then Section 4.610 will apply. Payment rates for the changeover period may be retrospectively established based on one or more cost reports for the changeover period. The cost reporting period shall: (1) begin on, or within the five calendar months after, the beginning date of the changeover period, and (2) end on, or within the five calendar months after, the end date of the changeover period. The adjusted payment rates shall be effective as of the effective date of the applicable change.

#### 4.630 Payment Rates After the Changeover Period

After completion of the changeover period, rates for a changed provider may be reestablished based on at least a six-month cost report for patient days and for direct care wages, purchased services and supply expenses. Such cost reporting period shall begin after the end of the changeover period or after the end of the optional cost reporting period used under Section 4.620.

#### 4.632 Modified Cost Report Period

The Department may modify the above cost reporting requirements for special situations or to accommodate the fiscal year end, reimbursement period, or other cost reports required in different sections of these *Methods* to permit more efficient or reliable cost reporting.

#### 4.635 July 1 Payment Rates

A base cost reporting period shall be designated by the Department for establishing a changed facility's payment rates for July 1 of the reimbursement period described in Section 1.314. If the changeover period includes the July 1 date, then payment rates for July 1 through the end of the changeover period may be established under the retrospective provisions for changeover period. If the cost report for the fiscal year specified in Section 1.302 begins before or during the changeover period, then the Department may designate a more current base cost reporting period for July 1 rates.

#### 4.650 Inflationary Adjustment of Expenses

Cost data from any cost reporting periods described above will be inflated or deflated to the reimbursement period described in Section 1.314.

#### 4.690 Special Care Payments/Non Rate Payments

#### 4.691 Ventilator Dependent Patients

Ventilator dependent patients who can be transferred from a hospital to a nursing home, may be able to receive a comparable level of service at a lower cost in a nursing home. Upon prior approval of the Department, payment of \$561 per in-house day, in lieu of the facility's daily rate, shall be paid for such an individual resident for a period determined by the Department if it has been demonstrated to the satisfaction of the Department that the facility can provide care in accordance with the specific patient's needs. This payment does not apply to patients receiving either Continuous Positive Airway or Bi-level Positive Airway pressure ventilator care. Any such payment or recoupment of same is contingent on care being needed and provided. Bed-hold day, if qualified, will be paid under Section 1.500. The costs of exceptional supplies related to care of ventilator-dependent residents are included in the above rates and cannot be billed separately after December 31, 2011.

#### 4.692 Facilities for the Treatment of Head Injuries

Facilities providing specialized treatment for head injuries may receive a negotiated rate, in lieu of the facility's daily rate, for each resident participating in the head injury program. Allowable cost principles and formula maximums may be applied to rate calculations. If average head injury occupancy drops below 50.0% for the reimbursement period, allowable costs will be proportionately reduced to reflect costs associated with unoccupied head injury unit beds. Rates may be updated periodically to account for changes in facility costs. The treatment program must be approved by the Department based on established criteria for admission, continuing stay, discharge and other program requirements as determined by the Department. Treatment and rates must be appropriate and receive prior approval of the Department.

Persons interested in a rate for treatment of head injured persons should contact:

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

#### 4.696 Isolation Rate

Subject to prior authorization from the Department a facility accepting a resident with a communicable disease requiring isolation pursuant to DHS 132.51(2)(b), Wis. Adm. Code, may receive an additional payment of the difference between the nursing home's private pay rate for a semi-private room and the private room rate up to \$35 per day in addition to the authorized rate.

#### 4.697 Property Appraisals

The nursing facility shall submit payment for property appraisal to the contractor under Section 3.531 upon receipt of appraisal invoice from said contractor after the Department has approved the appraisal. The nursing facility provider shall receive payment authorized by the Department upon verification of appraisal cost payment from the contractor.

#### 4.700 Other Special Adjustments

##### 4.710 Special Property Tax Adjustment

The property tax allowance per Section 3.400 may be adjusted when licensed bed areas are added or replaced or when service areas are added or replaced through construction, conversion, or renovation. This adjustment is available for both significant and non-significant bed increases. The provider may request this adjustment to the property tax allowance if the expense in the previous tax allowance had been based on an assessment date prior to the month of completion of the construction, conversion, or renovation. The adjustment shall be effective on January 1 of the year in which payment of the tax or municipal service fees are due but not earlier than the first of the month in which the request is delivered to the Department. The adjustment shall consider only current expenses, without any inflationary adjustment, and patient days from the cost report period that was used for the dietary and environmental services allowance in the January 1 payment rate.

