DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

FINAL

ORDER

Nursing Facility Quality Assessment

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Title XIX Medicaid State Plan regarding *Nursing Facility Quality Assessment*. Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the July 2012 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by July 31, 2012 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed amends the Title XIX Medicaid State Plan to implement a nursing facility quality assessment fee, also known as a nursing facility provider tax, effective June 1, 2012.

Statutory Authority

- Social Security Act §1902(a)(13)(A), *Public process for determination of rates of payment;*
- 42 CFR
- §§433.55 through 433.74, *Health Care-Related Taxes;*
- 42 CFR §440, Subpart A, *Definitions*;
- 42 CFR Part 447, Subpart C – *Payment for Inpatient Hospital and Long-Term Care Facility Services*;
- 42 CFR §447.205, *Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates*

Background

Congress passed the Medicaid Voluntary Contribution and Provider Specific Tax Amendments (P.L. 102-234) in 1991, amending Section 1903(w) of the Social Security Act (42 USC §1396b(w)). Those laws were later revised through the Tax Relief and Health Care Act of 2006 (P.L. 109-432). These laws, along with corresponding federal regulations (42 CFR §§433.54 through 433.74), provide the authority and guidelines that states must follow in order to fund a portion of the state share of Medicaid program costs by assessing/taxing health care providers or services. The federal authority for health care-related taxes is the Centers for Medicare and Medicaid Services (CMS).

Federal law permits states to collect revenues or "health care-related taxes" from nineteen (19) specified classes of health care providers or services. Revenues collected from health care-related taxes can be used to raise provider rates, fund other costs of the Medicaid program or be used for other non-Medicaid purposes, such as depositing the funds into the state's general treasury. States must meet strict federal requirements when implementing health care-related taxes, including taxing all providers or services in a class (i.e., the tax cannot be limited to Medicaid providers only) and applying a methodology that is similar for all providers or services in that class (i.e., same rate or amount of tax is applied).

Health care-related taxes are fees, assessments or other mandatory payments related to:

(1) Health care items or services;
(2) Provision of, or authority to provide, health care items or services; and,
(3) Payment for health care items or services.

In order to be permissible under federal law, any provider tax enacted by a state must be (1) broad based, (2) uniformly imposed and (3) cannot violate hold harmless provisions.

Summary of Proposal

Nursing facility services are a mandatory Medicaid state plan service. Delaware Medicaid's reimbursement policy establishes eight levels of care within nursing facilities based on patient acuity with up to three "add-ons" for additional services required by nursing facility residents as determined by Division of Medicaid and Medical Assistance (DMMA) nurses. Facility-specific per diem rates are computed annually based on annual facility cost reports. Because of potential budget shortfalls caused by the nation's poor economy, nursing facility Medicaid rates have been frozen since April 1, 2009 at the level they were as of December 31, 2008.

With approval of the Centers for Medicare and Medicaid Services (CMS) of a Title XIX State Plan amendment that will be submitted before June 30, 2012, effective for services provided on or after June 1, 2012, DMMA intends to modify reimbursement for nursing facility services provided under the Medicaid program by increasing the nursing facility per diem amounts for each facility by an amount computed annually that will use proceeds of a nursing facility provider tax to fund the state share of the increased per diem rates. The implementation of this increase in per diem payments is contingent upon passage by the Delaware General Assembly of legislation that defines the applicability of the Nursing Facility Quality Assessment provider tax.

In compliance with 42 CFR §447.205, Public Notice was published before the proposed effective date of the change on May 30, 2012 in the News Journal and on May 31, 2012 in the Delaware State News.

Fiscal Impact Statement

DMMA estimates that the proposed amendment to the Medicaid State Plan is expected to increase payments to nursing facilities by approximately $29 million in State Fiscal Year 2013 but will require no increase in spending from the General Fund because the state share of the increased claims will be funded by the proceeds of the Nursing Facility Quality Assessment Fund currently under consideration by the Delaware General Assembly.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

GACEC and SCPD have the following observations.

