**R414. Health and Human Services, Integrated Healthcare.**

**R414-504. Nursing Facility Payments.**

**R414-504-1. Introduction.**

(1) This rule adopts a case mix or severity-based payment system for nursing facilities that are not intermediate care facilities for persons with intellectual disabilities (ICF/IDs). This system reimburses facilities based on the case mix index of the facility. It also establishes rates for ICF/ID facilities.

(2) This rule is authorized by Sections 26B-1-213, 26B-3-108, and Title 26B, Chapter 3.

**R414-504-2. Definitions.**

The definitions in Sections R414-1-2 and R414-501-2 apply to this rule. In addition:

(1) "Bed addition" means, as used in the fair rental value calculation, a capitalized project that adds additional beds to the facility. This must be new and complete construction. An increase in total licensed beds and new construction costs support a claim of additional beds.

(2) "Bed replacement" means, as used in the fair rental value calculation, a capitalized project that furnishes a bed in the place of another, previously existing bed. Room remodeling is not a replacement of beds. This must be new and complete construction.

(3) "Behaviorally complex resident" means a long-term care resident with a severe, medically based behavior disorder, including traumatic brain injury, dementia, Alzheimer's, Huntington's Chorea, which causes diminished capacity for judgment, retention of information or decision-making skills, or a resident, who meets the Medicaid criteria for nursing facility level of care and who has a medically based mental health disorder or diagnosis and has a high level resource use in the nursing facility not currently recognized in the case mix.

(4) "Case mix index" means a score assigned to each facility based on the average of the Medicaid patients' case mix scores for that facility.

(5) "Case mix score" means the acuity or frailty of a resident based on medical needs resulting in a weight used to calculate rates.

(6) "Exception qualifying major renovation" means for purposes of a moratorium exception, a project in a facility that undergoes major renovations that involve significant structural changes of the physical facility and requires review and approval under Rule 432-4. The renovation includes a cost greater than or equal to $5,000 for total licensed beds and excludes flooring and paint.

(7) "Facility case mix rate" means the rate the Department issues to a facility for a specified period. This rate utilizes the case mix index for a provider, labor wage index application, and other case mix-related costs.

(8) "Fair rental value (FRV) data report" means a report that provides the Department with information related to capital improvements to be included in the FRV calculation.

(9) "FCP" means the facility cost profile report filed by the provider on an annual basis.

(10) "Major renovation" means, as used in the fair rental value calculation, a capitalized project with a cost equal to or greater than $500 for a licensed bed. A renovation extends the life, increases the productivity, or significantly improves the safety, such as by asbestos removal, of a facility as opposed to repairs and maintenance that either restore the facility to, or maintain it at its normal or expected service life. Vehicle costs are not a major renovation capital expenditure.

(11) "Minimum data set" (MDS) means a set of screening, clinical, and functional status elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for residents of long-term care facilities certified to participate in Medicaid.

(12) "Nursing costs" means the current costs from the annual FCP report reported on lines 070-012 Nursing Admin Salaries and Wages, 070-013 Nursing Admin Tax and Benefits, 070-040 Nursing Direct Care Salaries and Wages, 070-041 Nursing Direct Care Tax and Benefits, and 070-050 Purchased Nursing Services.

(13) "Nursing facility" or "facility" means a Medicaid-participating nursing facility, skilled nursing facility, or a combination thereof, as defined in 42 USC 1396r (a), 42 CFR 440.150, 42 CFR 442.12, and Section 26B-2-201.

(14) "Patient day" means the care of one patient during a day of service, excluding the day of discharge.

(15) "Patient-driven payment model" (PDPM) means the Medicare prospective payment system for classifying skilled nursing facility patients in a covered Medicare Part A stay.

(16) "Property costs" means the fair rental value (FRV) established by this rule.

**R414-504-3. Principles of Facility Case Mix Rates and Other Payments.**

The principles in this section apply to the payment of freestanding and provider-based nursing facilities for services provided to a qualified Medicaid patient. This rule does not affect the system for reimbursement for intensive-skilled Medicaid patient add-on amounts.

(1)(a) A portion of total payments to nursing facilities for qualified Medicaid patients is based on a prospective facility case mix rate.

(b) These facilities shall be paid a flat basic operating expense payment. The balance of the total payments will be paid in aggregate to facilities as required by this section based on other authorized factors, including property and behaviorally complex residents, in the proportion that each facility qualifies for the factor.

(2) Each quarter, the department shall calculate a new case mix index for each nursing facility. The case mix index is based on three months of MDS assessment data. The case mix index is applied to a new rate at the beginning of a quarter according to the following schedule:

(a) January, February, and March MDS assessments are used for July 1 rates.

(b) April, May, and June MDS assessments are used for October 1 rates.

(c) July, August, and September MDS assessments are used for January 1 rates.

(d) October, November, and December MDS assessments are used for April 1 rates.

(3) MDS data is used in calculating each facility's case mix index and upper payment limit gap.

(a) Each facility shall submit MDS data and is responsible for the accuracy of that data.

(b) Each facility shall ensure needed sections of the MDS are completed so that a PDPM or resource utilization group score may be calculated.

(c) The department may exclude inaccurate or incomplete MDS data from a calculation.