##### 4.720 Special Calculation of the All Resident Case Mix Index (CMI)

Many of the payment provisions of Section 4.000, Special Payment Rate Adjustments and Recalculations, require an updated cost report and/or a rate recalculation during a transition period and a rate recalculation upon completion of the transition activity. For facilities that qualify for these alternate calculations the case mix indices from the reporting periods in Sections 5.421 and 5.422 do not provide a representative sample for the special payment calculation. The Division of Medicaid Services will determine a representative cost reporting period(s) to be used.

##### 4.721 Special calculation of the Medicaid case mix index (CMI)

Many of the payment provisions of Section 4.000 special payment rate adjustments and recalculations, require an updated cost report and/or a rate recalculation during a transition period and a rate recalculation upon completion of the transition activity. For facilities that qualify for these alternate calculations the Medicaid CMI will be determined from the first picture period (see Section 5.422) subsequent to the significant licensure change unless the DLTC determines a more representative time period.

#### 4.800 Payment Rate Adjustment for Evacuations

#### 4.850 Payment for Services Provided During Temporary Evacuation

##### 4.851 General

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 following provisions will apply. The nursing home will be responsible for the services provided during the emergency. The Department shall provide retrospective 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 under Sections 3.100 through 3.700 but is net of insurance and third party payments.

##### 4.852 Payments

The Department will provide prospective payment during the evacuation period and retrospective payment for extraordinary expenses after the evacuation period.

##### 4.8521 Prospective Payment

The payment rates in effect at the time of the disaster will be paid to the evacuated facility for the care of the relocated residents. The Department may establish an interim payment for extraordinary expenses, subject to reconciliation with a retrospective settlement.

##### 4.8522 Retrospective Payment

The Department shall perform a retrospective cost and revenue settlement subsequent to the evacuation period for extraordinary expenses. 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 from these sources.

##### 4.853 Revenues

All revenue received from non-Medicaid sources for extraordinary expenses will be used to reduce reported expenses in cost reports during the period of the emergency. Expenses incurred during the emergency will not be allowable for subsequent prospective rate setting activities.

##### 4.854 Short Term Cost Report

The facility shall submit a short term cost report for the period of the evacuation as determined by the Department. The cost report shall include costs associated with the evacuated residents including costs incurred by other service providers as described in Section 4.851.

##### 4.855 Patient Days for Rate Calculations after the Evacuation Period

Patient days for the time period during the evacuation will be deducted from the cost report period. Patient days will then be annualized to obtain the adjusted patient day ratio.

##### 4.856 Bed hold

For bed hold, the criteria in Section 1.500 apply for the three month period following the evacuation except that for the occupancy criteria, the greater of the average patient day occupancy for the three month period prior to the evacuation or the actual for any of the three months following the evacuation period will be used in the bed hold occupancy test.



#### 4.857 Procedure

1. Normal Rate Setting. A 12 month fiscal year cost report including the evacuation time period shall be submitted by the facility. A separate short term cost report consisting of only the expenses and revenues attributable to the evacuation period shall also be submitted. The short term cost report shall then be subtracted from the 12 month cost report and the remaining costs annualized for normal rate setting purposes.
2. Rate Setting for the Evacuation Period. Expenses from the short term cost report shall have any revenues received as a result of insurance, third party liability, law suits, and related revenue sources for the evacuation offset. The portion of the difference attributable to Medicaid residents in excess of the Medicaid daily payment rates shall then result in additional Medicaid reimbursement.

#### 4.858 Facilities Receiving Evacuees

1. Patient Days. Patient days for evacuees will not be included in patient days used for normal rate setting unless the residents are permanently admitted to the receiving facility. Occupancy determinations used for the rate calculations for the payment system will use the three months period prior to admission of these temporary residents.
2. Base Cost Report Effect. Base cost reports including the evacuation period will be adjusted for all expenses billed to the evacuated facility or facilities and/or associated with the evacuated residents.

#### 4.900 New Facilities, Replacement Facilities, and Significant Licensed Bed Changes on or After July 1, 2017

For new facilities licensed on or after July 1, 2017, and facilities with significant licensed bed increases or decreases on or after July 1, 2017 (as defined in Sections 1.305 and 1.304 respectively), the property payment allowance will be recalculated using the cost reporting periods and procedures described in Sections 4.300, 4.400, or 4.500.

