Nursing Facility Narrative Instructions

I. The Basis of the UPL Formula

States generally demonstrate, and CMS has accepted as reasonable estimate of, the upper payment limit (UPL) based on a comparison of Medicaid payments to equivalent Medicare payment or Medicaid cost using Medicare principles. States may apply different UPL formulas for state government owned or operated facilities, non-state government owned or operated facilities and private facilities; however, the formula should be consistently applied to each provider within each category.

- Check-off boxes are provided for states to indicate if the demonstration is a cost based demonstration using Medicare cost report data or a Medicaid nursing facility cost report, or a payment based demonstration using the Medicare Resource Utilization Groups (RUGs) with appropriate adjustments to consider population and benefit difference in Medicare and Medicaid.
- States that limit providers to actual incurred Medicaid cost and demonstrate the UPL using the incurred cost methodology should select the cost basis or the nursing facility cost report demonstration (if using a state report) and detail the cost finding methodology in the narrative. Note that incurred Medicaid cost is typically found using Medicare cost principles but entails matching Medicaid charges to individual cost centers on the Medicare cost report or an approved Medicaid cost identification methodology.
- States that choose to deviate from those accepted methodologies should detail the alternative methodology in the "other" text box. Any alternative methodology must present a reasonable estimate of Medicare payment and be must accepted by CMS.
- Within the formula a state should provide a high-level overview of the UPL calculations and enter it in the text box. For instance: (Medicare routine per diem X Medicaid covered days) and (Medicare ancillary cost-to-charge ratio X Medicaid covered ancillary NF charges) = UPL.

II. Source of the UPL Medicare equivalent data

This section describes the source of the data used to estimate a Medicare amount for equivalent Medicaid services. We are using the term "Medicare equivalent" to broadly describe the various methods that states will use to determine the UPL, since the regulations describe the amount that Medicare would pay for equivalent Medicaid services.

- States may use the most recently filed or settled CMS 2540 and 2552 skilled nursing facility and hospital cost reports as the source of the Medicare data. Check-off boxes are provided to indicate if the cost reports are filed or settled.

- States may also use a standard statewide nursing facility cost report as the source of Medicaid cost data. Check-off boxes are provided to indicate if the cost reports are filed or settled.
- State may use the RUGs to calculate Medicare payment equivalent per diems. State should indicate through the check-off box if RUGs is the basis for the UPL calculation.
- If a state uses other data sources for the UPL calculation, the "other" text box should describe the data source and application. The state should explain how the other data sources link or cross-walk to Medicare payment or cost reporting principles.
- To calculate a reasonable Medicare estimate, the data should be from cost reports that are from a reporting period that is no more than two years prior to the current rate year. States should indicate the time period of base year data (the cost report data) and the rate year data and state whether the data is the most recently available to the state.

III. Medicare Cost Report Calculation

Source data from the Medicare cost reports is used to calculate cost-to-charge ratios from the cost centers on the CMS 2540 and 2552 that are used to report nursing facility cost and charge and per diem data. States generally determine a routine facility per diem amount and may apply Medicaid covered ancillary costs to determine the upper cost limit. The specific cost report references are explained in this section.

- Nursing facility cost-to-charge ratios may be calculated from data reported on worksheets B and C of the CMS 2552. The per diem costs are reported on worksheet D-1. Check-off boxes are provided for states to indicate whether worksheets B and/or C are used for a cost-based demonstration.
- Nursing facility cost to charge ratios may be calculated from data reported on worksheets B and C of the CMS 2540. The per diem costs are reported on worksheet D-1. Check-off boxes are provided for states to indicate whether worksheets B or C are used for a cost-based demonstration.
- States should specify the columns and lines from worksheets B, C and/or D that are used to determine the cost-to-charge ratio and the routine per diems.
- A text box is provided to explain additional cost report worksheets, columns and lines that are used in the demonstration. Within the text box, states will need to describe the basis for deviating from the standard references, how the references are applied, and the basis for included additional or alternative cost reporting worksheets, columns or lines.
- A check-box requests that states verify that the ancillary and routine costs are determined per facility.

- State should adjust the cost and charge data to account for differences in the Medicare and Medicaid programs. For instance, Medicare recognizes costs and charges associated with drugs, which are not covered under the Medicaid nursing facility benefit. All necessary adjustments should be detailed in the text box that is provided.

