249K.3 General provisions — instant relief — nondirect care limit exception.

1. A provider that constructs a complete replacement, makes major renovations to, or newly constructs a nursing facility may be entitled to the rate relief and exceptions provided under this chapter. The total period during which a provider may participate in any relief shall not exceed two years. The total period during which a provider may participate in any nondirect care limit exception shall not exceed ten years. A provider seeking assistance under this chapter may request both instant relief and the nondirect care limit exception.

2. If the provider requests instant relief, the following provisions shall apply:

a. The provider shall submit a written request for instant relief to the Medicaid program explaining the nature, timing, and goals of the project and the time period during which the relief is requested. The written request shall clearly state if the provider is also requesting the nondirect care limit exception. The written request for instant relief shall be submitted no earlier than thirty days prior to the placement of the provider's assets in service. The written request for relief shall provide adequate details to calculate the estimated value of relief including but not limited to the total cost of the project, the estimated annual depreciation expenses using generally accepted accounting principles, the estimated useful life based upon existing medical assistance and Medicare provisions, and a copy of the most current depreciation schedule. If interest expenses are included, a copy of the general terms of the debt service and the estimated annual amount of the interest expenses shall be submitted with the written request for relief.

b. The following shall apply to the value of relief amount:

(1) If interest expenses are disclosed, the amount of these expenses shall be added to the value of relief.

(2) The calculation of the estimated value of relief shall take into consideration the removal of existing assets and debt service.

(3) The calculation of the estimated value of relief shall be demonstrated as an amount per patient day to be added to the nondirect care component for the relevant period. The estimated annual patient days for this calculation shall be determined based upon budgeted amounts or the most recent annual total as demonstrated on the provider's Medicaid financial and statistical report. For the purposes of calculating the per diem relief, total patient days shall be the greater of the estimated annual patient days or eighty-five percent of the facility's estimated licensed capacity.

(4) The combination of the nondirect care component and the estimated value of relief shall not exceed one hundred and ten percent of the nondirect care median for the relevant period. If a nondirect care limit exception has been requested and granted, the combination of the nondirect care component and the estimated value of relief shall not exceed one hundred twenty percent of the nondirect care median for the relevant period.

c. Instant relief granted under this subsection shall begin the first day of the calendar quarter following placement of the provider's assets in service. If the required information to calculate the instant relief, as specified in paragraph "*a*", is not submitted prior to the first day of the calendar quarter following placement of the provider's assets in service, instant relief shall instead begin on the first day of the calendar quarter following receipt of the required information.

d. Instant relief granted under this subsection shall be terminated at the time of the provider's subsequent biannual rebasing when the submission of the annual cost report for the provider includes the new replacement costs and the annual property costs reflect the new assets.

e. During the period in which instant relief is granted, the Medicaid program shall recalculate the value of the instant relief based on allowable costs and patient days reported on the annual financial and statistical report. For purposes of calculating the per diem relief, total patient days shall be the greater of actual annual patient days or eighty-five percent of the facility's licensed capacity. The actual value of relief shall be added to the nondirect care component for the relevant period, not to exceed one hundred ten percent of the nondirect care median for the relevant period or not to exceed one hundred twenty percent of the nondirect care median for the relevant period if the nondirect care limit

exception is requested and granted. The provider's quarterly rates for the relevant period shall be retroactively adjusted to reflect the revised nondirect care rate. All claims with dates of service from the date that instant relief is granted to the date that the instant relief is terminated shall be repriced to reflect the actual value of the instant relief per diem utilizing a mass adjustment.

3. If the provider requests the nondirect care limit exception, all of the following shall apply:

a. The nondirect care limit for the rate setting period shall be increased to one hundred and twenty percent of the median for the relevant period.

b. The exception period shall not exceed a period of two years. If the provider is requesting only the nondirect care limit exception, the request shall be submitted within sixty days of the release of the July 1 rate determination letters following each biannual rebasing cycle, and shall be effective the first day of the month following receipt of the request. If applicable, the provider shall identify any time period in which instant relief was granted and shall indicate how many times the instant relief or nondirect care limit exception was granted previously.

2007 Acts, ch 219, §37, 41, 43; 2023 Acts, ch 19, §821
Referred to in §249K.4
Subsection 2, paragraphs a and e amended