#### 4.910 Significant Replacement Facilities on or After July 1, 2017

The property payment allowance will also be recalculated when a facility has replaced a significant number of licensed beds. ("Replacement" is defined in Section 1.306.) (A "significant" replacement is defined as the replacement of the lesser of: (1) 25% of licensed bed capacity or (2) 50 beds.) When a significant replacement has occurred, the property payment allowance will be based on at least a six-month cost reporting period which begins within five months after the first of the month following licensure of the replacement bed 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.

#### 4.920 Property Incentive for Innovative Project-Prior to July 1, 2012:

Facilities that have applied for and received Division approval for a property incentive prior to July 1, 2012, as a result of a total or partial replacement shall receive a \$10.00 per patient day incentive for each Medicaid patient in the approved innovative area.

Facility shall report the number of Medicaid patient days in the approved innovative area during the cost report used for rate setting. The property incentive of \$10.00 per patient day shall be multiplied times the number of reported nursing facility fee for service Medicaid days in the approved area and then divided by the total Medicaid fee for service patient days of the facility. This amount shall be added to all nursing facility fee for service Medicaid rates.

Facilities that received approval for a higher URC in the 2008-2009 *Methods* will receive the \$10.00 per patient day incentive rather than the higher URC due to occupancy requirements in the original approval criteria that required that \$10.00 per day incentive replace the higher URC in all reimbursement periods after that occupancy is not met.

## Section 5.000 Appendices Related to Reimbursement

### 5.100 Supplies and Equipment

#### 5.110 General

Dietary Supplies, Incontinence Supplies, Personal Comfort Supplies, Medical Supplies and Equipment, and other similar items reasonably associated with patients' personal living needs in normal and routine nursing home operations are to be provided to Medicaid recipient patients without charge to the patient, the patient's family, or other interested persons. Costs for any such durable and non-durable items are considered to be reimbursed in the facility's daily rate and, therefore, not to be billed or paid for separately.

If a Medicaid recipient specifically requests a brand of a non-durable item:

1. which the nursing home does not routinely supply; AND
2. for which there is no equivalent or close substitute brand routinely supplied to patients by the facility, 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 recipient cannot be charged. (Reference: DHS 107.09(2)(b), Wis. Adm. Code)

The following is a partial list of items covered by Section 5.000. The Department retains its authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items from the list.

#### 5.120 Dietary Supplies

Artificial sweeteners

Diet supplements (Metrecal, Ensure, Vivonex and related products)

Salt substitutes (Neocurtasal, etc.)

Sugar substitutes

(Note: The cost of dietary supplies is included in the support services allowance.)

#### 5.130 Incontinence Supplies

Catheters (Foley and Condom), catheter sets, component parts, (tubing, urine collection apparatus, e.g., bags, bed bags, etc.)

Diapers - disposable and reusable (including purchased diaper service)

Underpads - disposable and reusable

#### 5.140 Personal Comfort Items and Medical Supplies and Equipment

Alcohols (rubbing antiseptics and swabs)

Analgesic rubs (Ben-Gay, Infrarub, Vicks Vaporub, etc.)

Antiseptics (Betadine, iodine, mercurochrome, merthiolate and similar products)

Baby, comfort and foot powders

Body lotions, skin lubricants and moisturizers (olive oil, Nivea oil and cream, Lubath, Alpha-Keri, Keri Lotion, etc.)

Blood glucose testing supplies, including strips

Cotton tipped applicators and cotton balls

Deodorants

Denture products (adhesives and cleaning products)

Disposable tissues (Kleenex, etc.)

Dressings (adhesive pads, abdominal pads, gauze pads and rolls, eye pads, sanitary pads, stockinette, Opsite and related items)

Enema administration apparatus

Gloves (latex and vinyl)

Hydrogen peroxide

Lemon or glycerin swabs

Lubricating jellies (Vaseline, KY jelly, etc.)

Oral hygiene products (dental floss, toothpaste, toothbrush, Waterpik)

Phosphate enemas

Plastic or adhesive bandages (e.g. Band-aids)

Shampoos (except specialized shampoos as Selsun and similar products)

Soaps (antiseptic and non-antiseptic)

Straws (paper and plastic)

Syringes and needles, Lancets (disposable and reusable)

Tapes, all types

Tincture of benzoin

Tongue depressors

Tracheotomy care sets and suction catheters

Tube feeding sets and components part

**NOTE:** Although these are the most common of the personal comfort items, this is not intended to be an all-inclusive list.

