Supplemental Payment to Free-Standing Nursing Facilities

Effective October 1, 2011, free-standing nursing facilities will receive a supplemental Medicaid payment in addition to its standard or special care per diem payment. Supplemental payments are not available for nursing facilities owned by the State of Nevada or any of its political subdivisions. Fifty percent (50%) of the supplemental payment is based on Medicaid occupancy, MDS accuracy, and quality measures. Fifty percent (50%) of the payment is based on acuity. The amount available for supplemental payments is computed quarterly and reimbursed in the quarter in three equal monthly payments.

A. The amount available for Supplemental Payments to Nursing Facilities (NF) will be calculated each quarter based on actual net revenues from patient services and actual patient days for each facility during the Base Quarter.

1. The Base Quarter is defined as the quarter beginning six months prior to the quarter in which the supplemental payments are being distributed. (For the quarter beginning October 1, 2011, the supplemental payment computation would be based on actual net revenues and bed days for the quarter April 1 through June 30, 2011.)

2. The total amount available for Supplemental Payments is calculated by multiplying the net revenues from patient services in the Base Quarter by 6 percent.

3. One percent (1%) of this amount each quarter is retained by Nevada Medicaid to pay administrative costs associated with the Supplemental Payment Program. The remaining funds plus $2.50 per Medicaid nursing facility and long term care (LTC) hospice bed day in the Base Quarter is the amount available to pay the state share of Supplemental Payments to free-standing nursing facilities.

4. The amount available to pay the state share of Supplemental Payments to nursing facilities is matched by federal Medicaid funds calculated according to the formula in 42 CFR 433.10 (b).

B. Calculation of Fifty Percent of Supplemental Payments Based on Medicaid Occupancy, MDS Accuracy, and Quality

1. Fifty percent of the amount available to pay the state share of Supplemental Payments to Nursing Facilities is paid out based on the facility's Medicaid occupancy, MDS accuracy, and quality scores.

2. Calculations for the Medicaid occupancy and MDS accuracy components of Supplemental Payments require bed day counts, which are the actual bed days reported by the free-standing nursing facilities for the Base Quarter.

3. The Medicaid occupancy, MDS accuracy, and quality components are calculated by assigning points to each facility for each component according to the methodologies described below. The unit reimbursement value for each of the component points is

determined by calculating the amount available to pay the state share of Supplemental Payments to Nursing Facilities for that component plus the federal Medicaid matching funds and dividing by the total points in the component for all facilities receiving Supplemental Payments for that quarter.

Calculation of the Unit Reimbursement Value for a Component

	Total Dollars Available for Component
Divided by	Total Points for Component
Equals	Unit Reimbursement Value for Component

4. Supplemental Payment for Medicaid Occupancy, MDS Accuracy, and Quality Components

i. Medicaid Occupancy Component: Distribution of 82% of the state funds available for the portion of the Supplemental Payments based on Medicaid occupancy, MDS accuracy, and quality plus the federal Medicaid matching dollars is based on Medicaid occupancy. The facility receives a Medicaid occupancy rate modifier, which is the Medicaid nursing facility and LTC hospice bed days divided by total occupied bed days times 100. The facility's Medicaid occupancy rate modifier is multiplied by the number of Medicaid nursing facility and LTC hospice bed days to yield the Medicaid occupancy points. The Medicaid occupancy points will be multiplied times the unit reimbursement value to determine the Medicaid occupancy component of the facilities' reimbursement.

Calculation of the Facility Specific Medicaid Occupancy Component of the Supplemental Payment:

	Facility Occupied Medicaid NF and LTC Hospice Bed Days
Divided By	Facility Total Occupied Bed Days
Equals	Facility Medicaid Occupancy Rate
Times	100
Equals	Facility Medicaid Occupancy Rate Modifier
Times	Facility Occupied Medicaid NF and LTC Hospice Bed Days
Equals	Facility Medicaid Occupancy Points
Times	Medicaid Occupancy Component Unit Reimbursement Value
Equals	Facility Total Medicaid Occupancy Component Payment

ii. MDS Accuracy Component: Distribution of nine percent (9%) of the state funds available for the portion of the supplemental payments based on Medicaid occupancy, MDS accuracy, and quality plus the federal Medicaid matching dollars are based on MDS accuracy rate from the most current review performed by Medicaid staff. To qualify for MDS accuracy payments, the facility must have an accuracy rate of 70% or higher. Accuracy rates will be rounded to the nearest

whole percentage. If the partial percentage point is less than 0.5%, it will be rounded down to the next whole percentage point. If the partial percentage point is 0.5% or greater, it will be rounded up to the next whole percentage point. Facilities who qualify for MDS accuracy payments will be assigned an MDS accuracy modifier as follows:

Accuracy Rate	Modifier
0 – 69%	0
70 – 79%	1
80 – 89%	3
90 – 100%	5

The MDS accuracy modifier is multiplied times the number of Medicaid nursing facility and LTC hospice bed days to determine MDS accuracy points. Each facility's MDS accuracy points will be multiplied by the unit reimbursement value to determine the facility's total reimbursement for MDS accuracy component.

Calculation of the MDS Accuracy Component

Facility MDS Accuracy Modifier
Times Facility Occupied Medicaid NF and LTC Hospice Bed Days
Equals Facility MDS Accuracy Points
Times MDS Accuracy Unit Reimbursement Value
Equals Facility Total MDS Accuracy Component Payment

iii. Quality Component: Distribution of nine percent (9%) of the state funds available for the portion of supplemental payments based on Medicaid occupancy, MDS accuracy, and quality plus the federal Medicaid matching dollars is based on quality measures. The quality component of the supplemental payment provides reimbursement for a facility's efforts to improve resident care and safety. Quality measures are selected from MDS data compiled by the Nevada State Health Division Bureau of Health Care Quality and Compliance (HCQC). Four quality measures are chosen based on MDS data and input from HCQC and stakeholders. The four quality measures currently selected include: 1) Percent of long-stay residents who have moderate to severe pain; 2) Percent of high risk long-stay residents who have pressure sores; 3) Percent of long-stay residents who had a urinary tract infection; 4) Percent of long-stay residents who lose too much weight. Facilities receive one quality point for each percentage point they are better than the Nevada MDS average for each measure. Quality measure percentages are rounded to the nearest whole percentage. If the partial percentage point is less than 0.5%, it is rounded down to the next whole percentage point. If the partial percentage point is 0.5% or greater, it is rounded up to the next whole percentage point. The facility's total quality points are multiplied by the unit reimbursement value for the quality component to determine the facility specific amount of the quality component of the supplemental payment. Nursing facilities that are identified by

the Centers for Medicare and Medicaid Services as Special Focus Facilities are not eligible for the quality component of the supplemental payments. Special Focus Facilities are nursing homes that have a history of persistent poor quality of care. These nursing homes have been selected for more frequent inspections and monitoring. A current list of Special Focus Facilities is available at the CMS Certification and Compliance website.

5. Facilities that do not have MDS or MDS Accuracy data available have MDS accuracy and quality component payments calculated using the average component points of all facilities receiving Supplemental Payments for which data is available. Facilities that are not enrolled as Medicaid providers are not eligible for payments of the MDS accuracy or quality components or any other components of this supplemental payment for the quarter.

C. Calculation of the Component of the Supplemental Payments Based on Acuity

1. Nursing facility standard per diem reimbursement is calculated for each Medicaid provider quarterly based on methodology described in the Medicaid State Plan, Attachment 4.19-D, pages 5a through 5i. The per diem rate is adjusted for acuity and fair rental value. Fifty percent (50%) of the funds available for Supplemental Payments plus the Federal matching funds is paid under this acuity component as described below.

Calculation of the Supplemental Payment Portion Based on Acuity

The weighted average total amount of reimbursement based on acuity per Medicaid nursing and LTC hospice bed day is calculated by dividing the total for amount available for the acuity component of Supplemental Payments by the total nursing and LTC hospice bed days in the Base Quarter. This is added to the weighted average budget neutral per diem for all facilities to determine the total amount of reimbursement that will be based on acuity.

	Total Available for Supplement Payments
Times	50%
Equals	Total Available for Supplemental Payments Based on Acuity
	Total Available Supplemental Payments Based on Acuity
Divided by	Total Medicaid Nursing and LTC Hospice Days
Equals	Weighted Average Acuity Supplemental Payment Per Medicaid Day
	Weighted Average Budget Neutral Per Diem of $116.66
Plus	Weighted Average Acuity Supplemental Payment Per Medicaid Day
Equals	Weighted Average Portion of Reimbursement Based on Acuity

The full rate per diem is calculated by dividing the number of Medicaid nursing and LTC

hospice bed days in the Base Quarter for facilities receiving Supplemental Payments into the total amount of reimbursement these facilities would have received if they were paid at the full per diem amount. The full rate per diem is the amount the facilities would receive if the budget adjustment factor in Nevada Medicaid State Plan, Attachment 4.19-D, page 5i, were not applied to the per diem rates. The weighted average portion of reimbursement based on acuity is divided by weighted average full rate per diem to yield a budget adjustment factor for the acuity component of the Supplemental Payment.