As the Summary of Proposal section (p. 39) indicates, Medicaid reimbursement rates to nursing facilities "have been frozen since April 1, 2009 at the level they were as of December 31, 2008." DMMA proposes to impose a quality assessment "tax" on nursing home providers which would generate federal Medicaid matching funds. See S.B. No. 227, lines 35-38 and 118-119. Ninety percent (90%) of the collected quality assessment funds will be deposited in a Nursing Facility Quality Assessment Fund (lines 71-72) and ten percent (10%) will be diverted to the Delaware's General Fund (line 73). The "90%" in the Quality Assessment Fund would be used to increase nursing facility rates. DMMA anticipates increasing payments to nursing facilities by $29 million in State FY13. See regulatory "Fiscal Impact Statement" at p. 39. We infer that the federal match is being used to essentially offset the additional payments to nursing facilities. Some nursing facilities would be exempt from the assessment, including State-run facilities and facilities that exclusively serve children. See regulatory Section "(c)" on p. 41.

The Councils have one (1) technical observation. Literally, S.B. No. 227 requires all nursing facilities to be charged a quality assessment unless exempt under §6502(d). See lines 35-38 and 58-68. One would therefore expect the exemptions in the regulation (p. 41) to match the exemptions in §6502(d). They do not match. For example, the bill requires DHSS to exempt facilities with 46 or fewer beds and continuing care retirement communities (lines 62-65). The regulation [§(c)] on p. 41], does not exempt such facilities. Moreover, the regulation lists several facilities as exempt which are not exempt under the legislation.

Agency Response: DMMA wishes to thank the Councils for their comments on the proposed change to the Medicaid State Plan. In their letters, GACEC and SCPD indicated that they believe there was a discrepancy between Senate Bill 227 (S.B. 227), the law that creates a new Nursing Facility Quality Assessment and the DMMA proposed regulations with regard to facilities that are exempted from the Assessment per §6502(d) and the proposed regulation. The exclusions in the two documents are purposefully different.

The two documents serve different purposes: S.B. 227 creates the Assessment and the Medicaid State Plan Amendment, to which the published regulatory change relates, details the methodology by which the proceeds of the tax will be used to increase per diem payments to nursing facilities. The rules regarding which facilities are subject to the Assessment are defined in the law. The rules regarding which facilities may receive increased per diem payments and how those increased payments will be determined are defined in the State Plan Amendment. The two sets of exclusions are different and serve different purposes.

The law, S.B. 227 does the following: 1) creates the Assessment, 2) indicates which nursing facilities to be assessed and the maximum allowable rate for the initial period from June 1, 2012 through May 31, 2013, 3) requires the proceeds from the Assessment to be deposited into a specified fund and 4) indicates that 90% of the proceeds of the fund are to be used to secure federal Medicaid matching funds that will be used to provide "per diem rate adjustments in accordance with §10504 to Medicaid enrolled nursing facilities" and to "reimburse the Medicaid share of the quality assessment in accordance with §10504". The law does not indicate the method that will be used to determine the actual payment adjustment for each Medicaid enrolled nursing facility.

The State Plan Amendment, for which the proposed regulation was published, specifies the method by which the per

diem rates of certain Medicaid enrolled nursing facilities will be increased using the proceeds from the Assessment as the state match.

The table below shows the facilities that are exempted from the Assessment per S.B. 227 and which facilities are excluded from receiving the increased Medicaid per diems per the State Plan Amendment.

Type of Facility	Exempt from Assessment	Excluded from Increased Per Diems
Government Owned Facilities (§6501 (4))	Yes	Yes
Nursing Facilities that Exclusively Serve Children (§6501 (4))	Yes	Yes
Nursing Facilities with less than 46 Beds (§6502 (d)(1))	Yes	No
Continuing Care Retirement Communities (§6502 (d)(1))	Yes	No
Facilities that have no Medicaid paid bed days	No	Yes

No change to the regulation was made as a result of this comment.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the July 2012 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to update the Title XIX Medicaid State Plan regarding *Nursing Facility Quality Assessment* is adopted and shall be final effective September 10, 2012.

Rita M. Landgraf, Secretary, DHSS

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REVISIONS:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: **DELAWARE**
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
PROSPECTIVE REIMBURSEMENT SYSTEM
FOR LONG TERM CARE FACILITIES

Payment Methodology for Rate Periods Beginning January 1, 2009:

A. Notwithstanding any other provision of this section, the following adjustments will apply to reimbursement rates for all long term care facilities, except for state owned and operated facilities.

