Medicaid
Principles of Reimbursement
Table of Contents

APPLICABLE FEDERAL AND STATE LAWS

Legal Basis for Program

The Rhode Island Medical Assistance Program was established on July 1, 1966. It was formed under the provision of Title XIX of the Social Security Act, as amended by Public Law 89-97, which was enacted by the Congress on July 30, 1965. The enabling state legislation is Rhode Island General Law (RIGL) 40-8, as amended.

The Powers of the Director

Rhode Island General Laws 42-7.2-2(b) provides that the Secretary of the Executive Office of Health and Human Services shall make and promulgate rules, regulations, and fee schedules for the proper administration of the Medical Assistance Program, and to make the Office's State Plan for Medical Assistance conform to the provisions of the Social Security Act.

Penalties for Misrepresentation or Fraudulent Acts

Penalties for misrepresentation or fraudulent acts involving this program are covered by both Section 1909 (a) of the Social Security Act; RIGL Sections 11-41-3, 11-41-4, 40-8.2-3, 40-8.2-4, and 40-8.2-7; and any other applicable statutes. These criminal penalties are in addition to civil actions for damages, recoveries of overpayments, injunctions to prevent continuation of conduct in violation of RIGL 40-8.2, as well as suspension or debarment from participation in the program by state or federal authorities.

INTRODUCTION

On May 4, 2013, the Rhode Island Medical Assistance Program began to make payment to participating nursing facilities based on a price-based, acuity-adjusted reimbursement methodology.

These per diem reimbursement rates, as subsequently described, will constitute full and total payment for services provided.

RECORDS RETENTION

AS PROVIDED FOR BY THE RI STATUTE OF LIMITATIONS
(RIGL 12-12-17)

Each provider of long-term care services participating in the Title XIX Medical Assistance Program, in accordance with the provisions of these Principles of Reimbursement, will maintain within the State of Rhode Island all original records or hard copies of records and data necessary to support the accuracy of the entries on the annual BM-64 Cost Report. Original invoices, canceled checks, contracts, minutes of board of directors meetings, and any other material used in the preparation of the annual cost report must be retained in Rhode Island for at least ten (10) years following the month in which the cost report to which the materials apply is filed with the State Agency as required by the RI Statute of Limitations. Each provider will make available upon request such records and all other pertinent records to representatives of the State Agency, representatives of the Federal Department of Health and Human Services, and the state's Medicaid Fraud Unit.

The State Agency will maintain all cost reports submitted by providers and all audit reports prepared by the Agency for at least ten (10) years after the month in which the cost report was filed by the provider or at least ten (10) years after the month in which the audit was conducted.

These Principles of Reimbursement are implemented in accordance with the appropriate provisions of the state's Administrative Procedures Act.

The state will pay services by participating providers of long-term care facility services in accordance with these Principles of Reimbursement.

If an overpayment to a participating provider of long-term care services is identified, repayment will either be made by direct reimbursement or by offsetting future payments to the provider. Such repayment may include interest charges on the overpayment amount as provided for by RIGL 40-8.2-22.

GENERAL PROVISIONS

REPORTING

Reasonable Costs

The provision of Nursing Facility Care Services to Medicaid recipients is provided only to those individuals who meet resource and income eligibility criteria. Consequently, the cost of services for those individuals with limited income and resources must be reasonable. The Executive Office of Health and Human Services shall have the discretion to determine through its review of submitted costs, and in accordance with these principles, what constitutes reasonable and allowable cost.

Not all reasonable and allowable costs must be reimbursed. These Principles of Reimbursement—through the establishment and application of base rates for Direct Nursing Care, Other Direct Care, and Indirect Care—provide for payment of Nursing Facility Care services under the Medicaid Program on a prospective basis. Those provisions are made through rates that are reasonable and adequate to meet costs of efficiently and economically operated nursing facilities that provide services in conformance with state and federal laws, regulations, and quality and safety standards.

Reasonable costs shall mean those costs of an individual facility for goods and services which, when compared, will not exceed the costs of like goods and services of comparable facilities in license and size. Reasonable costs include the ordinary, necessary, and proper costs of providing acceptable health care subject to the regulations and limits contained herein.

Participants in the Medicaid program are expected to establish operating practices which assure that costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service.

In the absence of specific definitions and/or elements of allowable and disallowable costs that may not be contained herein, the Rules and Regulations of Federal Medicare - Title XVIII will prevail.

The state reserves the right to make determinations of allowable costs in areas not specifically covered in these Principles or in the Rules and Regulations of Federal Medicare - Title XVIII.

Annual Cost Report BM-64

All facilities must file an annual cost report BM-64 on a calendar year basis. The report format is determined by the RI Medicaid Rate Setting Unit and must be filed on or before March 31 following the close of the year.

The report must be completed in accordance with generally accepted accounting principles and prepared on the accrual basis of accounting wherein both revenues and expenditures are recognized in the period when earned or incurred regardless of when actual cash payments are made and received.

Providers who do not submit the BM-64 on time without an authorized extension from the Rate Setting Unit will have their rates frozen until an acceptable cost report has been filed.

A final BM-64 must be filed within ninety (90) days after an ownership change, facility closing, or

provider's departure from the Medicaid program.

Admission Policy

Participating Nursing Facilities must admit Title XIX patients to all parts of the facility without discrimination, in accordance with the provisions of RIGL 23-17.5-19 and 23-27.5-21, based solely upon specialized medical and related needs of the patient. In addition, as provided in RIGL 23-17.5-24, patients have the right to remain in a facility after the depletion of private funds.