5.150 All Non-Expendable, Reusable Materials

Abdominal binder	Lamp, heat and ultraviolet
Abdominal support	Lap boards/trays, wheelchair
Adaptive dressing equipment	Mat, exercise
Adaptive eating utensils	Mattress, air, alternating pressure, gel, foam
Adaptive hygiene equipment	Mattress pads
Air cleaner	Lower extremity splints/positioners (e.g. mulitodus)
Air splints	
All non-expendable, reusable materials (bedpans, thermometers, Towels, linen, ace bandages, rubber pants, etc.)	Name tags
Alternating pressure pumps	
Apnea monitor	Patient lifts
Aquaped (K pad)	Positioning equipment for wheelchairs, chairs and beds
	Prone standers
Bath bench	Pulse oximeter
Bath lifts	
Bath sling	Reachers
Bed, electric	Restraints
Bed, hospital	Roho, Jay or similar flotation cushion
Bed rails	
Blood glucose monitor	Safety rails – hallways, bathroom areas (tub, toilet, shower)
	Sitz baths – portable
Commodes	Sliding boards
Crib, hospital-type	Standing tables
Crib with enclosed top	Suction machine (standard)
Cushions, all types, wheelchairs (See note)	
	TENS units
Elbow protectors	Transfer devices
Elevated toilet seats	Traction apparatus
Enuretic alarm	Trapeze
Exercise equipment	Tub, rail
Exercycle (exercise bike)	
	Vaporizer, room
Floor stand, trapeze	Volumetric pump
Floor stand, weights	
Flotation pads	Walkers, canes, crutches (including quad-canes)
Food pumps	Water mattress
Foot boards (model)	Wheelchairs, all manual
Foot protectors	Wheelchairs, power (See Sec 5.160)
	Whirlpool
Geriatric chairs	Wrist bands and alarm systems
Gait belts	
Hand cones	
Hand splints, soft	
Hosiery, including support and thrombo-embolytic Disease stockings	
Hoyer or other hydraulic or non-hydraulic lift	
Humidifier	
IPPB (Intermittent positive pressure machine)	
IV Poles	

**NOTE: For the purposes of this section,** cushions for use in wheelchairs are those available through general medical supply houses and are not those created especially for any particular resident. Positioning equipment for wheelchairs (seating system) is personalized in nature, custom-made specifically for one resident and is used only by that resident. Such equipment may be separately billable as allowed under Section 5.166 below.

## 5.160 Durable Medical Equipment and Wheelchairs - Exceptions

### 5.162 General

Durable medical equipment and wheelchairs reasonably associated with a patient's personal living needs in normal and routine nursing home operations are to be provided to Medicaid recipients without charge to the patient, the patient's family, or other interested persons. The cost of all wheelchairs, including geriatric chairs but excluding motorized wheelchairs or vehicles, is included in the nursing home payment rate.

Under certain exceptions, durable medical equipment (DME) and wheelchairs may be billed separately by the supplier if prior authorized. The prior authorization request must document the need for the item according to the exception criteria described below.

### 5.164 Durable Medical Equipment

Exceptions to permit separate payment for DME may be allowed by the Department if the DME is personalized or custom-made for a recipient resident and is used by the resident on an individual basis for hygienic or other reasons. These items include orthoses, prostheses (including hearing aids), orthopedic or corrective shoes, or pressure relief beds.

### 5.166 Special Adaptive Positioning or Electric Wheelchairs

The Department may permit separate payment for a special adaptive positioning or electric wheelchair, while a recipient resides in a nursing home, if the wheelchair is prescribed by a physician and the following criteria are met:

1. The wheelchair is personalized in nature or is custom-made for a patient and is used by the resident on an individual basis for hygienic or other reasons, AND
2. The special adaptive positioning wheelchair or electric wheelchair is justified by the diagnosis and prognosis and the occupational or vocational activities of the recipient (i.e., educational, therapeutic involvement).

Exceptions for wheelchairs may be allowed for the recipient who is about to transfer from a nursing home to an alternate and more independent setting.

### 5.167 References

Information regarding DME and wheelchairs is contained in DHS 107.24, Wis. Adm. Code, and in the DME Provider Handbook. (For more information on prior authorization, see DHS 107.02(3), Wis. Adm. Code.)

