Payment Methodology
Nursing Facility

- South Dakota's reimbursement method pays a daily rate unique to each resident. Rates for residents with special or heavy care needs are higher while those with less needs are lower. This methodology is referred to as a "case mix methodology".
- A resident's care needs are identified through an assessment called the Minimum Data Set (MDS). The MDS is used to collect data regarding the individual's functional capacity including basic self care activities such as health, bathing, dressing, toileting, eating, and transferring. The assessments are completed by the nursing home staff and monitored by state staff.
- Each level of care from the MDS is assigned a Case Mix Weight.

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- Case mix scores range anywhere from .59 for an individual with lower care needs to 2.67 for a resident that requires extensive care.
  - Statewide average case mix: 1.22 State Fiscal Year 2019
- In addition to the individual resident assessment, a cost report is submitted annually by the facility and subject to review annually. The cost report also includes the number of residents served during the year.
- Nursing facilities utilize a range of timeframes for cost reporting with fiscal year ends ranging from December 31 to March 31. This impacts the lag time between submission of the data and use for rate setting.

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- "Ceilings" or limitations are applied to allowable costs based on a comparison of costs in each category among all facilities.
  - Administration
  - Direct Care
  - Non Direct Care
  - Capital
  - Occupancy
- Ceilings are applied to all allowable costs.
- A minimum occupancy level based on licensed beds is imputed for providers when actual occupancy falls below the statewide average. Incentive for providers to align licensed bed capacity closely to actual occupancy.
- A facility specific direct care and non direct care rate are established.

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South Dakota's current Medicaid reimbursement methodology for nursing facilities is a **prospective cost-based system:**

- Rates are established based upon actual costs incurred prior to the time during which the rates apply.
- Costs are inflated forward from each facility's individual cost report year to the rate year based upon the projected increase in the CPI for that time frame.
- Includes a minimum occupancy standard limiting the percentage of unoccupied licensed beds recognized for rate setting based on the statewide average occupancy for all nursing facilities.
- Includes cost ceilings by category of costs based upon statewide averages.

Rates are **facility specific** and **resident specific**

DHS

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Costs are segregated into direct care and non-direct care costs and daily rates are calculated separately for each:

- **Direct care costs** include only the costs associated with providing direct care to the residents such as nursing, nursing supplies and therapies.
  - Direct care rates are impacted by the **case mix score** of a facility's residents.
  - The case mix score identifies the individual care needs of each nursing facility resident, and range from a low of .59 for a resident that needs very little care to a high of 2.67 for a resident that requires extensive care.
  - The individual residents' case mix score is applied to the facilities direct care rate and then added to the facility's non-direct care rate to determine the total daily rate for each resident in the facility.
- **Non direct care costs** include health and subsistence, administration, plant and operational, and capital.

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Rates are calculated assuming a minimum percentage of occupied licensed beds:

- Costs inflated to the rate year are divided by resident days to calculate daily rates.
- A minimum occupancy limitation of three percent below the statewide average of occupied beds is assumed when calculating the daily rate for each facility.
- Declining occupancy has had a significant impact on the nursing home industry in South Dakota, as well as the Medicaid program. As statewide average occupancy declines, average costs per resident day grow.

DHS

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Cost ceilings: Case Mix Adjusted Direct Care:

- **Case mix adjusted direct care costs** (costs associated with resident care)
  - All of a facility's allowable costs are recognized up to a ceiling of 115 percent of the median cost of all nursing facilities
  - Between a minimum ceiling of 115% and a maximum ceiling of 125% of the median cost. 80% of the costs are recognized.
- The ceiling for direct care is higher than other ceilings, to ensure appropriate resident care.

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Cost Ceilings: Non-direct Care

- **Health & subsistence, plant & operational, and other operating:**
  - All of a facility's allowable costs are recognized up to a ceiling of 105 percent of the median cost of all nursing facilities.
  - Between 105 percent and 110 percent of the median cost only 80% of the costs are recognized.
- **Administration:**
  - All of a facility's allowable costs are recognized up to 105 percent of the median cost of all freestanding non-chain organization affiliated nursing facilities.
  - A second ceiling is established at 110 percent of the median cost of all freestanding non-chain organization affiliated nursing facilities. Between 105 and 110 percent of the median cost only 80% of the costs are recognized.
  - Chain organizations' administrative costs are not included in the calculation to determine the ceiling, since costs associated with the central operation of those facilities are often much greater than non-chain nursing facilities.

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Other Ceilings and Limitations

- **Capital**
  - Capital costs are currently a maximum of $16.19 per resident day increased each July 1 by the annual inflationary rate change
- **Overall Ceiling**
  - Annual rate increases are limited to 8% over the prior period's rate.
  - If a facility's rate increases more than 8%, the non-direct care rate is adjusted, rather than adjusting the direct care rate and potentially impacting appropriate resident care.

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- When facilities are reimbursed for services, the direct care component of the rate is multiplied by the resident's case mix score resulting in an individualized rate for each resident based on their specific care needs.

The total rate is calculated by:

Facility Direct Care Rate X Resident Case Mix + Facility Non Direct Care Rate = Total Rate per day

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Example 1: higher care needs

Sally's care requirements put her in the Extensive Category for reimbursement. Sally needs the assistance of 2 staff for multiple assistive daily living categories (bathing, dressing, assistance with feeding) along with a diagnosis of Multiple Sclerosis, IV Medication, and oxygen therapy.

Before Case Mix Adjustment:
Direct Care rate $54.78
Non-Direct Care rate $77.44
Total rate $132.22
Case Mix weight 2.67

After Case Mix Adjustment:
$54.78 * 2.67 = $146.26 + $77.44 = Total Daily Rate $223.70

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Example 2: lower care needs

Sue requires minimal assistance with assistive daily living activities, has mild cognitive decline and requires restorative therapy 3 days per week.

Before Case Mix Adjustment
Direct Care rate $54.78
Non-Direct Care rate $77.44
Total rate $132.22
Case Mix weight .59

After Case Mix Adjustment
$54.78 * .59 = $32.32 + $77.44 = Total Daily Rate $109.76

- Specialized populations - wound care, challenging behaviors, traumatic brain injury include additional cost of providing specialized services not captured through the case mix methodology.

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