(4)(a) An MDS assessment for a patient who is eligible for the intensive skilled add-on are excluded from the case mix calculation.

(b) The state average case mix index excludes:

(i) a facility with less than 20% of the facility's total census days as Medicaid fee-for-service paid days, as reported on the facility's FCP or FRV data report; or

(ii) a facility having less than six months of data reported under Rule R414-401.

(c) The state average case mix index is used to set the rate for:

(i) a facility with less than 20% of the facility's total census days as Medicaid fee-for-service paid days, as reported on the facility's FCP or FRV data report; or

(ii) a facility having less than six months of data reported under Rule R414-401.

(5)(a) A facility may apply for a special add-on rate for behaviorally complex residents by filing a written request with the Division of Integrated Healthcare (DIH).

(b) The department may approve an add-on rate if an assessment of the acuity and needs of the patient demonstrates that the facility is not adequately reimbursed by the case mix score for that patient. The rate is added on for the specific resident's payment and is not subsumed as part of the facility case mix rate. The Office of Long-Term Services and Supports determines qualification for any additional payment.

(c) DIH shall determine the amount of any add-on.

(6) The department pays any property cost separately from the case mix rate.

(7) Reimbursement for a nursing home rate is in accordance with Attachment 4.19-D of the Medicaid State Plan, which is incorporated by reference in Section R414-1-5.

(8)(a) A provider may challenge the rate set pursuant to this rule using the appeal in Rule R410-14. This applies to which rate methodology is used and to the specifics of implementation of the methodology.

(b) A provider must exhaust administrative remedies before challenging rates in any other forum.

(9) The department reimburses swing beds, transitional care unit beds, and small health care facility beds that are used as nursing facility beds, using the prior calendar year statewide average of the daily nursing facility rate.

(10) Unless specified otherwise, the department may withhold Title XIX payments from providers if:

(a) there is a shortage in a resident trust account managed by the facility;

(b) the facility fails to submit a complete and accurate FCP, as required by Attachment 4.19-D of the Medicaid State Plan;

(c) the facility fails to submit timely and accurate MDS data;

(d) the facility owes money to DIH because of an overpayment, nursing care facility assessment, civil money penalty, or other offset; or

(e) the facility fails to respond within ten business days to a written request for information.

(11) The department shall provide written notice before withholding any payment.

(12) When the department rescinds withholding of a payment to a provider, it will, without notice, resume payments according to the regular claims payment cycle.

(a) For ongoing operations, the department shall provide notice before withholding any payment.

(b) The department and provider may negotiate a repayment schedule acceptable to the department for any money owed to the department listed in Subsection R414-504-3(10).

(c) The repayment schedule may not exceed 180 days.

(d) When the department rescinds withholding of a payment to a facility, it will resume payments according to the regular claims payment cycle.

**R414-504-4. Quality Improvement Incentive.**

(1) Reimbursement for Nursing Home Quality Improvement Incentives is in accordance with Attachment 4.19-D of the Medicaid State Plan, which is incorporated by reference in Rule R414-1.

(2) DIH staff are not required to request additional information relating to any application submission.

(3) Providers shall ensure all necessary information is included in the application to qualify.

(4) For applications received and reviewed by DIH staff before the annual submission deadline, if the application is incorrect or lacks sufficient supporting documentation, then the application shall be denied. If it is received before the annual submission deadline, the provider may submit a subsequent application that includes all needed supporting documentation for consideration.

(5) For applications received before the annual submission deadline and reviewed by DIH staff after the annual submission deadline, then the provider's application may be considered for qualification of a reduced amount, where possible, based on the submitted documentation.

(6) In all cases, the Department does not accept additional applications, documentation, or explanation if submitted after the annual submission deadline.

**R414-504-5. Reimbursement for Intermediate Care Facilities for Persons with Intellectual Disabilities.**

The following principles apply to the payment of community-based ICF/IDs licensed under Section 26B-2-212.

(1) The Department pays according to rates established in Attachment 4.19-D of the Medicaid State Plan.

(2)(a) Reimbursement for the ICF/ID quality improvement incentive is in accordance with Attachment 4.19-D of the Medicaid State Plan, which is incorporated by reference in Rule R414-1.

(b) DIH staff are not required to request additional information relating to any application submission.

(c) Providers must ensure they include necessary information in the application to qualify.

(d) For applications received and reviewed by DIH staff before the annual submission deadline, the Department shall deny them if they are incorrect or lack sufficient supporting documentation. If the Department receives an application before the annual submission deadline, the provider may submit a subsequent application that includes needed supporting documentation for consideration.

(e) For applications received before the annual submission deadline and reviewed by DIH staff after the annual submission deadline, the Department may consider the provider's application for qualification of a reduced amount, where possible, based on the submitted documentation.

(f) The Department does not accept additional applications, documentation, or explanation if submitted after the annual submission deadline.

**R414-504-6. Moratorium Exception for Major Renovation as Allowable.**

(1) In accordance with Subsection 26B-3-311(7), a facility that requests to include beds as part of an exception qualifying major renovation, must submit to the Division of Integrated Healthcare an application within six months of approval of completing the renovation.

(2) The requirement of $5,000 for each bed excludes interest payments, and calculates costs related only to the exception qualifying major renovation as prescribed under Subsection 26B-3-311(7).

**KEY: Medicaid**

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