IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT2023118 SEPTEMBER 19, 2023

Long-term care changes being implemented

Beginning **July 1, 2023**, the Office of Medicaid Policy and Planning (OMPP) is implementing revisions to the Medicaid nursing facility reimbursement calculation, the supplemental payment program and related billing requirements. The following is a list of key changes with brief explanations. This bulletin is segregated into items that immediately affect providers and may require action to be taken, and other items that are more informational in nature. *Note: This communication is not intended to be all-inclusive; providers should review the proposed rule and state plan amendment for additional and clarifying information.*

Immediate provider impacts (action may be required)

The following items may immediately affect providers and require action to be taken.

Reporting year-end requirement

All providers with cost report year ending after March 31, 2023, are required to have a Dec. 31 reporting year end. See *Indiana Health Coverage Programs (IHCP) Bulletin BT2023116* for additional information.

Due dates for requests for additional information and reconsiderations

The OMPP has authorized changes to due dates for requests for additional information and reconsideration. The revised due dates for information and reconsideration requests were previously communicated via FSSA Announcement June 16, 2023.

Census data collection form

All nursing facility providers are required to submit monthly census information on the *Nursing Facility Census Data Collection Form* (Census Form) via the Indiana LTC Cost Reporting Web Portal. For more information, see FSSA Announcement July 27, 2023.

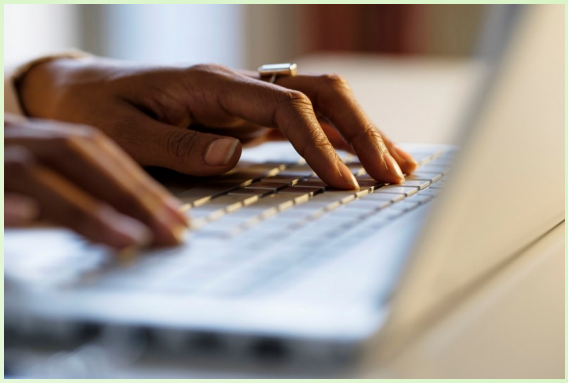
Schedule of special facility qualifications (Schedule Z)

There has been a recent update for provider enrollment in the special care unit (SCU) and/or ventilator programs. Providers that develop an SCU and/or ventilator program and submit Schedule Z prior to Dec. 31, 2023, may qualify to enroll in either program. The qualification date will be effective the date that all applicable program criteria were met.

Schedule Z and related SCU and ventilator program reimbursement changes were previously communicated via FSSA Announcement June 30, 2023 and *IHCP Bulletin BT202380*.

Reconsideration rights

Historically, the final cost profile provided reconsideration rights for all components of the rate calculation. Reconsideration rights will now be communicated through either an announcement, a cover letter and/or a rate letter associated with the following events with responses required within 15 calendar days of notification:



- *Draft cost profile*: Allows reconsideration rights communicated to providers through a cover letter for adjustments and allocations made to cost report data.
- *Total Quality Score (TQS):* Allows reconsideration rights after posted to the Myers and Stauffer website and communication to the provider community is made.
- *Case mix indexes (CMIs)*: Allows reconsideration rights after the final resident rosters are posted to the MDS Web Portal.
- *Schedule Z*: Allows reconsideration rights on qualification determinations.
- *Final cost profile*: Allows limited reconsideration rights related to the calculation of the reimbursement rates, which were not previously granted.

Additional system and process changes

The following sections detail additional system and process changes that are being made.

Non-state government-owned supplemental payment program

Minimum Data Set (MDS) assessments used in establishing the Medicare upper payment limit are changing. Prior to July 1, 2023, only resident assessments active on the last day of the supplemental payment quarter were used in the calculation. Beginning July 1, 2023, the facility's time-weighted resident rosters will be used as the source for Medicaid resident MDS assessment selection for the supplemental payment program.

After conclusion of the state fiscal year, the interim quarterly supplemental payments are subject to a final supplemental payment process. The underlying MDS resident assessments, Medicaid days, Medicare rates and Medicaid rate information will be reconciled to the actual payment period to calculate the final supplemental payment. This will result in the final settlement occurring later than the historical norm to allow sufficient time for claim adjudication.

Change of ownership or structure

For transactions beginning July 1, 2023, the OMPP will determine the nature of the transaction. If the nature of the transaction is determined to be any change in/to/from a related-party management company, or any change in a privately owned or operated nursing facility's ownership (operational license) except for when the seller (or their related entity) becomes the management company, the fiscal period will be determined in accordance with **one** of the following:

- From the start of the provider's required fiscal year through the day immediately preceding the transaction date

  Or
- From the transaction date through Dec. 31

For any fiscal period identified above, a cost report must be filed for the fiscal period that has a minimum of six full calendar months of actual historical data. The cost report is due not later than the last day of the fifth calendar month after the fiscal period or 30 days following notification by the OMPP that the cost report must be filed.