## 5.200 Over-the-Counter Drugs

### 5.210 General

Certain over-the-counter drugs are to be provided to Medicaid recipient patients without charge to the patient, the patient's family, or other interested persons. Costs for any such over-the-counter drugs are considered to be reimbursed in the facility's daily rate and, therefore, not to be billed or paid for separately.

The following is a partial list of items covered by Section 5.200. The Department retains its authority under s. 49.45(10), Wis. Stats., to amend, modify, or delete items from the list.

Aspirin	Vaginal products	Hemorrhoidal products
Ibuprofen	Digestive aids	Antibiotic Ointment
Vitamins	Saliva substitutes	Pediculicides
Non-covered cough & cold products	Acetaminophen	Decubitus treatments
Non-covered ophthalmic products	Laxatives	Capaicin Topical Products
Topical steroids	Minerals	Antidiarrheals
Antifungals	Antihistamines	

The above list does not represent the entire list of drugs covered under Section 5.200 and other non-covered over-the-counter drugs may be added to this section. Over-the-counter drugs covered under this section must be on the approved OTC list or index.

### 5.300 Cost Report Inflation and Deflation Factors

Inflation and deflation factors to adjust expenses from nursing home cost reports to the reimbursement period are given below. The factors listed below apply to annual nursing home cost reports ending in the following months.

#### 5.310 Direct Care

	<b>January February <u>March 2016</u></b>	<b>April May <u>June 2016</u></b>	<b>July August <u>September 2016</u></b>	<b>October November <u>December 2016</u></b>
Wages	6.3%	5.6%	4.9%	4.0%
Fringe Benefits	3.8%	2.9%	1.9%	1.5%
Supplies /OTC Drugs	4.7%	4.4%	4.1%	3.6%
Purchased Services	7.2%	6.4%	5.7%	4.9%

#### 5.320 Support Service

	<b>January February <u>March 2016</u></b>	<b>April May <u>June 2016</u></b>	<b>July August <u>September 2016</u></b>	<b>October November <u>December 2016</u></b>
Composite Support Service Expenses	5.3%	4.9%	4.3%	3.6%

#### 5.360 Alternate Cost Report Periods

The Department may establish alternate inflation or deflation factors for cost reporting periods not listed above. The Department used the forecasting services of Global Insights, Inc. to establish the inflation and deflation factors in section 5.300. The factors posted in this section assume an annual cost report and rates effective for the common period. The Global Insight projections have a relative value index for each quarter of the historical and projection period for each inflation index. The average relative value index for each alternate reporting period is divided into the average relative value index for the common period to compute the inflation/deflation factor. This calculation is repeated for each inflation index and for reporting period from 3 to 15 months duration.

#### 5.400 Direct Care Payment Parameters

##### 5.410 Labor Factors

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

<b>Labor Region</b>	<b>Final Labor Factor</b>	<b>Counties</b>
Rural Wisconsin	0.957	Adams, Ashland, Barron, Bayfield, Buffalo, Burnett, Clark, Crawford, Door, Florence, Forest, Grant, Green Lake, Iron, Jackson, Jefferson, Juneau, Lafayette, Langlade, Lincoln, Manitowoc, Marinette, Marquette, Menominee, Monroe, Oneida, Pepin, Polk, Portage, Price, Rusk, Sawyer, Shawano, Taylor, Trempealeau, Vernon, Walworth, Washburn, Waupaca, Waushara, Wood, Vilas
Minneapolis	1.178	Dunn, Pierce, Saint Croix
Duluth/Superior	1.076	Douglas
Eau Claire	0.977	Chippewa, Eau Claire
La Crosse	1.019	La Crosse
Wausau	1.036	Marathon
Madison	1.071	Columbia, Dane, Dodge, Green, Iowa, Janesville, Richland, Rock, Sauk
Racine	1.027	Racine
Kenosha	1.026	Kenosha
Green Bay	0.955	Brown, Kewaunee, Oconto
Sheboygan	1.029	Sheboygan
Milwaukee	1.057	Milwaukee, Ozaukee, Washington, Waukesha
Appleton	0.995	Calumet, Outagamie
Oshkosh	1.014	Winnebago
Fond Du Lac	0.966	Fond du Lac

##### 5.420 Case Mix Weights

Case Mix Weights for RUGS-IV 48-Cell Classification

<b>Level of Care</b>	<b>Case Mix Weight</b>
DD	1.94
DD Bed hold	1.07
Ventilator	3.89