Participation

Facilities and at least twenty-five (25) percent of all their nursing facility beds must be dually certified for participation in both Medicare (Title XVIII) and the Rhode Island Medical Assistance (Title XIX) Program on and after October 1, 1990. Ideally all nursing facility beds should be dually certified.

The Secretary of the Executive Office of Health and Human Services may waive the requirement for Medicare certification upon his or her determination, upon consultation with the director of the state surveying agency, that: (1) there is an imminent peril to public health, safety, or welfare; and/or (2) it is in the best interest of the state and the residents of the facility.

The Medicaid Director must approve an increase in the licensed bed capacity, new beds, or beds out of service brought back into service, for participation and payment in Title XIX Medicaid.

Method for Determining Nursing Facility Payment Rates

A. Per Diem Base Rate

Each nursing home will have a base per diem rate that applies to all residents. The base per diem rate is comprised of the following components.

□ Direct Nursing Care
Direct Nursing is comprised of nursing salaries, (RNs, LPNs, and CNAs) and fringe benefits. The base per diem rate for Direct Nursing Care is **$100.44.**

□ Other Direct Care
This component includes other direct care expenses such as recreational activity expenses, medical supplies, and food. The base per diem rate for Other Direct Care services is **$23.74.**

□ Indirect Care
This component includes all other nursing facility operating expenses, e.g. administration, housekeeping, maintenance, utilities, etc. A base rate for this component is **$53.53.**

□ Fair Rental Value (FRV)
The FRV component is facility specific. The base FRV for each nursing home is the 7/1/2012 rate calculated under the previous principles of reimbursement. A full description of the methodology used to calculate the Fair Rental Value for each nursing facility as of 7/1/2012 is described below.

□ Property Taxes

STATE OF RHODE ISLAND

The property tax component is facility specific, i.e., based on actual property taxes assessed and paid.

 Provider Assessment

The provider assessment is an amount equal to 5.82% of the sum of the above components to recognize the state's Provider Assessment Tax. Should the state's 5.5% Provider Assessment Tax rate change, this add-on will be adjusted accordingly. Below is an example of the adjustment to the add-on in the provider tax were to be changed to 4.0%.

1.	Per diem base rate (excl. provider tax):	$200.00
2.	Calculate per diem rate with 4.0% tax:	$200.00 divided by .96 = $208.33
3.	Calculate provider tax amount:	$208.33 minus $200.00 = $8.33
4.	Calculate add-on percent:	$8.33 divided by $200.00 = 4.165%
5.	Calculate provider tax add-on:	$200.00 times 4.165% = $8.33
6.	Calculate per diem rate incl. tax:	$200.00 plus $8.33 = $208.33

B. Adjustments to Base Rate

 Patient Acuity

The RUG-IV case-mix classification system recognition of patient acuity in the payment methodology. The case-mix classification system uses clinical data from the MDS assessment to assign a case-mix group to each patient that is then used to adjust a portion of the per diem payment based on patient resource use. (This is similar to how Medicare reimburses for care in a skilled nursing facility.) Each patient is assigned one of forty-eight
(48) RUG categories supplied by the provider or by the grouper based on his/her MDS record. A patient's MDS record must be updated every ninety (90) days or in the event of a significant change in condition. Acuity will be based on the patient specific RUG category, i.e. full RUG-based system. The acuity factor (RUG weight) is applied only to the Direct Nursing Care component.

To allow for necessary modifications to the state's MMIS claims processing system, full implementation of the RUG-based process will be implemented on June 1, 2013. In the interim, a facility specific case mix index was being used.

 Price Increases

Unless otherwise stated, the components of the base per diem rate will be increased annually, effective October 1 of each year, as follows:

1. Direct Nursing, Other Direct Care, and Indirect Care:
On an annual basis, unless otherwise specified, this component of the base per diem rate will be adjusted by the Center for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Prospective Payment System Market Basket Update without productivity adjustment.

STATE OF RHODE ISLAND

The adjustment will be applied annually on October 1 (the start of a new federal fiscal year), using the CMS' actual regulatory -market basket update without productivity adjustment for the previous federal fiscal year.

In addition to the annual nursing home inflation index adjustment, there shall be a base rate staffing adjustment of one-half percent (0.5%) on October 1, 2021, one percent (1.0%) on October 1, 2022, and one and one-half percent (1.5%) on October 1, 2023.

Effective October 1, 2021, eighty percent (80%) of any rate increase that results from application of the inflation index to a) the direct-care rate adjusted for resident acuity and b) the indirect-care rate, which is comprised of a base per diem for all facilities, shall be dedicated to increase compensation for all eligible direct-care workers in the following manner on October 1, of each year:

(i) compensation increases shall include base salary or hourly wage increases, benefits, other compensation, and associated payroll tax increases for eligible direct-care workers. This application of the inflation index shall apply for Medicaid reimbursement in nursing facilities. For purposes of this subsection, direct-care staff shall include registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), certified medication technicians, licensed physical therapists, licensed occupational therapists, licensed speech-language pathologists, mental health workers who are also certified nurse assistants, physical therapist assistants, housekeeping staff, laundry staff, dietary staff or other similar employees providing direct-care services; provided, however that this definition of direct-care staff shall not include: RNs and LPNs who are classified as "exempt employees" under the federal Fair Labor Standards Act (29 U.S.C. § 201 et seq.); or CNAs, certified medication technicians, RNs or LPNs who are contracted or subcontracted through a third-party vendor or staffing agency.

(ii) By July 31, 2022 -and by July 31st of each year thereafter, nursing facilities shall submit to the secretary or designee, a certification of compliance with increased compensation for all eligible direct care works that results from the inflation index applied on October 1. A collective bargaining agreement can be used in lieu of the certification form for represented employees. All data reported on the compliance form is subject to review and audit by EOHHS. The audits may include field or desk audits, and facilities may be required to provide additional supporting documents including, but not limited to, payroll records.

