ONE HUNDRED SECOND LEGISLATURE - FIRST SESSION - 2011
COMMITTEE STATEMENT
LB600

Hearing Date: Wednesday March 02, 2011
Committee On: Health and Human Services
Introducer: Campbell
One Liner: Adopt the Nursing Facility Quality Assurance Assessment Act

---

Roll Call Vote - Final Committee Action:

Advanced to General File with amendment(s)

Vote Results:

Aye:	7	Senators Bloomfield, Campbell, Cook, Gloor, Howard, Krist, Wallman
Nay:		
Absent:		
Present Not Voting:		

Proponents:	**Representing:**
Senator Kathy Campbell	District #25
Brendon Polt	Nebraska Health Care Association; Leading Age Nebraska
Roger Thompson	Seim Johnson
Keith Fickenscher	Lancaster Manor Rehabilitation Center of Lincoln; Homestead Rehabilitation Center of Lincoln
Jack Vetter	Vetter Health Services; Nebraska Health Care Association
Michael B. Harris	Rural Health Development
Clare Duda	Douglas County
Mark Intermill	AARP Nebraska

Opponents:	**Representing:**
Vivianne Chaumont	Nebraska Department of Health and Human Services/Division of Medicaid and Long-term Care

Neutral:	**Representing:**

Summary of purpose and/or changes:

LB 600 adopts the Nursing Facility Quality Assurance Assessment Act. The bill provides for a Quality Assurance Assessment, also referred to as a "provider tax". It is a mechanism used by 46 states, including Nebraska, to increase payments to "classes" of Medicaid providers by increasing federal funding. (In Nebraska, ICF/MRs are the only "class" of providers currently utilizing this system.) Under a Quality Assessment providers pay an assessment to the State which is reimbursed to facilities with the federal match. Under federal regulations (42 CFR 433.68) the assessment is made against days of service to Medicaid and private-pay residents (Medicare days are excluded). In general terms for every dollar assessed to a qualifying nursing facility the nursing facility receives approximately two dollars and fifty cents. The reimbursements as enhanced rates and/or supplements are to Medicaid days only therefore advantaging facilities with higher percentages of Medicaid residents over those with low or none. By selecting waivers and exemptions permitted under federal regulations, Nebraska's quality assessment under LB 600 would require a $3.50 per day assessment. Only approximately ten facilities, or less, of the 224 facilities in the state would pay more into the system than are

reimbursed. Under LB 600 the Nursing Facility Quality Assurance Assessment Act would benefit approximately 215 facilities. The plan would need to be approved by CMS as a quality assessment waiver plan; the approval process timeframe has varied from roughly three to nine months in other states.

Section Summary:

Section 1. Sections 1 to 30 shall be known as the Nursing Facility Quality Assurance Assessment Act.

Sec. 2-16 Definitions:

3. Bed-hold day means a day during which a bed is kept open pursuant to the bed-hold policy of the nursing facility or skilled nursing facility which permits a resident to return to the facility and resume residence in the facility after a transfer to a hospital or therapeutic leave.

4. Continuing care retirement community (CCRC) means an operational entity or related organization which, under a life care contract, provides a continuum of services, including, but not limited to, independent living, assisted-living, nursing facility, and skilled nursing facility services within the same or a contiguous municipality as defined in section 18-2410.

5. Department means the Department of Health and Human Services.

6. Gross inpatient revenue means the revenue paid to a nursing facility or skilled nursing facility for inpatient resident care, room, board, and services less contractual adjustments, bad debt, and revenue from sources other than operations, including, but not limited to, interest, guest meals, gifts, and grants.

7. Hospital has the meaning found in section 71-419.

8. Life care contract means a contract between a CCRC and a resident of such community or his or her legal representative which:

(1) Includes each of the following express promises:

a. The community agrees to provide services at any level along the continuum of care levels offered by the community;

b. The base room fee will not increase as a resident transitions among levels of care, excluding any services or items upon which both parties initially agreed; and

c. If the resident outlives and exhausts resources to pay for services, the community will continue to provide services at a reduced price or free of charge to the resident, excluding any payments from Medicare, the medical assistance program, or a private insurance policy for which the resident is eligible and the community is certified or otherwise qualified to receive; and

(2) Requires the resident to agree to pay an entry fee to the community and to remain in the community for a minimum length of time subject to penalties against the entry fee.

