

Emergency Rules

Title 13—DEPARTMENT OF SOCIAL SERVICES Division 70—MO HealthNet Division Chapter 10—Nursing Home Program

EMERGENCY AMENDMENT

13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF//MR/IID Services. The division is amending sections (1)–(7) and adding new subparagraph (4)(A)1.O.

PURPOSE: This amendment changes the terminology of the services addressed in this regulation from “nonstate-operated intermediate care facility/mentally retarded (ICF/MR) services” to “nonstate-operated intermediate care facility for individuals with intellectual disabilities (ICF/IID) services” and provides for trend factors to be applied to adjust per diem rates for nonstate-operated ICF/IID facilities participating in the MO HealthNet program.

PURPOSE: This rule establishes a payment plan for nonstate-operated intermediate care facility/[mentally retarded] for individuals with intellectual disabilities services. The plan describes principles to be followed by Title XIX intermediate care facility/[mentally retarded] for individuals with intellectual disabilities providers in making financial reports and presents the necessary procedures for setting rates, making adjustments, and auditing the cost reports.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division, by rule and regulation, must define the reasonable costs, manner, extent, quantity, quality, charges and fees of medical assistance provided. Effective for dates of service beginning February 1, 2016, the appropriation by the General Assembly included additional funds to increase nonstate-operated ICF/IID reimbursement rates by one percent (1%). The MO HealthNet Division is carrying out the General Assembly’s intent by providing for a per diem increase to ICF/IID reimbursement rates of one percent (1%). The one percent (1%) increase is necessary to ensure that payments for ICF/IID per diem rates are in line with the funds appropriated for that purpose. There are a total of seven (7) nonstate-operated ICF/IID providers currently enrolled in Missouri Medicaid, all of which will receive a one percent (1%) increase to their reimbursement rates. This emergency amendment will ensure payment for ICF/IID services to approximately seventy-seven (77) ICF/IID Missourians in accordance with the appropriation authority. For the State Fiscal Year 2016 trend increase to be implemented, a Medicaid State Plan Amendment (SPA) was required to be submitted to and approved by the Centers for Medicare and Medicaid Services (CMS). The SPA was approved by CMS on May 10, 2016, but the proposed state regulation will not be effective until approximately February 28, 2017. This emergency amendment must be implemented on a timely basis to ensure that quality ICF/IID services continue to be provided to Medicaid patients in ICF/IID facilities in accordance with the appropriation authority. As a result, the MO HealthNet Division finds an immediate danger to public health, safety, and/or welfare and a compelling governmental interest, which requires emergency action. The Missouri Medical Assistance program has a compelling governmental interest in providing continued cash flow for ICF/IID services. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the Missouri and United States Constitutions. The MO HealthNet Division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed August 15, 2016, becomes effective September 1, 2016, and expires February 27, 2017.

(1) Objectives. This rule establishes a payment plan for nonstate-operated intermediate care facility/[mentally retarded] for individuals with intellectual disabilities (ICF//MR/IID) services.

(2) General Principles.

(A) The MO HealthNet program shall reimburse qualified providers of ICF//MR/IID services based solely on the individual MO HealthNet participant’s days of care (within benefit limitations) multiplied by the facility’s Title XIX per diem rate less any payments made by participants.

(B) Effective November 1, 1986, the Title XIX per diem rate for all ICF//MR/IID facilities participating on or after October 31, 1986, shall be the lower of—

1. The average private pay charge;
2. The Medicare per diem rate, if applicable;

3. The rate paid to a facility on October 31, 1986, as adjusted by updating its base year to its 1985 fiscal year. Facilities which do not have a full twelve- (12-) month 1985 fiscal year shall not have their base years updated to their 1985 fiscal years. Changes in ownership, management, control, operation, leasehold interests by whatever form for any facility previously certified for participation in the MO HealthNet program at any time that results in increased capital costs for the successor owner, management, or leaseholder shall not be recognized for purposes of reimbursement; and

4. However, any provider who does not have a rate on October 31, 1986, and whose facility meets the definition in subsection (3)(J) of this rule, will be exempt from paragraph (2)(B)3., and the rate shall be determined in accordance with applicable provisions of this rule.