(iii) Any facility that does not comply with the terms of certification shall be subjected to a clawback of the unspent or impermissibly spent funds, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification and a twenty-five percent (25%) penalty based upon the amount of unspent or impermissibly spent funds, paid by the nursing facility to the state, in the amount of increased reimbursement subject to this provision that was not expended in compliance with that certification

STATE OF RHODE ISLAND

Each facility shall have the necessary nursing personnel (licensed and non-licensed) in sufficient numbers on a twenty-four (24) hour basis, to assess the needs of residents, to develop and implement resident care plans, to provide direct resident care services, and to perform other related activities to maintain the health, safety, and welfare of residents. The facility shall have a registered nurse on the premises twenty-four (24) hours a day.

Effective, January 1, 2022, nursing facilities shall provide a quarterly minimum average of three and fifty-eight hundredths (3.58) hours of direct nursing care per resident, per day, of which at least two and forty-four hundredths (2.44) hours shall be provided by certified nurse assistants.

Effective January 1, 2023, nursing facilities shall provide a quarterly minimum of three and eighty-one hundredths (3.81) hours of direct nursing care per resident, per day, of which at least two and six-tenths (2.6) hours shall be provided by certified nurse assistants. Director of nursing hours and nursing staff hours spent on administrative duties or non- direct caregiving tasks are excluded and may not be counted toward compliance with the minimum staffing hours requirement in this section. The minimum hours of direct nursing care requirements shall be minimum standards only. Nursing facilities shall employ, and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all relevant state and federal staffing requirements.

For facilities that have an offense in three (3) consecutive quarters, The State Medicaid Agency shall deny any further Medicaid Assistance payments with respect to all individuals entitled to benefits who are admitted to the facility on or after January 1, 2022 or shall freeze admissions of new residents.

The penalty shall be imposed regardless of whether the facility has committed other -violations of this chapter during the same period that the staffing offense occurred. The penalty may not– be waived except~~,~~: No monetary penalty may be issued for noncompliance with the increase in the standard set forth in state law from January 1, 2023, to March 31, 2023; The State Survey Agency has the discretion to determine the gravity of the violation in situations where there is no more than a ten percent (10%) deviation from the staffing requirements and make appropriate adjustments to the penalty.

Per state law the State Survey Agency has discretion to waive the penalty when unforeseen circumstances have occurred that resulted in call-offs of scheduled staff. This provision shall be applied

no more than two (2) times per calendar year.
The State Survey Agency will determine when a nursing facility has come back into compliance with direct care minimum staffing levels as follows:

(i) Upon written notification by the State Survey Agency of a nursing facility's non-compliance for three (3) consecutive quarters, EOHHS will send a letter to the nursing facility providing written notification of an imposed enforcement action (i.e., freeze on admissions of new Medicaid nursing facility residents). The State Survey Agency will be provided with a copy of the notification;

(ii) The State Survey Agency will provide written notification to the nursing facility of the opportunity to correct the staffing deficiency(ies) and the need to submit a written plan of correction;

(iii) The nursing facility's plan of correction will constitute their Credible Allegation of Compliance;

(iv) Upon receipt of the Credible Allegation of Compliance/ plan of correction, the State Survey Agency will obtain further evidence of compliance and/ or complete an inspection to verify staffing levels and compliance with the plan of correction;

(v) If all deficiencies are corrected, the State Survey Agency so notices the State Medicaid Agency in writing that the freeze on admissions of new Medicaid nursing facility residents for the previously non-compliant facility is lifted.

(vi) Minimum staffing requirements and compliance enforcement by the State Survey Agency meet Federal Survey and Certification standards and requirement

2. Fair Rental Value:
IHS Markit Healthcare Cost Review second-quarter report, Skilled Nursing Facility Total Market Basket FY Table, Capital Costs %MOVAVG, third quarter.

3. Property Taxes~~:~~
Facility specific property tax payments

The Fair Rental Value rate for each nursing home was most recently increased effective 7/1/2012. The Property Tax rates are based on allowable tax payments and total patient days reported in each facility's most recently filed cost report.

 Exceptions to price increases
Annual adjustments to the base per diem rates for Direct Nursing, Other Direct Care, and Indirect Care stated above will not occur in the following years, and will instead be adjusted as noted below:
-2015 no increase
-2017 no increase
-2018 base rates increased by 1.5% effective July 1 and 1% effective October 1
-2019 base rates increased by 1% effective October 1
-2022 base rates increased by 3% effective October 1

C. Transition Adjustments

In recognition of the impact this change will have on nursing homes, the state has implemented a transition plan of at least four years in length. This change will be completed after October 1, 2016. The features of this transition are described below.

 Adjustment to Direct Care (Direct Nursing Care and Other Direct Care components)
For those nursing homes whose Direct Care per diem costs are greater than the Direct Care base rates, i.e the sum of the Direct Nursing Care and Other Direct Care base rate components, which would result in a loss in reimbursement, the state has added a policy adjustment to fully compensate for that loss. This will ensure that patient care is not adversely impacted. See example below:

Actual Direct Care cost:	$130.00
Minus Direct Nursing Care rate:	($100.44)
Minus Other Direct Care rate:	($23.74)
Policy adjustment equals:	$5.82

This policy adjustor will be phased out over the transition period as follows:

- 10/1/16 100%
- 10/1/17 75%
- 10/1/18 50%
- 10/1/19 25%
- 10/1/20 0%

 Adjustment to Overall Care
In addition to the above policy adjustment, the state has also implemented a gain/loss policy adjustment ensuring that, exclusive of the direct care policy adjustment, no nursing home will experience a gain or loss in year one of the transition of greater than $5.00 per day. See example below:

