Medicaid Case Mix Reimbursement
New Jersey Nursing Facilities

Frequently Asked Questions
Posting May 24, 2011

The following questions were raised during a seminar series offered by Myers and Stauffer LC regarding the new Medicaid Case Mix Reimbursement System for New Jersey's nursing facilities. The seminars were held April 25-27, 2011, at three sites throughout the state. Cost report preparation and filing questions that were submitted after the training sessions are also included.

1. When were the October, January and April rates for the 2010-2011 rate year mailed?

The rate notifications were sent via certified mail May 9, 2011, to the administrator of each Class I and Class II facility. Class III rates are the same as the rates provided on the July 1 rate notification for the entire rate year.

2. Why did my facility receive $17.12 as a Provider Tax Distribution and now you are indicating my facility will only receive $8.88?

The provider tax distribution included in your facility's rate effective June 30, 2010, was comprised of two components: $9.18 as the first add on that represents the Medicaid portion of the provider tax paid by your facility and $7.94 as the Quality add on. The funding previously used for the Quality add on is now used as a portion of the funding for the case mix system and is not provided as a separate add on. The first add on amount has changed from $9.18 for the 2009-2010 rate year to $8.88 for the 2010-2011 rate year for facilities that are not exempt from the provider tax.

3. Is the phase-in provision that indicates my nursing facility's case mix rate can be no more than $5.00 above my June 30, 2010, rate and no less than $5.00 below that rate calculated in a cumulative manner by rate quarter? How about next year when then phase-in provision increases to $10.00?

The phase-in provision is not cumulative but rather each quarter's calculated case mix rate is independently compared to the nursing facility's rate in effect on June 30, 2010, exclusive of the provider tax first add on amount. For the 2011-2012 rate year, the same June 30, 2010, rate will be used to determine if the calculated case mix rate is within $10.00 of the June 30 rate.

4. Can Myers and Stauffer include the formulas used to calculate the rates in the spreadsheet posted on the Myers and Stauffer New Jersey Web site?

For the October, January and April rates, a Quarterly Adjusted Rates Description document was posted along with the rate spreadsheets that explains the content of the rate spreadsheets and provides the formulas used to calculate significant
rate components. This document can be found at http://nj.mslc.com/Downloads.aspx

5. If my facility did not submit an FRV Data Report or the submitted report was in error, how do we rectify that and when would the submitted report affect my rate?

Based on a response to a comment received regarding the proposed N.J.A.C. 8:85 regulation, the Department will allow updates to the FRV data report to allow the revision of the FRV allowance based on new FRV data reports submitted to the Department’s contractor. The effective date of any change to the nursing facility’s rate will be the next quarterly adjusted rate calculated after receipt of the information. For example, an updated FRV data report received May 30, 2011, will affect rates for July 1, 2011, and after and will not be retroactive to July 1, 2010.

6. When is the FRV Re-Age Request due?

The FRV Re-Age Request is due by June 15 preceding the rate year.

7. Can the statewide case mix indices for each resident roster quarter be published on the Myers and Stauffer New Jersey Web site?

The statewide case mix indices for the four resident roster quarters in 2010 have been posted at http://nj.mslc.com/Downloads.aspx and will be updated following each resident roster quarter.

8. Will the due date for the 12/31/2010 YE cost reports be extended since the cost reporting Medicaid supplemental schedules were not finalized until May 2011?

The due date for the December 31, 2010, cost reports has been extended to June 30, 2011. Subsequent cost reporting years are due on May 31 following the end of the cost reporting period.

9. When will the calendar year 2010 cost reports be used in the case mix system? What cost reports will be used to rebase the Direct Care portion of our rates for the 2011-2012 rate year?

The cost reports for the period ending December 31, 2010, are due June 30, 2011. Assuming those reports are validated by May 1, 2012, they will be used in the rebasing of the Direct Care limit for the 2012-2013 rate year as well as setting the Direct Care rate. The Direct Care limit and rates for the 2011-2012 rate year will primarily be based on 2009 cost reports.

10. Are nursing facilities allowed to submit corrections or modifications to their cost report after the original submission?
A nursing facility cost report cannot be substituted or revised by a nursing facility unless the substitution/revision would prevent an overpayment to the facility.