9. Medical assistance program means the medical assistance program (Medicaid) established pursuant to the Medical Assistance Act.

10. Medicare day means any day of resident stay funded by Medicare as the payment source and includes a day funded under Medicare Part A, under a Medicare Advantage or special needs plan, or under Medicare hospice.

11. Medicare upper payment limit means the limitation established by 42 C.F.R. 447.272 establishing a maximum

amount of payment for services under the medical assistance program to nursing facilities, skilled nursing facilities, and hospitals.

12. Nursing facility has the meaning found in section 71-424.

13. Quality assurance assessment means the assessment imposed under section 17 of this act.

14. Resident day means the calendar day in which care is provided to an individual resident of a nursing facility or skilled nursing facility that is not reimbursed under Medicare, including the day of admission but not including the day of discharge, unless the dates of admission and discharge occur on the same day, in which case the resulting number of resident days is one resident day.

15. Skilled nursing facility has the meaning found in section 71-429. (A facility where medical care, skilled nursing care, rehabilitation, or related services and associated treatment are provided for a period of more than 24 consecutive hours to persons residing at such facility who are ill, injured, or disabled.)

16. Total resident days means the total number of residents residing in the nursing facility or skilled nursing facility between July 1 and June 30, multiplied by the number of days each such resident resided in that nursing facility or skilled nursing facility. If a resident is admitted and discharged on the same day, the resident shall be considered to be a resident for that day.

Sec. 17. Except for facilities which are exempt, each licensed nursing facility shall pay an assessment of $3.50 based on Medicaid and private-pay days of care. Medicare days are exempt.

Sec. 18. The department shall exempt the following providers from the assessment: (1) State-operated veteran's homes; (2) Facilities with 26 or fewer beds; and (3) Continuing care retirement communities (CCRC).

Sec. 19. The department shall reduce the assessment for high-volume Medicaid facilities serving 70,000 or more Medicaid days. This includes Lancaster Manor and Douglas County Health Center. This is done to meet federal "redistribution tests" in 42 CFR 433.68(e) (2).

Sec. 20. The aggregate quality assurance assessment shall not exceed the lower of the amount necessary to accomplish the uses specified under the act or the maximum amount that may be assessed pursuant to the "indirect guarantee threshold" as established pursuant to 42 C.F.R. 433.68(f)(3)(i). This is currently set at 5.5% of total revenue. In October, 2011 this increases to 6%. Nebraska's proposal is assessed far below this maximum at 1.9%.

Sec. 21. Each facility shall pay the assessment to the department on a quarterly basis after the Medicaid rates of the facility are adjusted pursuant to section 26 of this act. The department shall prepare and distribute a form on which facilities shall calculate and report the assessment. Facilities shall submit the completed form with the assessment no later than 30 days following the end of each calendar quarter.

Sec. 22. The department shall collect the assessment and remit the assessment to the State Treasurer for credit to the Nursing Facility Quality Assurance Fund. No proceeds from the quality assurance assessment, including the federal match, shall be placed in the General Fund unless otherwise provided in the Nursing Facility Quality Assurance Assessment Act (payment of administrative costs).

Sec. 23. Facilities shall report the assessment on a separate line of the Medicaid cost report. The assessment shall be treated as a separate component in developing rates paid to facilities and shall not be included with existing rate components. In developing a rate component for the assessment, it shall be treated as a direct pass-through to each facility, retroactive to the operative date of this act. The assessment shall not be subject to any cost limitation or revenue offset.

Sec. 24. If the department determines that a facility has underpaid or overpaid the assessment, the department shall

notify the facility of the unpaid assessment or refund due. Such payment or refund shall be due or refunded within thirty days after the issuance of the notice.

Sec. 25. (1) A facility that fails to pay the assessment within the timeframe specified in section 21 or 24 of this act, shall pay, in addition to the outstanding quality assurance assessment, a penalty of XX percent of the quality assurance assessment amount owed for each month or portion of a month that the assessment is overdue. If the department determines that good cause is shown for failure to pay, the department shall waive the penalty or a portion of the penalty.

(2) If an assessment has not been received by the department within thirty days following the quarter for which it is due, the department shall withhold an amount equal to the assessment and penalty owed from any payment due such facility under the Medicaid.

(3) The assessment shall constitute a debt due the state and may be collected by civil action, including, but not limited to, the filing of tax liens, and any other method provided for by law.