Direct and Indirect Care base rate:	$177.71
Actual Direct and Indirect Care costs:	$160.00
Rate variance:	$17.71
Maximum gain/loss	$5.00
Gain/loss policy adjustment	($12.71)

This policy adjustor will be phased out over the transition period as follows:

- 10/1/12 100% ($12.71)
- 10/1/13 75% ($9.53)
- 10/1/14 50% ($6.36)
- 10/1/16 25% ($3.18)
- 10/1/17 0% $0.00

E. Periodic Rate Review

Beginning in October 2024, the state may revise rates as necessary based on increases in direct and indirect costs utilizing data from the most recent finalized year of facility cost report. The direct care and indirect care components will be adjusted accordingly to reflect changes in direct and indirect care costs since the previous rate revision. Nursing homes are required to submit cost reports annually.

Rates for Newly Constructed Facilities

Newly constructed facilities will be paid a rate determined in the manner described for all facilities under these Principles. The initial Fair Rental Value component shall be calculated using the methodology described on pages 15-18. The Tax component will use an occupancy rate equal to 98% of the statewide average.

Appeals Process

Any provider who is not in agreement with the reimbursement rate assigned for the applicable rate period, may within fifteen (15) days from the date of notification of rate assignment file a written request for a review conference to be conducted by the Medicaid Director, or other designee assigned by the Secretary of the Executive Office of Health and Human Services. This written request must identify the rate assignment issue(s). The Medicaid Director or designee shall schedule a review conference within fifteen (15) days of receipt of the request. As a result of the review conference, the Medicaid Director or designee may modify the rate of reimbursement. The Medicaid Director or designee shall provide the provider with a written decision within thirty (30) days from the date of the review conference.

Appeals beyond the Medicaid Director or the designee appointed by the Secretary of the Executive Office of Health and Human Services will be in accordance with the Administrative Procedures Act. The provider must file a written request for an Administrative Procedures Act hearing no later than fifteen (15) days of the decision noted in the paragraph above.

Appeal Requests For Prospective Rate Increments

The Executive Office of Health and Human Services may consider the granting of a prospective rate that reflects demonstrated cost increases in excess of the rate that has been established by the application of the percentage increase, that are the result of:

1. Demonstrated errors made during the rate determination process.

2. Significant increases in operating costs resulting from the implementation of new or additional programs, services, or staff specifically mandated by the Rhode Island Department of Health.

3. Significant increases in operating costs resulting from capital renovations, expansion, or replacement required for compliance with fire safety codes and/or certification requirements of the Rhode Island Department of Health.

4. Extraordinary circumstances including, but not limited to, acts of God, provided that such increases will be rescinded immediately upon cessation of the extraordinary circumstance.

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4. Extraordinary circumstances including, but not limited to, acts of God, provided that such increases will be rescinded immediately upon cessation of the extraordinary circumstance.

Special Prospective Rate Appeal

Any facility that has been directed by the Department of Health to appoint an independent quality monitor, engage an independent quality consultant or temporary manager, and/or develop and implement a plan of correction to address concerns regarding resident care and coincident financial solvency may file for a Special Rate Appeal. The Special Rate Appeal components are as follows:

1. The provider must submit a written request (including a copy of the plan of correction) to the EOHHS Rate Setting Unit.

2. The request must be based on the approved spending plan set forth in the plan of correction and remediation.

3. The provider must submit evidence that the approved spending plan cannot be accommodated by the existing per diem rate.

4. The rate appeal will not be for a period of less than six (6) months.

5. EOHHS, at its discretion, may provide for subsequent extensions for six (6) month periods for a maximum total period of twenty-four (24) months.

6. The provider must submit a BM-64 Cost Report for each six (6) month appeal period.

7. EOHHS will recoup any funds not expended during the six (6) month appeal period.

8. In calculating the Special Prospective Rate Appeal, the Office may establish a per diem amount to be added to the facility's existing per diem rate.

9. Upon conclusion of the six (6) month period (or subsequent extension periods), the per diem rate will revert to the provider's normal per diem rate.

Payment

Rhode Island reimburses a provider monthly for Medicaid patient days times the assigned prospective per diem rate. This also applies to state-only days.

The state reserves the right to investigate and adjust reimbursement rates for facilities which do not substantially comply with all standards of licensure.

In determining the number of days for which payment may be made the date of admission is counted, however the date of death or discharge is not counted.

The per diem rate for eligible Title XIX recipients is a full payment rate and, therefore, under RIGL 40-8.2-3 and federal regulations, subsidy for patient care by the patient, relatives, or friends to the facility in any manner is prohibited.

RECORD KEEPING

Adequacy of Cost Information

Long-term care providers under the state Medicaid Program are required to maintain detailed records supporting the expenses incurred for services provided to Medicaid patients. The underlying records must be auditable and capable to substantiating the reasonableness of specific reported costs. Records include all ledgers, books, and source documents (invoices, purchase orders, time cards, or other employee attendance data, etc.). All records must be physically maintained within Rhode Island and/or be made readily available to the state upon request.

Census Data

Statistical records supporting both Medicaid and total patient days must be maintained in a clear and consistent manner for all reporting periods. The detailed record of all patient days must be in agreement with monthly attendance reports. In calculating patient days the date of admission is counted as one day, however, the date of death or discharge is not counted as a day.

Financial Reviews of Provider Costs

The state can conduct reviews of the financial and statistical records of each participating provider in operation. Examples in which financial reviews could be necessary are:

- Oversight by state agencies;
- Evaluation due to emergency or extraordinary situations;
- Examination or review for purposes of program integrity;
- Assessment of evolving adverse financial condition;
- Fair rental value adjustment requests;
- Establishing rates for newly constructed facilities;
- Appeal requests for prospective rate increments;
- Evaluating hardship requests
- Compliance with reimbursement for staffing;
- Assessment of potential changes to the rate setting methodology.