11. The NHA-100 days for the provider tax are submitted separately for facilities that have both a NF and a Special Care Nursing Facility (SCNF) unit. Do we need to complete the Medicaid supplemental Schedule B-1 twice?

A separate Schedule B-1 for SCNFs has been added to the Medicaid supplemental schedules.

12. Does an original Medicaid supplemental Certification Schedule need to be mailed or can the signed Certification Schedule be scanned and e-mailed with the remainder of the cost report and supporting documents?

It is acceptable to scan the signed Certification Schedule and e-mail the document with the other cost report and supporting document information.

13. What cost reporting forms need to be completed and submitted for NFs that had a change of ownership (CHOW) in 2010 and under what circumstances are those required to be file?

The Department is aware of CHOWs that occurred in August 2010 and December 2010. The previous owner is requested to complete the Medicare cost report with supporting Medicaid schedules for the period January 1, 2010, through the last date of ownership. If those reports cover more than a six-month period, the reports will pass to the new owner and be used in the 2012-13 rate year Direct Care rebasing process. For CHOWs occurring in August 2010, the new owner should complete the Medicare cost report with supporting Medicaid schedules from the date of ownership through December 31, 2010, even though those reports will not be eligible for inclusion in the rate setting process. For CHOWs occurring in December 2010, the new owner should complete the Medicare cost report with supporting Medicaid schedules from the date of ownership through December 31, 2011, which follows the Provider Reimbursement Manual Section 102.1. In this situation, there is no need to notify the Department that the nursing facility will not be filing a December 31, 2010, year end cost report.

For years after December 31, 2010, the previous owner will be required to file a closing cost report as a provision will be added in follow-up regulation to identify the penalty for non-compliance.

14. If the cost report files and supporting documentation are e-mailed on or before the due date, does that meet the due date requirement? For cost reports that are mailed, is the submission date the date the information was mailed or the date the information was received?

Due date compliance is measured by the date either the e-mail or mailed information is received.
15. My facility has a SCNF unit. Do we complete a separate Medicare cost report and supporting Medicaid supplemental schedules?

A separate cost report for the SCNF unit should not be completed for the period ending December 31, 2010, and after, but rather the combined NF/SCNF operation should be reported as two service units on the 2540 filed with the Medicaid program. The direct cost associated with each unit should be placed on a separate routine cost center line. For example, the NF should be on the nursing facility line, and the SCNF could be on an Other LTC line. The statistics will need to be adjusted to separate the NF stats from the SCNF stats. This approach will allow for separate cost allocations from the general service (overhead) cost centers to the NF and SCNF units. The supplemental cost report (Medicaid forms) will need to be completed to provide additional information in order to set payment rates for the NF and SCNF.

16. On the Crosswalk form included with the Medicaid supplemental schedules, nursing administration appears to be assigned to the Direct Care – non case mix adjusted rate category. On the current cost study form, those costs are grouped into the Operating and Administrative category. Please explain this discrepancy.

In the transition to using the Medicare cost reporting forms, there was no intent to change the cost category into which any particular type of costs were placed when compared to those reported on the Cost Studies for periods prior to December 31, 2010. Rather it appears there is a need to define what type of costs are included in nursing administration for purposes of case mix reimbursement. Therefore, the final Crosswalk and supplemental Medicaid schedules have been altered to indicate the positions of Director of Nursing (DON) and Assistant (ADON) are included in Direct Care Case-Mix Adjusted, other positions that were previously identified as nursing administration such as Ward Clerks, MDS Coordinator, QA Coordinator and Inservice Coordinator are included in the Operating and Administrative cost center.

17. The Crosswalk indicates that medical supplies placed on line 10 (central supply) will be included in the direct care rate but medical supplies included on line 29 (medical supplies charged to patients) will not be included in the rates. What is the logic behind the separate treatment of medical supplies? In addition, many nursing facilities do not split their billable vs. non-billable supplies when recording the expense. In this situation, how should medical supplies be recorded?

The reimbursement methodology excludes the direct cost of ancillary services from allowable cost, but recognizes overhead (general service) costs that are stepped down to the ancillary cost centers as allowable costs. This cost treatment was agreed upon during the development of the reimbursement methodology. It reflects a compromise that recognizes most Medicaid nursing facility residents have Medicare Part B coverage, and is a process used instead
of removing both the direct and indirect ancillary service cost applicable to Medicare Part A and Part B, and other non-Medicaid payers.