(3) Definitions.

(H) ICF//MR/IID. Nonstate-operated facilities certified to provide intermediate care for [the mentally retarded] individuals with intellectual disabilities under the Title XIX program.

(L) Providers. A provider under the Prospective Reimbursement Plan is a nonstate-operated ICF//MR/IID facility with a valid participation agreement, in effect on or after October 31, 1986, with the Missouri Department of Social Services for the purpose of providing long-term care (LTC) services to Title XIX-eligible participants. Facilities certified to provide intermediate care services to [the mentally retarded] individuals with intellectual disabilities under the Title XIX program may be offered a MO HealthNet participation agreement on or after January 1, 1990, only if 1) the facility has no more than fifteen (15) beds for [mentally retarded residents] individuals with intellectual disabilities, and 2) there is no other licensed residential living facility for [mentally retarded] individuals with intellectual disabilities within a radius of one-half (1/2) mile of the facility seeking participation in the MO HealthNet program.

(4) Prospective Reimbursement Rate Computation.

(A) Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF//MR/IID services certified to participate in Missouri’s MO HealthNet program.

1. ICF//MR/IID facilities.

A. Except in accordance with other provisions of this rule, the MO HealthNet program shall reimburse providers of these LTC services based on the individual MO HealthNet-participant days of care multiplied by the Title XIX prospective per diem rate less any payments collected from participants. The Title XIX prospective per diem reimbursement rate for the remainder of state Fiscal Year 1987 shall be the facility’s per diem reimbursement payment rate in effect on October 31, 1986, as adjusted by updating the facility’s allowable base year to its 1985 fiscal year. Each facility’s per diem costs as reported on its Fiscal Year 1985 Title XIX cost report will be determined in accordance with the principles set forth in this rule. If a facility has not filed a 1985 fiscal year cost report, the most current cost report on file with the department will be used to set its per diem rate. Facilities with less than a full twelve- (12-) month 1985 fiscal

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year will not have their base year rates updated.

B. For state FY-88 and dates of service beginning July 1, 1987, the negotiated trend factor shall be equal to two percent (2%) to be applied in the following manner: Two percent (2%) of the average per diem rate paid to both state- and nonstate-operated ICF//MR/IID facilities on June 1, 1987, shall be added to each facility's rate.

C. For state FY-89 and dates of service beginning January 1, 1989, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF//MR/IID facilities on June 1, 1988, shall be added to each facility's rate.

D. For state FY-91 and dates of service beginning July 1, 1990, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF//MR/IID facilities on June 1, 1990, shall be added to each facility's rate.

E. FY-96 negotiated trend factor. All nonstate-operated ICF//MR/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning January 1, 1996, of six dollars and seven cents (\$6.07) per patient day for the negotiated trend factor. This adjustment is equal to four and six-tenths percent (4.6%) of the weighted average per diem rates paid to nonstate-operated ICF//MR/IID facilities on June 1, 1995, of one hundred and thirty-one dollars and ninety-three cents (\$131.93).

F. State FY-99 trend factor. All nonstate-operated ICF//MR/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1998, of four dollars and forty-seven cents (\$4.47) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF//MR/IID facilities on June 30, 1998, of one hundred forty-eight dollars and ninety-nine cents (\$148.99).

G. State FY-2000 trend factor. All nonstate-operated ICF//MR/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1999, of four dollars and sixty-three cents (\$4.63) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF//MR/IID facilities on April 30, 1999, of one hundred fifty-four dollars and forty-three cents (\$154.43). This increase shall only be used for increases for the salaries and fringe benefits for direct care staff and their immediate supervisors.

H. State FY-2001 trend factor. All nonstate-operated ICF//MR/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 2000, of four dollars and eighty-one cents (\$4.81) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF//MR/IID facilities on April 30, 2000, of one hundred sixty dollars and twenty-three cents (\$160.23). This increase shall only be used for increases for salaries and fringe benefits for direct care staff and their immediate supervisors.