(4) The department shall remit any penalty collected pursuant to this section to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.
Sec. 26. (1) The Nursing Facility Quality Assurance Fund is created. Interest and income earned by the fund shall be credited to the fund. Any money in the fund available for investment shall be invested by the state investment officer pursuant.

(2) The department shall use the Fund, including the matching federal funds for the purpose of enhancing Medicaid rates, exclusive of the (regular) Medicaid reimbursement, and shall not use the fund to replace or offset existing state funds paid to nursing facilities.

(3) The Nursing Facility Quality Assurance Fund shall also be used as follows:

(a) To pay the department an administrative fee for enforcing and collecting the quality assurance assessment. The administrative fee shall be XXX dollars for fiscal year 2011-12 and XXX dollars for fiscal year 2012-13.

(b) To pay the share under the Medicaid program of an assessment as an add-on to the Medicaid rate for costs incurred by facilities. This rate add-on shall account for the cost incurred by a nursing facility in paying the assessment but only with respect to the pro rata portion of the assessment that correlates with the resident days in facility attributable to Medicaid residents;

(c) To rebase rates in accordance with the Medicaid state plan. In calculating rates, the proceeds of the assessments and federal match shall be used to enhance rates by increasing the annual inflation factor to the extent allowed by such proceeds and any funds appropriated by the Legislature; and

(d) To increase payments to fund covered services to recipients of benefits from the medical assistance program within Medicare upper payment limits as determined by the department following consultation with nursing facilities and skilled nursing facilities.

Sec. 27. (1) On or before XX, 2011, the department shall submit an application to CMS amending the Medicaid state plan by requesting a waiver of the "uniformity requirement" pursuant to federal regulations to exempt certain facilities from the quality assurance assessment and to permit other facilities to pay the quality assurance assessment at lower rates.

(2) The assessment is not due and payable until an amendment to the Medicaid state plan which increases the rates paid to nursing facilities and skilled nursing facilities is approved by CMS and the facilities have been compensated retroactively for the increased rate for services pursuant to section 26 of this act.

(3) If the waiver requested under this section is not approved by CMS, the Nebraska Department of Health and Human Services may resubmit the waiver application to address any changes required by CMS in the rejection of such application, including the classes of facilities exempt and the rates or amounts for assessments, if such changes do not exceed the authority and purposes of the Nursing Facility Quality Assurance Assessment Act.

Sec. 28. (1) The department shall discontinue collection of the quality assurance assessments if:

(a) The waiver requested pursuant to section 27 of this act or the Medicaid state plan amendment reflecting the enhanced payment rates is given final disapproval by the CMS;

(b) In any fiscal year, the state appropriates funds rates at an amount that reimburses facilities at a lesser percentage than the median percentage appropriated to other classes of providers of covered services under the medical assistance program;

(c) If money in the Nursing Facility Quality Assurance Fund is appropriated, transferred, or otherwise expended for any use other than uses permitted pursuant to this act; or

(d) If federal match under the act becomes unavailable under federal law. In such case, the department shall terminate the collection of the quality assurance assessments beginning on the date the federal statutory, regulatory, or interpretive change takes effect.

(2) If collection of the assessment is discontinued as provided in this section, the money in Fund shall be returned to facilities on the same basis as the assessments were assessed.

Sec. 29. A facility aggrieved by an action of the department under the Act may file a petition for hearing with the director of the Division of Medicaid and Long-Term Care of the department. The hearing shall be conducted pursuant to the Administrative Procedure Act and rules and regulations of the department.

Sec. 30. The department may adopt and promulgate rules and regulations to carry out the Nursing Facility Quality Assurance Assessment Act.

Sec. 31. This act becomes operative on July 1, 2011.

Sec. 32. Since an emergency exists, this act takes effect when passed and approved according to law.

Explanation of amendments:
The Committee Amendment specifies:

1) A penalty of one and one-half percent of the quality assurance assessment owed for each month, or portion of a month, the assessment is overdue.

2) A reasonable administrative fee for enforcing and collecting the quality assurance assessment, in addition to any federal medical assistance matching fund, shall be paid from the Nursing Facility Quality Assurance Fund.

3) On or before September 30, 2011, or after that date if allowable by CMS, the department shall submit an application amending the Medicaid state plan to include the Nursing Facility Quality Assurance Assessment Act.

Kathy Campbell, Chairperson