<b>RUGs Group</b>	<b>Case Mix Weight</b>
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 Bed hold	0.25



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

Reporting Period	Picture Quarter	Available Data Used, as of Date
Jan 2015-Mar 2015	Jan 2015 – Mar 2015	June 30, 2017
Apr 2015-Jun 2015	Apr 2015 – Jun 2015	June 30, 2017
Jul 2015-Sep 2015	Jul 2015 – Sep 2015	June 30, 2017
Oct 2015-Dec 2015	Oct 2015 – Dec 2015	June 30, 2017
Jan 2016 – Mar 2016	Jan 2016 – Mar 2016	June 30, 2017
Apr 2016 – Jun 2016	Apr 2016 – Jun 2016	June 30, 2017
Jul 2016 – Sep 2016	Jul 2016 – Sep 2016	June 30, 2017
Oct 2016 – Dec 2016	Oct 2016 – Dec 2016	June 30, 2017

5.422 Source of the Reimbursement Period Case Mix Index

Picture Quarter	Available Data Used, as of Date	Rate Effective Date
Oct - Dec 2016	June 30, 2017	July 1, 2017
Jan - Mar 2017	Aug 31, 2017	Oct 1, 2017
Apr - Jun 2017	Nov 30, 2017	Jan 1, 2018
Jul - Sep 2017	Feb 28, 2018	Apr 1, 2018

5.430 Direct Care Base

	Nursing Facilities	ICFs-IID
The Nursing Services Base is	\$81.33	\$67.63
The Other Direct Care Supplies and Services Base is	\$13.66	\$14.60

5.450 Statewide Employee Meal Allowance

The statewide employee meal allowance is \$4.25

5.460 Behavior/Cognitive Impairment Incentives

The Behavior/Cognitive Impairment Access Incentive Base Rate is \$4.590

The Behavior/Cognitive Impairment Improvement Incentive Base Rate is \$0.454

5.500 Support Services Payment Parameters

5.510 Support Services Target	
Nursing Facilities	ICFs-IID
\$46.21	\$46.21

5.700 Property Tax Payment Parameters

5.710 Real Estate Tax and Municipal Fees Inflation Rates

1. Inflation for real estate taxes = 0.7%
2. Inflation for municipal fees = 0.7%

5.800 Property Payment Parameters

5.810 Service Factors

T1 = 7.5% of equalized value (after adjustments under Sections 3.531(a) and (b))

5.820 Equalized Value

5.821 URC maximum: \$75,900 per licensed bed

5.823 Qualified Approvals under Section 3.655 Innovative Area Incentives  
URC Maximum: \$135,000 per licensed bed

5.830 Cost Share Value

- a. Cost Share Value: 20%
- b. Cost Share Value for nursing facilities (licensed as NF-only) with 50 or fewer beds for rate setting: 40%

5.900 Other Payment Parameters

5.920 Exceptional Medicaid/Medicare Utilization Incentive

Min	Max	Incentive	Incentive	Incentive
MM%	MM%	>50 Beds	<=50 Beds	City of Milw.
95.00%	100.00%	2.70	4.20	4.60
90.00%	94.99%	2.45	3.65	4.00
85.00%	89.99%	2.20	3.10	3.40
80.00%	84.99%	1.90	2.50	2.75
75.00%	79.99%	1.70	2.00	2.20
70.00%	74.99%	1.50	1.50	1.65

Beds referred to in this table are beds for rate setting.

5.930 Private Room Incentive

Base allowance for the private room incentive = \$1.00  
Replacement allowance for the private room incentive = \$2.00