I. State FY-2007 trend factor. All nonstate-operated ICF//MR/IID facilities shall be granted an increase of seven percent (7%) to their per diem rates effective for dates of service billed for state fiscal year 2007 and thereafter. This adjustment is equal to seven percent (7%) of the per diem rate paid to nonstate-operated ICF//MR/IID facilities on June 30, 2006.

J. State FY-2008 trend factor. Effective for dates of service beginning July 1, 2007, all nonstate-operated ICF//MR/IID facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF//MR/IID

facilities on June 30, 2007.

K. State FY-2009 trend factor. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF//MR/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF//MR/IID facilities on June 30, 2008.

L. State FY-2009 catch up increase. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF//MR/IID facilities shall be granted an increase to their per diem rates of thirteen and ninety-five hundredths percent (13.95%). This adjustment is equal to thirteen and ninety-five hundredths percent (13.95%) of the per diem rate paid to nonstate-operated ICF//MR/IID facilities on June 30, 2008. This increase is intended to provide compensation to providers for the years (2003, 2004, 2005, and 2006) where no trend factor was given. The catch up increase was based on the CMS PPS Skilled Nursing Facility Input Price Index (4 quarter moving average).

M. State FY-2012 trend factor. Effective for dates of service beginning October 1, 2011, all nonstate-operated ICF//MR/IID facilities shall be granted an increase to their per diem rates of one and four tenths percent (1.4%) for the trend factor. This adjustment is equal to one and four tenths percent (1.4%) of the per diem rate paid to nonstate-operated ICF//MR/IID facilities on September 30, 2011.

N. State FY-2014 trend factor. Effective for dates of service beginning January 1, 2014, all nonstate-operated ICF//MR/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF//MR/IID facilities on December 31, 2013.

O. State FY-2016 trend factor. Effective for dates of service beginning February 1, 2016, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of one percent (1%) for the trend factor. This adjustment is equal to one percent (1%) of the per diem rate paid to nonstate-operated ICF/IID facilities on January 31, 2016.

2. Adjustments to rates. The prospectively determined reimbursement rate may be adjusted only under the following conditions:

A. When information contained in a facility's cost report is found to be fraudulent, misrepresented, or inaccurate, the facility's reimbursement rate may be reduced, both retroactively and prospectively, if the fraudulent, misrepresented, or inaccurate information as originally reported resulted in establishment of a higher reimbursement rate than the facility would have received in the absence of this information. No decision by the MO HealthNet agency to impose a rate adjustment in the case of fraudulent, misrepresented, or inaccurate information in any way shall affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rule. The fact that fraudulent, misrepresented, or inaccurate information reported did not result in establishment of a higher reimbursement rate than the facility would have received in the absence of the information also does not affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rules;

B. In accordance with subsection (6)(B) of this rule, a newly constructed facility's initial reimbursement rate may be reduced if the facility's actual allowable per diem cost for its first twelve (12) months of operation is less than its initial rate;

C. When a facility's MO HealthNet reimbursement rate is higher than either its private pay rate or its Medicare rate, the MO HealthNet rate will be reduced in accordance with subsection (2)(B) of this rule;

D. When the provider can show that it incurred higher cost due to circumstances beyond its control, and the circumstances are not experienced by the nursing home or ICF//MR/IID industry in general, the request must have a substantial cost effect. These circumstances include, but are not limited to:

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(I) Acts of nature, such as fire, earthquakes, and flood that are not covered by insurance;

(II) Vandalism, civil disorder, or both; or

(III) Replacement of capital depreciable items not built into existing rates that are the result of circumstances not related to normal wear and tear or upgrading of existing system;

E. When an adjustment to a facility's rate is made in accordance with the provisions of section (6) of this rule; or

F. When an adjustment is based on an Administrative Hearing Commission or court decision.

(B) In the case of newly constructed nonstate-operated ICF//MR/ID facilities entering the MO HealthNet program after October 31, 1986, and for which no rate has previously been set, the director or his/her designee may set an initial rate for the facility as in his/her discretion s/he deems appropriate. The initial rate shall be subject to review by the advisory committee under the provisions of section (6) of this rule.

