In addition to the uniform Medicaid rates for nursing facilities, any nursing facility that is owned or operated by a non-state governmental entity and that has entered into an agreement with the Office to participate in the nursing facility supplemental payment program shall receive an additional Medicaid payment adjustment, which shall not exceed its upper payment limit pursuant to 42 CFR 447.272.

This Medicaid supplemental payment adjustment will be calculated as follows:

The Office of Medicaid Policy and Planning (Office) shall calculate a supplemental payment according to the methodology below. The supplemental payment is created to increase Medicaid reimbursement to participating nursing facilities that are owned or operated by a non-state governmental entity. The supplemental payment is subject to the Medicaid upper payment limits found at 42 CFR 447.272.

For each state fiscal year (SFY), the Medicaid supplemental payment shall be calculated as the difference between:

1) the amount that the Office reasonably estimates would have been paid to nursing facilities that are owned or operated by a non-state governmental entity using the Medicare Resource Utilization Group (RUGs) prospective payment system. For each Medicaid resident that is in a nursing facility on the last day of a calendar quarter, the MDS assessment that is in effect on that date is classified using the Medicare RUG system. The Medicare rate applicable to the Medicare RUG, adjusted by the Medicare geographic wage index, equals the Medicaid resident's estimated Medicare rate. A simple average Medicare rate is determined for each nursing facility by summing the estimated Medicare rate for each Medicaid residents in the facility and dividing by total Medicaid residents in the facility, and
2) the Medicaid per diem rate for nursing facilities that are owned or operated by a non-state governmental entity. The Medicaid rate shall be adjusted to include laboratory, radiology, and pharmacy services to account for program differences in services between Medicaid and Medicare. The statewide average of laboratory, radiology, and pharmacy services is calculated using Medicaid cost report data.

Each participating non-state government owned or operated nursing facility's upper payment limit (UPL) gap shall be determined as the difference between the estimated Medicare rate calculated in 1 above and the adjusted Medicaid rate calculated in 2 above. Each facility's UPL gap is multiplied by Medicaid days to arrive at its supplemental payment amount. Medicaid days are taken from the Medicaid cost report.

For each calendar quarter, an estimated interim supplemental payment will be calculated as described above utilizing the latest Medicare RUGs and payment rates and Medicaid cost reports and payment rates available. Payments will be made to each nursing facility that is owned or operated by a non-state governmental entity and that has entered into an agreement with the Office to participate in the supplemental payment program.

Following the completion of the state's fiscal year, the final supplemental payment amount for the state fiscal year just ended will be calculated. These calculations will be based on the final Medicare RUGs and payment rates and the most recently reviewed Medicaid cost reports and payment rates that cover the just ended state fiscal year period. The final supplemental payment calculations will be compared to the estimated interim supplemental payments and the difference if positive will be paid to the non-state governmental entity, and if negative collected from the non-state governmental entity.