B. Effective for dates of service on or after April 1, 2009, per diem rates for long term care facilities will be adjusted to the rates that were in effect on December 31, 2008. However, if Delaware has in effect a nursing facility quality assessment fee applicable to assessment periods beginning on June 1, 2012 and thereafter, the per diem rates for long term care facilities computed for the period ending December 31, 2008 shall be increased by a Quality Assessment Rate Adjustment Amount as follows:

Except as excluded in section (c) below, each nursing facility's rates shall be increased for dates of service beginning on or after June 1, 2012 by a per day dollar amount equal to the sum of:

(a) a per day dollar amount equal to the per day dollar amount of the Nursing Facility Quality Assessment Fee that will be owed for the upcoming rate year by each facility as specified in Delaware Code Title 30, Chapter 65 section 6502 (b) and (d), plus

(b) a per day dollar amount computed as follows:

Step 1. Obtain the total annual Medicaid patient days for all participating nursing facilities from the Delaware Medicaid nursing facility cost reports for the fiscal year ending June 30 of the previous year for each facility, excluding government-operated and pediatric nursing facilities. Sum the Medicaid patient days for each facility to compute the total aggregate statewide Medicaid patient days.

Step 2. For each facility identified in Step #1, multiply the per day dollar amount of the Nursing Facility Quality Assessment Fee that will be owed per paragraph B. (a) above by each facility times the

number of Medicaid patient days for each facility from Step #1. Sum the dollar amounts for all facilities to compute the aggregate statewide total annual assessment amount to be paid to the facilities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Step 3. Obtain the Total annual patient days and non-Medicare patient days for the fiscal year specified in Step 1 from each of the facilities that will be subjected to the quality assessment specified in paragraph (a) above for the upcoming State fiscal year for both Medicaid and non-Medicaid nursing facilities licensed to operate in Delaware.

Step 4. For each facility identified in Step #3, multiply the per day dollar amount of the nursing facility quality assessment fee that will be owed by each facility as specified in Delaware Code Title 30, Chapter 65 section 6502 (b) and (d) times the number of non-Medicare patient days for each facility from Step #3. Sum the dollar amounts for all facilities to compute the statewide total aggregate annual dollar amount of the assessment.

Step 5. Multiply the aggregate assessment computed in Step #4 by 0.9.

Step 6. Determine the total computable funding amount using the assessment amount from Step 5 as the state share at the applicable FMAP (and any other allowable Federal match) for the payment period.

Step 7. Subtract the Medicaid portion of the assessment computed in Step #2 from the total computable payment amount computed in step #6.

Step 8. Divide the dollar amount computed in step #7, by the statewide aggregate patient days from Step #1 to compute a per day dollar amount to be added to (a) above.

(c) The following Long Term Care nursing facilities are excluded from the quality assessment rate adjustment amounts computed in (a) and (b) above:

- government-owned nursing facilities,
- facilities that exclusively serve children,
- facilities with no Medicaid patients,
- facilities that are subject to penalties under Delaware Code Title 30, Chapter 65 section 6503 for dates of service in the months that penalties apply,
- facilities not located within the State of Delaware,
- all nursing facilities are excluded from this Quality Assessment Rate Adjustment Amount if the State of Delaware does not implement or if implemented, subsequently terminates, a nursing facility quality assessment fee

C. Future rate adjustments will be suspended until further notice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE:**DELAWARE**
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
PROSPECTIVE REIMBURSEMENT SYSTEM
FOR LONG TERM CARE FACILITIES

I. General Provisions

A. Purpose

This plan establishes a reimbursement system for long-term care facilities that complies with federal requirements, including but not limited to:

- Requirements of the Omnibus Reconciliation Act of 1981 that nursing facility provider reimbursements be reasonable and adequate to assure an efficient and economically operated facility.
- The requirement that Medicaid payments in the aggregate do not exceed what would have been paid by Medicare based on allowable cost principles.
- Limitations on the revaluation of assets subsequent to a change of ownership since July 18, 1984.
- Requirements of the Omnibus Reconciliation Act of 1987 to establish one level of nursing care, i.e., Nursing Facility Care, to eliminate the designation of Skilled and Intermediate Care, and to provide sufficient staff to meet these requirements.
- The requirement to employ only nurse aides who have successfully completed a training and competency evaluation program or a competency evaluation program.

B. Reimbursement Principles

1. Providers of nursing facility care shall be reimbursed prospectively determined per diem rates based on a patient based classification system. Providers of ICF-MR and ICF-IMD services shall be reimbursed prospectively determined per diem rates.