(5) Covered Services and Supplies.

(A) ICF//MR/ID services and supplies covered by the per diem reimbursement rate under this plan, and which must be provided, as required by federal or state law or rule and include, among other services, the regular room, dietary and nursing services, or any other services that are required for standards of participation or certification. Also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service, and enemas;

2. Items which are furnished routinely and relatively uniformly to all participants, for example, gowns, water pitchers, soap, basins, and bed pans;

3. Items such as alcohol, applicators, cotton balls, bandaids, and tongue depressors;

4. All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners, and nonlegend vitamins. Any nonlegend drug in one (1) of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; all must be provided as needed within the existing per diem rate;

5. Items which are utilized by individual participants but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable, nondepreciable medical equipment;

6. Additional items as specified in the appendix to this plan when required by the patient;

7. Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, including dietary supplements written as a prescription item by a physician;

8. All laundry services except personal laundry which is a non-covered service;

9. All general personal care services which are furnished routinely and relatively uniformly to all participants for their personal cleanliness and appearance shall be covered services, for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos, and shaves to the extent necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service;

10. All consultative services as required by state or federal law or regulation or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report. Failure to do so will result in the penalties specified in section (9) of this rule;

11. Semiprivate room and board and private room and board

when necessary to isolate a participant due to a medical or social condition, such as contagious infection, irrational loud speech, and the like. Unless a private room is necessary due to a medical or social condition, a private room is a noncovered service, and a MO HealthNet participant or responsible party may therefore pay the difference between a facility's semiprivate charge and its charge for a private room. MO HealthNet participants may not be placed in private rooms and charged any additional amount above the facility's MO HealthNet per diem unless the participant or responsible party in writing specifically requests a private room prior to placement in a private room and acknowledges that an additional amount not payable by MO HealthNet will be charged for a private room;

12. Twelve (12) days per any period of six (6) consecutive months during which a participant is on a temporary leave of absence from the facility. Temporary leave of absence days must be specifically provided for in the participant's plan of care. Periods of time during which a participant is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence; and

13. Days when participants are away from the facility overnight on facility-sponsored group trips under the continuing supervision and care of facility personnel.

(6) Rate Determination. All nonstate-operated ICF//MR/ID providers of LTC services under the MO HealthNet program who desire to have their rates changed or established must apply to the MO HealthNet Division. The department may request the participation of the Department of Mental Health in the analysis for rate determination. The procedure and conditions for rate reconsideration are as follows:

(E) Rate Adjustments. The department may alter a facility's per diem rate based on—

1. Court decisions;

2. Administrative Hearing Commission decisions;

3. Determination through desk audits, field audits, and other means, which establishes misrepresentations in or the inclusion of unallowable costs in the cost report used to establish the per diem rate. In these cases, the adjustment shall be applied retroactively; or

4. Adjustments determined by the department without the advice of the rate advisory committee.

A. Prospective payment adjustment (PPA). A FY-92 PPA will be provided prior to the end of the state fiscal year for nonstate-operated ICF//MR/ID facilities with a current provider agreement on file with the MO HealthNet Division as of October 1, 1991.

(I) For providers which qualify, the PPA shall be the lesser of—

(a) The provider's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjustment factor (PPAF) times the nonstate-operated intermediate care facility for *[the mentally retarded] individuals with intellectual disabilities* ceiling (ICF//MR/IDC) on October 1, 1991 ($FPGF \times PPD \times PPAF \times ICF//MR/IDC$). For example: A provider having nine hundred twenty (920) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of twenty-eight thousand five hundred sixty-one (28,561) represents an FPGF of three and twenty-two hundredths percent (3.22%). So using the FPGF of $3.22\% \times 114,244 \times 24.5\% \times \$156.01 = \$140,659$; or

(b) The provider FPGF times one hundred forty-five percent (145%) of the amount credited to the intermediate care revenue collection center (ICRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

(II) FPGF—is determined by using each ICF//MR/ID facility's paid days for the service dates in May 1991 through July 1991 as of September 20, 1991, divided by the sum of the paid days for the same service dates for all provider's qualifying as of the determination date of October 16, 1991.