Nonemergency medical transportation (NEMT) add-on

A $1.21 NEMT add-on will be included in the nursing facility Medicaid per diem reimbursement rate. This add-on will be phased-out in future years as facility NEMT cost information is available through cost-report filings.

Total Quality Score (TQS) measures

The nursing facility retention measure (10 quality points) and the advanced care planning measure (5 quality points) have been replaced for the state fiscal year (SFY) 2024 TQS calculation with a staffing ratio measure worth 15 quality points (see Table 1). There are no changes to metrics used to allocate the remaining 85 quality points for SFY 2024.

Table 1 – TQS quality metrics for SFY 2024

SFY 2024 Quality Metrics	Possible Points
Long-Stay Scores (no change)	60
Nursing Home Health Survey (no change)	25
Staffing Ratio (NEW – replacing ACP and Retention)	15

The staffing ratio is derived from data published by the Centers for Medicare & Medicaid Services (CMS). The staffing ratio is calculated as Total Reported Nurse Staffing Hours per Resident Day divided by the Case Mix (Expected) Total Nurse Staffing Hours per Resident Day. The numerator of the staffing ratio score will also include the addition of respiratory therapy hours, payroll based journal job code 24 (Respiratory Therapist) and job code 25 (Respiratory Therapy Technician).

Points for the new staffing ratio metric will be allocated as shown in Table 2. Facilities with a staffing ratio between 0.909 and 1.138 will be allocated points proportionately, depending on where they are in the range.

Table 2 – Staffing ratio and earned points for SFY 2024

SFY 2024 Staffing Ratio	Earned Points
Less than 0.909	0
0.909 to 1.138	Between 0 and 15
1.139 or above	15

For additional information, see the new *Quality Program Manual,* which will be published on the Myers and Stauffer website.

Owner, related party and management (ORPM) limitation

The maximum allowable reimbursement for ORPM will now be limited to a base value of $2.75 per patient day that will be adjusted each year for inflation.

Low utilization/no Medicare cost report providers

The ratios presented in Table 3 will be used in the indirect ancillary cost adjustment calculation for providers that are not required by the Medicare administrative contractor to file a full Medicare cost report (low-utilization cost report).

Table 3 – Ratios used for low utilization/no Medicare cost report providers

Physical therapy	Speech therapy	Occupational therapy	Respiratory therapy	X-ray	Laboratory	Pharmacy
23.11%	28.84%	22.15%	5.49%	2.50%	2.75%	1.60%

Bed days available

Bed days available will now be calculated using the number of licensed beds as of the first calendar day immediately following the cost report period end. However, with the cost report submission, providers may request in writing for the weighted average of the number of beds licensed during the cost report period to be used in the bed days available calculation.

Providers may notify the OMPP in writing when the number of nursing facility beds licensed by Indiana Department of Health (IDOH) changes. Beginning Feb. 1, 2024, provider requests for a change in licensed bed capacity for use in rate setting may be made on a biannual basis as opposed to the historic quarterly process. Notifications must be received by the OMPP by the due dates in Table 4 for incorporation into the biannual rate-setting process.

Table 4 – Due dates for notification of change in nursing facility beds available

Rate effective date	Due date
July 1, Year 1	Jan. 31, Year 1
Jan. 1, Year 2	July 31, Year 1

Sub-regulatory manuals

Certain provisions of the rule and the Indiana Medicaid State Plan have been relocated into supporting policy manuals, which will be published to the Myers and Stauffer website. These manuals are as follows:

- *Indiana Medicaid Provider Reimbursement Manual (IMPRM)* – Replaces the *Instructions for Medicaid Nursing Facility Financial Report*. This document provides instruction for Medicaid cost report completion, definitions of allowable cost, and appropriate rate component and cost classifications.
- *MDS and Case Mix Index Supportive Documentation Manual* – Replaces the *Time-weighted User Guide* and the *Supportive Documentation Requirements User Guide*. This document provides guidance for calculating the Medicaid and facility average CMIs and the related required documentation standards for MDS resident assessment submissions.
- *Quality Program Manual* – This is a new document that details the quality program calculations and relevant source data.

Median calculation cycle

Medians will now be calculated only annually at each July 1 annual rebase.

Long-term care web portal requirement

All providers with cost report year ending after March 31, 2023, are required to sign up for and use the Indiana LTC Cost Reporting Web Portal.

All the information provided in this bulletin is with the expected approval of the state plan amendment and the proposed rule and reflects the current guidance as of the publishing date.

QUESTIONS?

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