The Department will rely upon the distinction between routine and ancillary services as defined in the Medicare and Medicaid Provider Reimbursement Manual. Please refer to Sections 2202.6 and 2202.8.

18. What is being included in the definition of medical supplies? Does it include the handling of oxygen in a respiratory unit, supplies like catheters, colostomy, ostomy, trach kits etc.

Medical supplies (routine services) verses medical supplies charged to patients (ancillary services) are distinguished based on the charge practices of the provider. Please refer to the Provider Reimbursement Manual (PRM) Sections 2202.6 and 2202.8.

19. Are dietary supplements and enteral supplies considered a medical supply to be included in the Direct Care rate component?

Dietary supplements and enteral supplies that are not ancillary services will be included in the dietary cost center, which is part of the operating and administration section of the rate.

20. Are disposable diapers considered laundry and linen?

Disposable diapers that are not ancillary services may be reported as laundry and linen.

21. For the Employee Benefits cost center, there is a difference in what is posted to this cost center versus what shows up in Exhibit 6 of the CMS-339. Is the Department adopting Exhibit 6 as the only fringe benefits to be considered or will anything properly posted to the Employee Benefits cost center (line 3 on the Medicare CR) be allowed? For instance, uniform costs are expressly not included in Exhibit 6 but none the less is a bona fide fringe benefit posted to line 3 on the Medicare cost report. Other examples are employee physicals, holiday parties, and sympathy or congratulatory gifts/flowers to employees.

The intent is to recognize as employee benefits the expenses properly reported on line three of the cost report, which may include costs not shown on the 339. Only those costs properly reported on line three of the cost report will be recognized as employee benefits. For example, an automobile leased for the administrator is not an employee benefit. The cost is considered part of the administrator’s compensation and should be reported as such.

22. The leases referred to in N.J.A.C. 8:85-3.7(f) are not clear. Does the FRV Allowance cover just building leases or also equipment leases/rentals such as minor equipment "rentals" and copy machines that could be posted to the capital cost category?
All capital costs reported on lines 1 and 2 of the Medicare cost report will be reimbursed through the FRV allowance. Minor equipment rentals (e.g., copy machines) may be expensed within the general or routine service cost centers they service per cost report requirements. The leases will not be reclassed to the capital cost center, but the expenses will be recognized where properly reported within the cost report.

23. Will chaplin personnel be considered as a direct care component under social services or in the activities cost center or administrative?

The chaplin’s job function will determine where the expense should be reported. For example, if the chaplin is performing social service or activity functions, and meets all credentialing requirements, then the costs should be recognized in the cost center served.

24. The checklist included with the supplemental Medicaid schedules indicates that a Monthly Census Summary by Resident Name and Payor Source is needed as supporting documentation. I have concerns about e-mailing this type of information and question whether that degree of detail is necessary for the validation of the cost report.

The request to include a monthly census summary has been removed from the checklist. However, census information may be requested during the cost report validation or audit process when deemed necessary by the auditor.

25. The cost instructions do not specify what media is to be used for transmitting the Medicare ECR and Medicaid Excel file when filing the cost report. Are 3.5” floppy disks, CDs and travel drives all acceptable formats?

Yes.

26. When submitting the cost report by e-mail, is there a limit to the size of a file attachment?

There is no limit on the receiving e-mail system. However, if the attachments are large, there will be a delay before the e-mail is delivered. Therefore, any attachment larger than 30MB should be sent on CD.

27. A County nursing facility files employment information together with all other county entities. What should be provided for the requested copy of 941s or state unemployment reports in this instance?

In this situation, whatever supporting schedule was used to identify the County NFs portion of salaries should be submitted with the cost report.

28. The Medicaid supplemental Schedule C, part C-2 requires the identification of separate salaries, taxes and general benefits and other contract fees for all direct care services obtained through a contractual situation. Is this also
required when the contract is directly with the person providing the service or only when the contract is with an intermediary party?

The Department has granted a blanket waiver of reporting the breakout of contract fees for the NF’s Pharmacy Consultant and Medical Director. In addition, if the total contracted Direct Health services are less than 25 percent of total Direct Health salaries, fringe benefits and contract fees, the break out of contracted services has been waived.