Financial reviews include any tests of the provider's records deemed necessary to ascertain that costs are proper and in accordance with Medicaid principles of reimbursement and that personal needs accountability are in compliance with existing regulations. The knowing and willful inclusion on non-business related expenses, non-patient related expenses, or costs incurred in violation of the prudent buyer concept may be subject to criminal and/or civil sanctions. Failure of auditors of EOHHS to identify the above items or their adjustment of same shall not constitute a waiver of any civil or criminal penalty.

OPERATING COSTS

Property Payment: Fair Rental Value System

The property payment effective September 1, 2004 will be a Fair Rental Value (FRV) system which will provide a payment in lieu of the Other Property Related Cost Center. This will eliminate reimbursement for depreciation, interest, rent, and/or lease payments on property, plant and equipment, working capital interest, all other interest, and vehicle depreciation and/or lease payments. The FRV establishes a facility's value based on its age: the older the facility, the lower its value. Additions and renovations (subject to a minimum per bed limit) and bed replacements will be recognized by lowering the age of the facility and, thus, increasing the facility's value. The facility's established value is not affected by sale or transfer and new facilities will be assigned a rate based upon a completed survey. All FRV Surveys are subject to field audit.

The FRV payment rate received by a facility as of September 1, 2004 shall be no lower than the Other Property Related Cost Center payment rate received as of June 30, 2004. This rate will remain in effect until such time as the FRV rate exceeds the facility rate received as of June 30, 2004.

The parameters of the FRV and the start up of the system are as follows:

1. The initial age of each nursing facility participating in the Medicaid Program and used in the FRV calculation shall be determined as of September 1, 2004, utilizing a statewide survey to determine each facility's construction year and entry date into the Medicaid program. In addition, this age will be reduced for replacements, renovations, and/or additions that have occurred since the facility's construction.

2. A bed value, based on a standard facility size of 450 square feet per bed, will be determined using the R.S. Means Building Construction Data Publication or a comparable valuation system adjusted by the location index for Providence, Rhode Island. The bed value for September 1, 2004, is $66,000 per bed. This value per bed includes an amount of $4,000 per bed for equipment.

3. The value will be increased by a factor of ten (10) percent to approximate the cost of land and other "soft" costs.

4. For each facility, the trended value will be depreciated, except for the value portion assigned as land, at a rate of 1.5% per year based upon the weighted age of the facility. Bed replacements, additions, and renovations shall lower the weighted average age of the facility. The maximum age of a nursing home shall not exceed thirty-five (35) years.

5. The value assigned shall be trended forward annually to the mid-point of the rate year (starting July 1, 2005) based on the percentage change in the R. S. Means Construction Cost Index, or comparable index, for the previous calendar year end up to a ceiling of four (4.0) percent.

6. A nursing facility's FRV is calculated by multiplying the facility's current value per bed times the number of licensed (including beds approved as out of service) times a rental factor. The rental factor will be the twenty (20) year Treasury bond rate as published in the Federal Reserve Bulletin using the average for the calendar year preceding the rate year plus a risk

factor of 3.0 percent with an imposed floor of 9.0 percent and a ceiling of 12.0 percent. The rental factor to be utilized for September 1, 2004, will be 9.0 percent.

7. The calculated FRV shall be divided by patient days for the cost reporting period. For FRV start up, this is considered to be calendar year 2002 for FRV rate assignment effective September 1, 2004. For rate calculations July 1, 2005 and later, the census will be predicated on the previous calendar year patient days.

8. The age of each facility will be further adjusted each July 1, to make the facility one year older, up to the maximum age, and to reduce the age for those facilities that have completed and placed into service major renovations, bed additions, or replacements.

9. The age adjustments for major renovations, bed additions, and replacements will be averaged into the age of the facility the July 1st following the year the major renovations or beds were placed in service. Major renovations are defined as a project, or series of projects, with capitalized cost equal to or greater than $1000 per bed. To qualify as a bed replacement, the cost of the renovation/improvement must be equal to or greater than the cost of constructing one nursing facility bed in the year in which the renovation takes place. This is calculated on a calendar year basis.

10. Continued explanation and examples of the FRV are as follows:

Facility of 120 beds, constructed in 1994, with no major renovations or bed additions and occupancy of 95.0%:

Value per bed	$66,000.
Number of beds	120
Value (value per beds x beds)	$7,920,000
Accumulated Depreciation (1.5% x 10 yrs. = 15.0%)	$1,188,000
Net Value (value less accumulated depreciation)	$6,732,000
Land Value (10% x value per bed x # of beds)	$792,000
Total Value	$7,524,000
Fair Rental Value Return (total value x 9.0%)	$677,160
Fair Rental Value Per Diem Rate (41,610 patient days)	$16.27

Bed addition:
The addition of beds will require a computation on the weighted average of the facility based on the construction dates of the original facility and the additional beds placed into services.

A facility of 120 beds, constructed in 1994, which added 40 beds in 1999:

Beds	Age	Weighted
120	5	600
40	0	0
160		3.75

The new base year is 1995 (1999 – 3.75) as compared to 1999.