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(III) ICF//MR//IDC—is one hundred fifty-six dollars and one cent (\$156.01) on October 1, 1991.

(IV) PPAF—is equal to twenty-four and five-tenths percent (24.5%) for fiscal year 1992 which includes an adjustment for economic trends.

(V) PPD—is the projection of one hundred fourteen thousand two hundred forty-four (114,244) patient days made on October 1, 1991, for the adjustment year;

5. FY-92 trend factor and Workers' Compensation. All facilities with either an interim rate or a prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of eight dollars and eighty-six cents (\$8.86) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents (\$118.14) for all nonstate-operated ICF//MR//IDC facilities; or

6. FY-93 negotiated trend factor. All facilities with either an interim rate or prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of one dollar and sixty-six cents (\$1.66) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents (\$118.14) for all nonstate-operated ICF//MR//IDC facilities; and

(7) Allowable Cost Areas.

(N) Utilization Review. Incurred cost for the performance of required utilization review for ICF//MR//IDC is an allowable cost area. The expenditures must be for the purpose of providing utilization review on behalf of a Title XIX participant. Utilization review costs incurred for Title XVIII and Title XIX must be apportioned on the basis of reimbursable participant days recorded for each program during the reporting period.

(R) Apportionment of Costs to MO HealthNet Participant Residents.

1. Provider's allowable cost areas shall be apportioned between MO HealthNet program participant residents and other patients so that the share borne by the MO HealthNet program is based upon actual services received by program participants.

2. To accomplish this apportionment, the ratio of participant residents' charges to total patient charges for the service of each ancillary department may be applied to the cost of this department. To this shall be added the cost of routine services for MO HealthNet program participant residents determined on the basis of a separate average cost per diem for general routine care areas or at the option of the provider on the basis of overall routine care area.

3. So that its charges may be allowable for use in apportioning costs under the program, each provider shall have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonable and consistently related to the cost of providing these services.

4. Average cost per diem for general routine services means the amount computed by dividing the total allowable patient costs for routine services by the total number of patient days of care rendered by the provider in the cost-reporting period.

5. A patient day of care is that period of service rendered a patient between the census-taking hours on two (2) consecutive days, including the twelve (12) temporary leave of absence days per any period of six (6) consecutive months as specifically covered under section (5) of this rule, the day of discharge being counted only when the patient was admitted the same day. A census log shall be maintained in the facility for documentation purposes. Census shall be taken daily at midnight. A day of care includes those overnight periods when a participant is away from the facility on a facility-spon-

sored group trip and remains under the supervision and care of facility personnel.

6. ICF//MR//IDC facilities that provide intermediate care services to MO HealthNet participants may establish distinct part cost centers in their facility provided that adequate accounting and statistical data required to separately determine the nursing care cost of each distinct part is maintained. Each distinct part may share the common services and facilities, such as management services, dietary, housekeeping, building maintenance, and laundry.

7. In no case may a provider's allowable costs allocated to the MO HealthNet program include the cost of furnishing services to persons not covered under the MO HealthNet program.

AUTHORITY: section 208.159, RSMo 2000, and sections 208.153 and 208.201, RSMo Supp. 2013. This rule was previously filed as 13 CSR 40-81.083. Original rule filed Aug. 13, 1982, effective Nov. 11, 1982. For intervening history, please consult the Code of State Regulations. Emergency amendment filed Aug. 15, 2016, effective Sept. 1, 2016, expires Feb. 27, 2017. An emergency amendment and a proposed amendment covering this same material will be published in the September 15, 2016, issue of the Missouri Register.