
Glossary

Activities of daily living (ADLs): A set of measures used to gauge a person's ability to perform basic self-care tasks such as: eating, bathing, dressing, getting to and using the bathroom, and getting in and out of a chair or bed. A person may require assistance from others to perform these activities. A nursing home resident's ability to perform ADLs are usually classified as independent, requiring assistance, or dependent. States frequently use a person's ability to perform these activities as one factor in defining a person's case-mix category.

Allowable costs: Allowable costs are a facility's actual costs that are eligible for reimbursement after appropriate adjustments as required by state Medicaid regulations. Allowable costs include the routine costs of nursing home services needed to provide quality care.

Ancillary services: Ancillary services include physical, speech and other therapies, prescription and non-prescription drugs, medical services, durable medical supplies, and medical transportation services. Ancillary services may be included in the Medicaid nursing home reimbursement rate or billed to Medicaid separately and outside of the rate. The level and type of ancillary services included in the Medicaid nursing home reimbursement rate differ among the states examined.

Care-related or direct-care costs: Each state examined defines care-related or direct-care costs differently. Care-related or direct-care costs generally include nursing salaries and supplies, therapies, pharmacy, and other direct patient care services. In Minnesota, social services, activities, raw food and dietary consultant fees are also included in care-related costs.

Case mix: Case mix classifies residents based on dependencies in activities of daily living, needs for special nursing, and behavioral conditions. In states with case-mix classification systems, nursing home residents are assessed and assigned a case-mix score. Higher case-mix scores are assigned to residents with higher care needs. Then, case-mix scores are used to adjust nursing or direct-care rates and reflect differences in the costs of providing care. Minnesota, North Dakota and South Dakota use different case-mix systems: Minnesota has 11 case-mix categories, compared with 16 in North Dakota and 35 in South Dakota.

Cost reporting year: The cost reporting year is the year for which a nursing home incurs costs which are used to set a future reimbursement rate. In Minnesota, the cost report year runs from October 1 to September 30. North Dakota's cost year runs from July 1 to June 30. In Iowa, South Dakota and Wisconsin, cost reporting years are based on each nursing home provider's fiscal year.

Freestanding nursing home: Freestanding nursing homes are not affiliated with or attached to a hospital.

Hospital-attached nursing home: Specific definitions vary by state, however, a nursing home is "hospital-attached" if it shares a building, specific services, and/or costs with an adjoining or nearby hospital. In Minnesota, a nursing home is considered hospital-attached if it is recognized by the federal Medicare program to be a hospital-based nursing facility for purposes of being subject to higher cost limits and uses the Medicare cost reporting format. In some instances in Minnesota, multiple nursing homes in different locations from a hospital may also be considered attached facilities. To be considered a "hospital-attached" nursing home, effective for the 1995 rate year, any additional homes must be physically attached or connected by a tunnel or skyway to a hospital, or be recognized as hospital-attached by Medicare as of January 1, 1995, and must have continuously maintained this status. (*Minn. Stat. §256B.431, Subd. 2(j)(c).*)

Nursing facility: A nursing facility is "an institution which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons; or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services which can be made available to them only through institutional facilities." (Omnibus Budget Reconciliation Act of 1987 (OBRA), Laws of 100th Congress First Session, Public Law 100-203, Subtitle C: Nursing Homes Reform, Part 2 Medicaid Program, Section 1919(a).)

Until 1990, the federal government classified nursing homes into two categories: skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). SNFs provided 24-hour nursing care which was prescribed by a physician with a registered nurse working on the day shift seven days a week. SNFs provided the highest possible level of care. In contrast, ICFs generally were required to have only one licensed nurse working on the day shift seven days a week. After October 1, 1990, all nursing facilities are required to provide 24-hour nursing care.

Omnibus Budget Reconciliation Act of 1987 (OBRA): Federal nursing home reform legislation which required states to improve access to and quality in Medicaid and Medicare facilities, mandated comprehensive assessment and care planning, and eliminated the distinctions between intermediate care facilities and skilled nursing facilities. (Swan, et. al., *Medicaid Nursing Facility Reimbursement Methods Through 1994*, 5.)

Other operating costs: Each state defines, groups and names other operating costs differently. Other operating costs generally include dietary, housekeeping, laundry and linen, plant operations and maintenance, and general and administrative expenditures, as adjusted by state Medicaid regulations on allowed costs.

Pass-through costs: Pass-through costs are reimbursed without application of a cost limitation.

Productive nursing hours: In Minnesota, productive nursing hours are on-duty hours during which nurses and nursing assistants are engaged in nursing duties. Productive hours exclude vacations, holidays, sick leave, in-service training, and lunches. (*Minn. Stat.* §144A.04, Subd. 7.)

Prospective facility-specific payment methods: Prospective facility-specific payment methods set reimbursement rates in advance for individual nursing homes based on a prior year's allowable costs, or historical costs, for each home.

Rate year: The year for which the Medicaid payment rate is effective. In Minnesota, Iowa, South Dakota and Wisconsin, the rate year runs from July 1 to June 30. North Dakota's rate year runs from January 1 to December 31.

Rate equalization: Nursing homes participating in the Medicaid program cannot charge higher rates to private residents than the rates set for similar Medicaid residents. Minnesota and North Dakota are the only states with rate equalization. In Minnesota, rate equalization does not apply to single-bed rooms. (*Minn. Stat.* §256B.48; North Dakota Department of Human Services, Rate Setting Manual for Nursing Facilities, (Bismarck. Oct. 1995), 11.)

Resident day: A day for which nursing services are provided and billable.

Rule 80 facility (Minnesota): Rule 80 facilities provide nursing home care to non-geriatric residents with severe impairments.

Short-length-of-stay facility (Minnesota): A short-length-of-stay facility is certified to provide a skilled level of care and has an average length of stay of 180 days or less and 225 days or less in facilities with more than 315 licensed beds.

Standardized resident day: In states using case mix, a standardized resident day is the sum of actual resident days in a nursing home in each case-mix category multiplied by the case-mix weight for that category.