Renovation or major improvement:
The cost of major renovations and improvements is factored into a facility's age provided that the renovations and improvements meet the definition that it is a project with capitalized cost equal to or greater than $1,000. per bed. This is based on a calendar year basis. Renovation/improvement cost must be documented through cost reports, depreciation schedules, etc. and are subject to audit. Costs must be capitalized in order to be considered a renovation or improvement. Individual assets with a cost of $500.00 or more and a useful life of at least three (3) years must be capitalized. Useful lives for assets acquired after September 1, 2004, are determined by utilizing the American Hospital Association (AHA) guidelines of Depreciable Hospital Assets, 1998 edition or subsequent. Assets acquired in quantity at a total cost of $1,000 or more and multiple purchases of similar individual assets during a reporting period must be capitalized if the useful life is three (3) years or more. In establishing the age of a facility, renovations/improvements are converted into an equivalent number of new beds. The equivalent number of new beds would then be used to determine the weighted average age of all beds for the facility. The equivalent number of new beds will be determined by dividing the project cost by the construction cost of a new bed in the year of the renovation/improvement project. Refer to Appendix 'D' for historical cost data indexes.

Example: Facility of 120 beds constructed in 1994 and had a major renovation project totaling $1,000,000 in 2000

Cost of renovation	$1,000,000
Divided by replacement cost index in 2000 of	$60,443
Equals	16.54 beds (figure cannot exceed total number of beds)

Beds	Age	Weighted
6.54	0	0
103.46	6	620.76
120.00		620.76

New base year is 1995 as compared to 2000.

Bed replacement:
The replacement of existing beds will result in an adjustment to the age of the facility. A weighted average age will be calculated according to the year of initial construction and the year of bed replacement. This differs from the addition of beds in that a certain number of beds have replaced those that were initially constructed.

If a facility has a series of additions or replacements, it is assumed that the oldest beds are ones being replaced.

Example: Facility of 120 beds, constructed in 1984, replaced 40 beds in 1999.

Beds	Age	Weighted Average
40	0	0
8	15	1200
120		1200
		10.00

New base year is 1989, instead of 1999.

REAL ESTATE AND PERSONAL PROPERTY TAXES

For Medicaid purposes, the allowable real estate and personal property taxes will be the four quarterly amounts due and payable during the reporting year or the tax based upon the assessed valuations of the prior December 31. For example, the amount allowable for calendar year 2012 will be the four (4) quarterly installments due and payable during calendar year 2012 or the total tax based on the December 31, 2011 valuations. The basis for reporting will be determined by the provider but must remain consistent from year to year.

PERSONNEL COSTS

Owner Compensation

Compensation to an owner or related individual must be reasonable and associated with patient care in order to be reimbursable.

Criteria for Determining Reasonable Compensation to Owners and/or Related Individuals

To judge reasonableness, the Rate Setting Unit may use but is not limited to:

1. Comparison with payments to individuals, other than owners, in comparable facilities or industries.

2. Equating responsibilities and functions performed with a satisfactory salary range.

The allowance for fringe benefits must be consistent with the compensation above.

Administrator Compensation

An administrator must be a duly licensed person in the State of Rhode Island and be responsible for the overall management and supervision of a facility. Administrators must work on a full-time basis and be substantiated by appropriate time records. Assistant Administrators working full-time or part-time must also be substantiated by time records. Compensation of an administrator is an allowable cost to the extent it does not exceed established maximums governed by bed capacity as shown on the attached schedule.

Administrator Compensation is detailed in the Appendix. The Appendix will be adjusted annually by the amount of percentage change reflected by the Wage and Salary Component of the National Nursing Home Input Price Index as projected by the Centers for Medicare and Medicaid Services.

Facilities Operated by Members of a Religious Order

The recognized salary allowance for members of a religious order providing patient care services will be limited to the lower of actual stipend paid on their behalf or the salary equivalent that would be recognized by these Principles of Reimbursement for similar services.

PROFESSIONAL SERVICES

The fees must meet the test of reasonable costs, and must be fully documented by billing which clearly describes the nature of the services rendered.

An example of admissible cost is the fee for legal services in connection with a directive to comply with fire codes regulations. A legal or accounting charge resulting from a buy/sell agreement between related parties is inadmissible. Professional fees associated with future construction must be deferred and included with the project construction costs.

Fringe Benefits

Fringe benefits such as prepaid health insurance, group life insurance, employees' child daycare, dental plans, and retirement plans, are allowable costs, providing they are offered to all full-time employees. Similar benefits or partial benefits offered to all permanent part-time employees working at least twenty (20) hours per week will also be recognized. Fringe benefits which advantage officers, owners, or other related individuals in a disproportionate manner will be adjusted to reflect equity of application. Fringe benefits by employee classification must be addressed in the facility's personnel and policy manual in order to be recognized. Benefits other than those stated above must be reasonable and necessary for the efficient, effective, and economical operation of similar facilities participating in the Rhode Island Medicaid Program.

Vacation time and sick leave time are not recognized for reimbursement under the accrual method of accounting. Vacation time and sick leave time will be recognized as an expense when actually paid to the employee by the facility.

Other Operating Costs

All operating costs, including nursing, medicine chest, and over-the-counter drug supplies which have been determined as reasonable and acceptable will be allowed after reduction for items not related to patient care.

Accounting and Auditing Fees

Accounting and auditing services are generally a necessary and proper function in the fiscal operation of long-term care facilities. The employed firm must clearly identify recognized fees associated with these services for responsibility, function of activity, hourly billing rate, and time element for each function. The Rate Setting Unit shall determine an appropriate amount for such services to be recognized for reimbursement purposes taking into consideration such factors as facility employed accountant(s), controller(s), comptroller(s), bookkeeper(s), condition of books and records maintained by the facility, and the necessary direct involvement of the Accounting/Auditing firm.

Routine Services

Expenses pertaining to utilization review of all patients, physical therapy, and other remedial therapeutic services will be accepted and considered as routine services for rate calculation.