	Total Full Rate Reimbursement for Facilities Receiving Supplemental Payments
Divided by	Total Nursing and LTC Hospice Days
Equals	Weighted Average Full Rate Per Diem

	Weighted Average Portion of Reimbursement Based on Acuity
Divided by	Weighted Average Full Rate Per Diem
Equals	Budget Adjustment Factor for Supplemental Payment

The budget adjustment factor for supplemental payments is applied to the facility specific full rate per diem to arrive at a facility specific unit reimbursement value based on acuity.

The facility specific NF per diem rate for each facility is calculated by multiplying the budget adjustment factor described in Attachment 4.19-D, page 5i, times the facility specific full per diem rate. This budget adjustment factor also equals the weighted average budget neutral per diem for all facilities divided by the weighted average full rate per diem.

The facility specific NF per diem rate is subtracted from the facility specific unit reimbursement value based on acuity to yield the facility specific unit reimbursement value for the Supplemental Payment based on acuity. The facility specific reimbursement unit value for the Supplemental Payment portion based on acuity is multiplied by the number of Medicaid nursing facility and hospice days in the Base Quarter to determine the quarterly Supplemental Payment based on acuity.

Calculation of the Facility Specific Supplemental Payment Based on Acuity

	Facility Specific Full Rate Per Diem
Times	Budget Adjustment Factor for Supplemental Payment
Equals	Facility Specific Unit Reimbursement Value Based on Acuity

	Facility Specific Full Rate Per Diem
Times	Budget Adjustment Factor for Base NF Rates
Equals	Facility Specific NF Per Diem Rate

Facility Specific Unit Reimbursement Value Based on Acuity

Minus	Facility Specific NF Per Diem Rate
Equals	Facility Specific Unit Value of Supplemental Payment Based on Acuity
Times	Number of Medicaid NF and LTC Hospice Days in Base Quarter
Equals	Facility Specific Quarterly Supplemental Payment Based on Acuity

D. The facility Supplemental Payment based on Medicaid occupancy, MDS accuracy, and quality is added to the facility specific Supplemental Payment based on acuity to yield the total facility specific Supplemental Payment amount for the quarter. The quarterly facility specific amount is divided by three to calculate the monthly Supplemental Payment.

E. Nursing facilities with negotiated facility-specific rates that exceed the standard or special care rates in the Nevada Medicaid State Plan are ineligible for supplemental payments.

OS Notification

State/Title/Plan Number: Nevada State Plan Amendment 11-012

Type of Action: SPA Approval

Effective Date of SPA: October 1, 2011

Required Date for State Notification: May 10, 2012

Fiscal Impact: $0 federal for FFY 2011

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification:

Provider Payment Increase or Decrease: NA

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail: This amendment provides for a supplemental payment to private freestanding nursing facilities, funded by a Nevada nursing home tax. There is no federal fiscal impact as this tax previously funded an increase in nursing facility per diem rates but is now used to reimburse the nursing facilities through a supplemental payment. The providers have been involved in the development of the supplemental payment and agree to the resulting methodology. Quarterly supplemental payments of approximately $16.6M, funded by $6.7M in tax revenue and $600,000 in State appropriations, will be paid out to around 38 providers. Each provider's supplemental payment is based on four components: Medicaid occupancy; case mix accuracy; quality; and acuity. We have consulted with Division of Quality Evaluation & Health Outcomes on the quality component of this supplemental payment, which is based on the facility's performance in four selected Nursing Home Minimum Data Set (MDS) measures. Public notice was issued timely; tribal consultation requirement has been satisfied; and funding questions have been answered satisfactorily. The State has also provided a demonstration that its nursing facility Medicaid payments are within the nursing facility upper payment limit (UPL). Furthermore, the Nevada nursing facility tax waiver has also been approved by CMS.

Other Considerations: We do not recommend the Secretary contact the Governor.

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