5.940 Medicaid Access Incentive

Nursing Facilities = \$9.65  
ICFs-IID = \$33.24

5.950 Specialized Psychiatric Rehabilitation Services = \$9.00 per qualifying resident per day

5.971 BEHCI – MDS Behavioral Score

VARIABLE MDS 3		CODE	BEHAVIORAL SCORE WEIGHT
WANDERING:			
E0900	Wandering Presence & Frequency	1	.4
		2	.8
		3	1.2
E01000A	Wandering Impact	1	1.5
E01000B	Wandering Impact	1	1.5
BEHAVIOR SYMPTOMS:			
E0200A	Physical directed toward others	1	.6
		2	1.2
		3	1.8
E0200B	Verbal directed toward others	1	.6
		2	1.2
		3	1.8
E0200C	Other symptoms	1	.6
		2	1.2
		3	1.8
E0500A	Risk of physical injury	1	1.5
E0500B	Interferes with care	1	.75
E0500C	Interferes with activities	1	1.5
E0600A	Others at risk	1	1.5
E0600B	Intrudes on others	1	.75
E0600C	Disrupts care	1	.75
E0800	Rejects care	1	.6
		2	1.2
		3	1.8
SEVERITY SCORE:			
D0300	Resident Mood Interview	15 or greater	1.5
D0600	Staff Assessment of Mood	15 or greater	1.5
LOCOMOTION:			
G0110E	Resident movement	0	1.0
		1	.75
		2	.75

## Section 6.000 Medicaid Nursing Home Payment Rate Methods Addendum for State Plan Purposes

### 6.100 Cost Finding and Reporting

#### 6.110 Provider Cost Reports

All NF and ICFs-IID certified to participate in the Medicaid program must complete the uniform cost report prescribed by the Department. Completed cost reports must be submitted to the Department normally no later than five months after the close of each cost reporting period. The cost of central administrative services generally are to be reported using the Department's home office cost allocation report, a Medicare cost allocation report, or another cost allocation report acceptable to the Department.

The cost reports must be completed in accordance with the published cost report written instructions issued each year by the Department, as well as generally accepted accounting principles (GAAP) and the accrual method of accounting. The Department may allow exceptions to reporting under certain specific accounting standards. Facilities under 30 beds may be exempted from accruing certain items. Governmental institutions normally operated on a cash method of accounting may use this method, if they so desire.

Also see Section 1.170 of this *Methods* regarding cost reporting requirements.

#### 6.120 Cost-Finding Method

The cost-finding method used by NF and ICFs-IID is described in the cost report. The cost report requires basic cost and statistical information used in the calculations of the payment rates.

#### 6.130 Actual Costs Considered

The *Methods* referenced in this *Methods* are intended to take into account the reasonable, actual costs of nursing home services and to provide rates which will be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated. This level is determined from study and analysis of cost reports submitted by facilities. Such an analysis may include the use of representative sample of facilities' cost reports.

### 6.200 Audits

#### 6.210 General

The Department will periodically audit cost reports submitted by nursing home providers and the related financial and statistical records of the providers. The providers selected for on-site audit and the scope of the on-site audit will be determined by: (1) a desk analysis of the cost report submitted by each provider or (2) other criteria determined by the Department. On-site audits will generally be selective in scope.

#### 6.220 Desk Analysis of Cost Reports

Upon submission of the cost reports to the Department, desk reviews will be conducted by Department auditors to determine that, to the extent possible and necessary for rate-setting: (1) only those expense items that the Department has specified as allowable costs are included in the computation of the costs of the nursing home services and (2) expenses have been reliably reported.

Based on the results of the cost report analysis, some of the submitted cost reports will be selected for further on-site examination. The audit will be limited to specific items in the cost report based on the desk analysis or other observations.

#### 6.230 Overpayments Identified and Recovered

Overpayments identified in the audit of a nursing home provider's cost report(s) will be recovered from the provider. Immaterial amounts may not be recovered.

#### 6.400 Reimbursement of Out-of-State Nursing Homes

Nursing home services may be provided to a Wisconsin Medicaid recipient in a nursing home located outside the State of Wisconsin, provided the home is certified in the Medicaid program of the other state.

Payment for temporary coverage of the Wisconsin recipient at the out-of-state home will be at a standardized 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 standardized payment rate based on the approximate average payment rate for a comparable level of care as paid to Wisconsin nursing homes in the July preceding the admission date.

A payment rate more specific to the out-of-state nursing home may be established if: (1) the temporary coverage payment rate is not appropriate for the patient; (2) the temporary rate is not appropriate for the nursing home; (3) the facility requests a specific payment rate; or (4) the period of the temporary payment rate has been completed.

In determining a different rate, the Department may take into consideration: Medicaid rates which are being paid to the facility by states other than Wisconsin; payment for similar services in Wisconsin; available information on the cost of the facility's operation; and any specialized services or unique treatment regimens which may not be available in Wisconsin at a similar or lesser cost.

Ancillary items listed in Section 3.800 may be separately reimbursed to the out-of-state nursing home, if coverage for such materials or services is not included in the daily care rate.