Expenses pertaining to the services of a Behavior Health Specialist, licensed by the State of Rhode Island and not eligible for direct reimbursement under the Rhode Island Medical Assistance program, will be considered routine services and accepted for rate calculation.

Educational Activities

The reasonable cost of full-time employee educational activities will be included as an allowable cost provided that such activities are directly related to improving adequate patient care or the administration of the facility. In addition, the activity must be formally organized by a recognized school or organization approved by the state. Educational activities do not cover nurse's aide training and competency evaluation expenditures, as these expenditures are not reimbursable through the Medicaid Program.

Physicians' Fees

Reasonable fees which pertain to utilization review, medical director, employees' physical examinations and services required by OBRA-87 are considered allowable costs.

Conference Expenses

Reasonable expenses related to attendance at meetings and conferences are considered allowable costs.

Medicine Chest Supplies, Transportation, and Laundry Expenses

The established per diem base rates include the expenses of nursing and medicine chest supplies; transportation of patients who can be transported by auto to and from physician's office, dental services, medical laboratories, and hospitals for outpatient treatment; as well as laundry expenses including personal laundry with the exception of dry cleaning costs; therefore, facilities must not charge Title XIX patients or their relatives for these services.

Insurance

Generally acceptable insurance coverage for business enterprises, including the types listed below, is reimbursable:

1. Liability Insurance
2. Malpractice Insurance
3. Worker's Compensation
4. Property Insurance

Payment of health and life insurance premiums which provide benefits to an employee or his/her beneficiary are considered fringe benefits and should be claimed as such by the provider. Premiums related to insurance on the lives of officers and key employees which name the provider as beneficiary are not allowable costs. If the individual or his estate are beneficiary, the premiums can be considered compensation to the individual and the cost would be allowable to the extent his/her

total compensation is reasonable.

Insurance costs applicable to transportation vehicles will be allowable.

Mortgage insurance premiums are generally not an allowable cost. However, where the principal mortgagee specifically requires that the insurance be obtained as a prerequisite to completing financing arrangements and the insurance agreement stipulates that total proceeds must apply to the mortgage balance, then the premiums shall be reimbursable.

COST NOT RELATED TO PATIENT CARE

The following are examples of, but not limited to, items which are not recognized for cost reimbursement purposes:

1. Personal expenses,
2. Items and services for which there is no legal obligation to pay,
3. Business expenses not related to patient care,
4. Physician fees, prescription drugs and medications, as they are covered by means of a separate program,
5. Reimbursed expenses,
6. Costs of meals sold to visitors and employees,
7. Costs of drugs, items, and supplies sold to other patients,
8. Cost of operation of a gift shop intended to produce a profit. Where expenses cannot be specifically identified the revenue derived will be used to reduce the total operating expenses of the facilities
9. Expenses which exceed amounts under the prudent buyer concept,
10. Accrued expenses not paid within ninety (90) calendar days after close of the reporting period, except for bankruptcy proceedings, or at time of the audit, examples include, but are not limited to:
    a. Professional services including attorney and accounting fees,
    b. Unpaid compensation of employees, officers, and directors owning stock in a closely-held corporation,
    c. Fringe benefits,
    d. Consultant fees,
    e. Suppliers and vendors, and
    f. Trade association dues.

Any accrued expenses so disallowed will, however, be recognized when eventually paid by adjusting the costs of the year in which the expense was incurred.

11. State and federal income taxes,
12. Directory and display advertising or other means of advertising,
13. Bad debts,
14. Management fees,

15. Expenses attributed to anti-union activities as specified in H.I.M.-15,

16. Excessive purchases of supplies when compared to previous years and years subsequent to base years,

17. Employment agency fees/agency contract for purpose of recruitment,

18. Costs of beepers,

19. Costs of telephone in motor vehicles, and,

20. Costs of nurse aide training and competency evaluations.

The inclusion of costs, such as those set forth in 1-20 above, which are not related to patient care may constitute a violation of RIGL 40-8.2-4, as well as other provisions of state and federal law and may result in criminal and civil sanctions and possible exclusion from participation in the Medicaid Program.

The state reserves the right to make determinations of admissible and/or inadmissible costs in areas not specifically covered in the principles.

SERVICE AND AFFILIATED ORGANIZATIONS

General

Any company or business entity which provides products and/or services to an affiliated nursing home or group of homes, where common ownership exists, must be reported to the Rate Setting Unit in order to meet reimbursement requirements.

Reporting Requirements

The report form required to be filed will include but not be limited to:

1. Explanation of the need for such an organization,

2. Ownership interest and legal form of organization,

3. Type of product or services to be rendered, and

4. Names of all affiliated facilities to be serviced.

Submission of this information will allow for a determination of whether or not charges from the related service company to the nursing facility are reasonable.

The state requires in addition to the BM-64, the following:

1. Financial statements of the related service company,

2. Tax returns if above statements are not available.

If centralized services such as accounting, purchasing, administration, etc., are involved, complete details regarding the allocation of charges must be provided.

Cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. Costs include those actually incurred to which may be added reasonable handling and administrative charges. Profit add-on in the form of markups or by other means is neither permitted nor acceptable for reimbursement under the Rhode Island Medical Assistance Program.

Home Office Charges

Long-term care facilities sometimes operate through a central home office resulting in home office charges. Cost-related expenses may be reimbursable providing that the central home office is physically located within the state of Rhode Island and if they can satisfy the reasonable cost-related concept previously described and if they can demonstrate and document that central management, purchasing, and accounting services were uniformly performed for all facilities.

Home office cost-related expenses, if the above is satisfied, will be pro-rated to each facility and enterprise for which services are being provided. The central home office must prepare and file with the Rate Setting Unit a cost report annually, in an approved format showing line-cost and allocation to each facility or enterprise. Additionally each enterprise for which services are provided must be fully disclosed.