Application of Medicaid ancillary charge data to Medicare ancillary cost-to-charge ratios:

Medicaid adjudicated nursing facility charge data from each of the nursing facilities in the demonstration is applied to each nursing facilities' specific and adjusted ancillary cost-to-charge data. This determines a reasonable Medicare equivalent ancillary cost amount for Medicaid equivalent services. The source, adjustments and exclusions applicable to the Medicaid charge data are described in this section.

- A check-off box is provided for states to indicate that the Medicaid charge data is reported to the MMIS. If the data is from another source, the state should indicate the source of the charge data. Note that CMS will request clarification of the basis for using data that is not adjudicated through the MMIS.
- The Medicaid charge data should be from the same dates of services as the cost reporting period used to derive the cost-to-charge ratios. This is important to ensure that the UPL is a reasonable estimate of Medicare payment since the nursing facility's charges will be uniform for all payers for the reporting period. If the dates of services do no match states should provide an explanation of the discrepancy.
- Only charge data from in-state Medicaid residents should be included in the UPL calculation. This ensures that applied charges are not duplicative among state UPL demonstrations.
- CMS recommends that states exclude cross-over claims, for which Medicare is the primary payer, from the UPL calculation. A state's payment obligation for those claims is governed by the state's third party liability policies rather than the nursing facility reimbursement methodology. In addition, states have struggled to develop a Medicaid payment proxy for those claims that would reasonably compare to the Medicare equivalent estimate and not overstate the UPL. If a state selects that cross-over claims are included, we will need to discuss how the Medicare estimate is not overstated by the inclusion.
- The nursing facility benefit covers services billed and paid to nursing facility providers. Professional services that are covered, billed and paid under the Medicaid state plan should be excluded from the nursing facility UPL. States should confirm that professional services that are covered, billed and paid outside of the nursing facility state plan authority are excluded from the UPL calculation and explain the inclusion of any professional service charges.

Calculation of Medicare routine cost per diem:

Routine costs are consistently recognized across all payers. States often calculate a Medicare routine cost per diem for each facility and apply that to Medicaid covered days to determine the routine portion of the upper payment limit.

- A text box is provided for states to describe the calculation of the Medicare routine cost per diem for nursing facilities within the demonstration. The cost report references and the per diem formula should be explained in this section.
- The state should indicate through the provided check box that the Medicaid covered days are reported from the MMIS.
- If the Medicaid covered days are from a state nursing facility cost report, the state should describe the worksheets, columns and lines used to determine the covered days in the text box.

IV. Medicaid State Nursing Facility Cost Report Calculation

A number of states use an audited state nursing facility cost report to collect cost data from providers. The cost report should clearly cross-walk to the Medicare 2552 and 2540 and be standard for all nursing facilities providers. For purposes of the UPL calculation, states use state nursing facility cost reports to calculate a Medicaid per diem cost and apply the per diem cost to Medicaid days. The total is compared to Medicaid payment data for same dates of service as the cost report period for each facility within the demonstration to determine UPL compliance.

- Within the text box provided, states should describe the state nursing facility cost report and provide a cross walk of the data reported on the state report to the equivalent worksheets, lines and columns from the 2552 and/or 2540. All variations between the state report and the Medicare reports should be noted.
- The treatment of capital expenditures should be clearly explained within the state nursing facility cost report. States should use the text box to describe the capital costs that are recognized for purposes of the UPL calculation.
- In the text box provided, states should describe how the Medicaid reported data is used to calculate a per diem amount for each facility.
- If the Medicaid cost report is used to determine Medicaid covered days, the state should reference the cost report worksheets, columns and lines that serve as the source for Medicaid covered days.
- If MMIS is the source the Medicaid covered days, states should indicate this by checking check box that is provided.

V. Medicare Resource Utilization Groups Calculation

States may use the Medicare RUGs, the system used to set Medicare per diem payment for skilled nursing facilities, as the basis to demonstration a Medicare payment estimate.

- In the text box provided, states should indicate the version of RUGs used for the demonstration and describe how the case mix index is applied to Medicaid nursing home residents.
- States will also need to make necessary adjustments to account for differences between the Medicare RUGs system and the state's Medicaid nursing facility reimbursement policies. For instance, adjustment may be required to account for programmatic differences in the treatment of pharmacy, laboratory and radiology services. States should also discuss how Medicaid bed hold days are factored into the UPL calculation.