In-State Central/Home Office

Cost will be allocated and reimbursed through the Indirect Care Base Rate. An in-state central office requires maintaining a minimum of three (3) Nursing Care Facilities.

Out-of-State Central/Home Office

Charges will be recognized to the extent of the lesser of reported reasonable costs of central home office plus costs in Account Numbers:

- No. 7421-Other Administrative Salaries,
- No. 7435-Computerized Payroll and Data Processing Charge,
- No. 7436-Accounting and Auditing Fees, or the average allowable amount for facilities of like size and licensure for Account Numbers
- No. 7421-Other Administrative Salaries,
- No. 7435-Computerized Payroll and Data Processing Charge, and
- No. 7436- Accounting and Auditing Fees.

Transactions which Reduce Reported Cost of Patient Care

Operations may result in the receipt of revenue from sources other than the direct care of patients. Where it is determined that these amounts are in fact, reductions of previously incurred costs or are

added revenue associated with the business purposes of the facility, such amounts must be offset against operating costs. For example, sale of meals, interest income, sale of supplies, etc., should be used to reduce costs.

Refunds, Discounts, and Allowances

Refunds, discounts, and allowances received on purchased goods or services must be netted against the purchase price.

Energy Conservation Retention Credit

In accordance with RIGL 40-8-20.2, every licensed nursing facility participating in the Medicaid medical assistance program that:

1. Expends funds for energy conservation measures and the use of renewable fuels, energy sources, and so called "green" sources of energy that result in a reduction of energy consumption; and

2. Which methods the facility can demonstrate, to the satisfaction of EOHHS, result in the facility's "pass through" per diem cost in the next base year in comparison to the immediately preceding base year, shall be permitted to retain the difference in the previous per diem and the new per diem for a period of twenty-four (24) months.

Provided that such retained funds shall be utilized by the nursing facility solely for either (1) costs directly associated with employing labor at the facility or (2) to pay down any debt of said nursing facility incurred directly through the purchase of energy saving, conservation and renewable energy, or so-called "green" devices.

Energy conservation measures would include but not be limited to; insulation, lighting projects and retrofits, furnace replacements, HVAC upgrades, weatherproofing, window and door replacements, energy managements systems, etc. Renewable fuels energy sources and green sources of energy would include but not be limited to; wind power, solar power, geothermal, water related power, etc.

Providers must document savings from one calendar year to the next calendar year in similar energy cost categories such as, electricity, fuel, gas, etc. The first documented savings year would be calendar year 2008, as compared to calendar year 2007, which would assign a credit effective October 1, 2009.

APPENDIX:
ADMINISTRATORS' COMPENSATION
May 4, 2013

NO.OF BEDS	Maximum Salary Allowance
1-75	$75,652
76	$77,253
77	$77,642
78	$78,028
79	$78,417
80	$78,801
81	$79,193
82	$79,568
83	$79,960
84	$80,342
85	$81,149
86	$81,948
87	$82,752
88	$83,556
89	$84,364
90	$85,168
91	$85,964
92	$86,772
93	$87,574
94	$88,379
95	$89,175
96	$89,982
97	$90,792
98	$91,597
99	$92,394
100	$93,204
Each Additional Bed	$ 361

Assistant Administrators will be limited to the lower of actual salary paid or 75% of the Administrator's salary allowance.

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (D) of this State plan.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below:

The RI PPCS/HACS project team focused on additional work scope components related to the PPCs/HACs project initiative that were identified in August 2012. The specification changes outlined additional processing to support the identification of erroneous surgery claims for claim types of Inpatient (I), Outpatient (O) and Professional (M). New edits would be constructed to identify "never conditions" (erroneous surgery) claims and process to deny. In addition, an edit for "no-pay" bills would be added for Outpatient and Inpatient claim types. System modifications were completed and the 3 new edits were implemented on 10/31/2012.

The RIMA Production Implementation on 10/31/2012 Included:

The new edits implemented within RI MMIS 10/31/2012 will identify "never" (erroneous surgery) claims and process to deny for claim types of Outpatient (O), Inpatient (I) and Professional (M) . An edit for "no-pay" bills has been added for Outpatient and Inpatient claim types. The 3 new edits are:

1. ESC 287 - Do Not Pay - Erroneous Surgery Procedure Code Modifier (this will set for claim types Outpatient and Professional, if the Procedure Modifier Code of "PA-Surgery Wrong Body Part", "PB-Surgery Wrong Patient" or "PC-Wrong Surgery on Patient" is

submitted. In this scenario the entire claim will be denied (there are no modifiers on Inpatient claims).

2. ESC 288 - Do Not Pay - Erroneous Surgery Diagnosis Code (this will set for claim types Inpatient, Outpatient and Professional if the diagnosis code(s) of "E8765- "Performance of wrong operation (procedure) on correct patient, or "E8766-Performance of operation (procedure) on patient not scheduled for surgery" or "E8767-Performance of correct operation (procedure) on wrong side/body part" is submitted). In this scenario the entire claim will be denied.

3. ESC 289 - Do Not Pay - Zero Pay Bill Type (this will set for claim types Inpatient and Outpatient if type of bill submitted is "110- Inpatient Claim, Zero Pay Bill" or "130 -Outpatient Claim, Zero Pay Bill"). In this scenario the entire claim will be denied.

In the event that individual cases are identified throughout the PPC implementation period, July 1, 2012 through January 10, 2013, the State will adjust reimbursements according to the methodology above.

- *No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.*
- *Reductions in provider payment may be limited to the extent that the following apply: (i) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.*

  A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.