VI. Medicaid Payment Data

The Medicare estimate for equivalent Medicaid services is compared to the Medicaid payment data from the demonstration rate year. If the Medicaid payment data is at or below the Medicare estimate the state's nursing facility reimbursement methodology complies with the UPL regulations. The source, adjustments and exclusions applicable to the Medicaid payment data are described in this section.

- The Medicaid payment data should be from adjudicated Medicaid service claims from the MMIS. A check-box is provided to confirm that the source of the payment data is the MMIS. If the state uses a source other than the MMIS for the payment data, please explain the other source in the text box.
- Many states make base payments for nursing facility services and additional supplemental payments that are lump-sum adjustments or add-ons to the base payments. The UPL must include total nursing facility payments made to nursing facility providers (base and supplemental). States must identify the base and supplemental payments separately within the demonstration. If any payments are made outside of the MMIS, we ask the state to explain those payments in the text box that is provided.
- Consistent with the Medicaid charge data, we recommend that states exclude cross-over claims from the Medicaid payment data. State should confirm that cross-over claims are excluded or explain the inclusion of cross-over claims in the Medicaid charge data section where a check-box is provided.
- Consistent with the Medicaid charge data any net adjustments to the Medicaid payment data should be noted in the methodology. If adjustments are made to the Medicaid payment data to consider primary care payments, deductibles and copays, adjustments should also be made to the Medicare payment data.

- As part of the calculation, states should make adjustments for changes in nursing facility payments that occurred between the demonstration period and the current rate year. For instance, if a state has implemented or intends to implement a new supplement payment, the amounts associated with the supplemental payment should be reflected in the Medicaid payment data.
- The amounts reported on the CMS-64 expenditure system for nursing facility payments should match or closely align with the amounts reflected in the base period for the UPL demonstration. We ask the state to verify the consistency with the reported expenditures and the UPL payment data and explain any inconsistencies.

VII. Trends and Adjustments to the UPL Data

Because UPL calculations rely on data from prior periods, states often trend the data to the current rate year using inflationary and volume adjustments. In addition, states may use completion factors for charge and payment data to compensate for claiming lags. All trend sources and trending applications to the UPL data are described in this section.

- States should verify that trends are used for inflation and describe the inflationary trend source and application. CMS has accepted the Medicare economic index inflationary factor for nursing facility services as an appropriate UPL trend.
- State may trend the RUGs data using the RUGs frequency distribution for each facility. If this is applied within the demonstration, the state should indicate so and describe the application.
- The trend data should be applied as a “mid-point to mid-point” application in order to accurately project the trended historic data into the current rate year.
- Volume adjustments may be made to reflect changes in the Medicaid program that have occurred between the base and current rate year periods. The volume adjustment source should be based on data that reflects real program experience and the adjustment must be equally applied to the Medicaid payment and Medicare equivalent data. Within the narrative, states should verify that adjustments are used to account for increases (or decreases) in volume and describe the volume adjustment source and application.
- If the state adjusts UPL data using additional or alternative factors, we have requested an explanation and the basis for those adjustments in the text box provided.
- States occasionally apply completion factors to the Medicaid charge and payment data to account for lags in claims adjudication. The narrative requests that states indicate when claims completion factors are used for charge and payment data, the application of the factors and an assurance that the factors are applied consistently for the charge and payment data.

VIII. State UPL Data Demonstration Structure

Though the UPL is an aggregate demonstration for state government owned or operated, non-state government owned or operated and private facilities, the data is presented for each nursing facility provider that receives Medicaid payments.

- The state is asked to assure that the UPL data demonstrates UPL compliance in the aggregate for state government-owned or operated facilities, non-state government owned or operated facilities, and privately owned or operated facilities. The state must demonstrate compliance distinctly for each nursing facility category. The designation of providers as state government-owned or operated facilities, non-state government owned or operated facilities, and privately owned or operated facilities must be consistent between UPL demonstrations.
- All service providers that receive Medicaid payments under the applicable UPL service category must be included within the UPL calculations. We ask that states confirm the inclusion of all providers in the UPL demonstration.
- All Medicaid payments made to nursing facility providers for services that are covered and paid under the nursing facility benefit category must be included in the demonstration. Base and supplemental payments should be separately identified.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.