4.19(d) Nursing facility payment rates are based on Maryland regulations COMAR 10.09.10 in order to account for the cost of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for Medicaid benefits. Payment rates for nursing facilities are the sum of per diem reimbursement calculations in 4 cost centers: administrative/routine, other patient care, capital, and nursing service; and payment for therapy services. Payments in the aggregate may not exceed Medicare upper limits as specified at 42 CFR 447.272.

In accordance with the Omnibus Budget Reconciliation Act of 1987, nursing facility payment rates, effective October 1, 1990, take into account the costs of nursing facilities' compliance with the requirements of Sections 1919(b) (other than paragraph (3)(F)), 1919(c), and 1919(d) of the Social Security Act.

During State fiscal periods beginning on or after July 1, 2009, rates are not revised using updated cost data. Rather, rates from the prior fiscal period are adjusted by applying a percentage reduction to each provider's net payments in the Administrative/Routine, Other Patient Care, and Capital cost centers. Effective July 1, 2011, these payments shall be reduced by 1.623 percent.

Nursing facilities that are owned and operated by the State are not paid in accordance with the provisions described below, but are reimbursed reasonable costs based upon Medicare principles of reasonable cost as described at 42 CFR 413. Aggregate payments for these facilities may not exceed Medicare upper payments limits as specified at 42 CFR 447.272.

Administrative/Routine Costs

The Administrative/Routine cost center includes the following expenses: administrative, medical records, nurse aide registry fees, training, dietary, laundry, housekeeping, operation and maintenance, and capitalized organization and start-up costs. There are 3 reimbursement groups in this cost center: based on geographic location, as specified under COMAR 10.09.10.24A (which is appended to this attachment).

Provider's per diem costs are calculated at the actual occupancy of the nursing facility beds or at the Statewide average occupancy of nursing facility beds plus 2 percent, whichever is higher, for the calculation of ceilings, current interim costs and final costs.

Although an interim Administrative/Routine rate is calculated for each provider, based on indexed cost report data, the final per diem reimbursement rate, after cost settlement, is the sum of:

(1) The provider's allowable per diem costs for covered services according to the principles of reasonable cost reimbursement established under 42 CFR Part 413, subject to the ceiling calculated for the provider's reimbursement class, and

Pay-for-Performance

Maryland nursing facilities are eligible to participate in a pay-for-performance program if they have 45 or more licensed nursing facility beds, are not a continuing care retirement community, and have not been, during the 1-year period ending March 31, denied payment for new admissions, identified as delivering substandard quality of care, or identified as a Special Focus Facility.

Providers shall be scored and ranked based on the following criteria:

(1) Staffing levels and staff stability.

In order to evaluate and compare staffing, the Program will use its annual Nursing Facility Wage Survey. Comparison of staff hours and facility census enables the Program to calculate average hours of care per resident per day. Using a 4.13 hours standard for a facility with an average resident acuity, the Program sets an acuity-adjusted goal for each provider based on its resident mix. Providers are scored on their actual staffing relative to their facility-specific goal. Providers that meet or exceed their goal shall be scored at 100 percent.

Continuity and stability of nursing staff will be measured by the percent of nursing staff who have been employed by the facility for 2 years or longer.

Staff levels (20%) and staff stability (20%) will comprise 40 percent of the overall score.

(2) Family satisfaction.

Family satisfaction is based on results from the facility's most recent Nursing Facility Family Survey conducted by the Maryland Health Care Commission. Providers are scored on questions regarding general satisfaction (20%) and on several categories of questions regarding specific aspects of care and environment in the facility (20%). These questions will comprise 40 percent of the overall score.

(3) Minimum Data Set quality indicators.

Providers shall receive scores for the 3-month period ending December 31 of the most recent prior State fiscal year based on the following quality indicators for long-stay residents from the Minimum Data Set published by the Centers for Medicare & Medicaid Services. (Payments distributed during State fiscal year 2012 shall be based upon scores for the 3-month period ending September 30, 2010.) These scores will comprise 16 percent of the overall score.

- Percent of High-Risk Residents Who Have Pressure Sores
- Percent of Residents Who Were Physically Restrained
- Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder
- Percent of Residents with a Urinary Tract Infection
- Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season
- Percent of Long-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination

(4) Employment of infection control coordinator.

Providers are required to employ an infection control coordinator who has attended an approved training program. Providers shall receive 1 point (1%) for complying with this requirement and may receive 1 additional point (1%) if, in a facility with 200 or more beds, the coordinator is dedicated 35 hours or more per week to infection control responsibilities, or, in a facility with fewer than 200 beds, the coordinator is dedicated 15 hours or more per week to infection control responsibilities. These scores will comprise 2 percent of the overall score.

(5) Staff immunizations.

Providers shall receive 2 points if 80 percent or more of the nursing facility's staff, which includes all staff classifications, have been vaccinated against seasonal influenza. This score will comprise 2 percent of the overall score.

OS Notification

State/Title/Plan Number: Maryland 11-018

Type of Action: SPA Approval

Required Date for State Notification: December 28, 2011

Fiscal Impact in Millions:

FY 2011	$2,279,000
FY 2012	$9,115,000

Number of Potential Newly Eligible People: 0
Eligibility Simplification: No
Provider Payment Increase: Yes
Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail:

MD 11-018 maintains the current rate setting methodology, but increases NF rates by decreasing the net reduction factor for the Administrative/Routine, Other Patient Care, and Capital cost centers of the reimbursement rate to 1.623% (from the current 4.158%) effective July 1, 2011. Average projected reimbursement increase by 1.5% for Medicaid services.

MD 11-018 also proposes modifications to qualifying criteria for NF supplemental payments that are based on quality care indicators. The SPA removes a requirement that providers have at least 40% of their days of care paid by Medicaid and establishes that the MDS indicators will be based on the 3-month period ending 9/30/2010. Each facility receives a score comprised of points awarded for five components: 1) acuity adjusted staff levels and staff retention, 2) satisfaction surveys, 3) MDS indicators, 4) infection control coordinator FTE status, and 5) staff immunizations. These changes are expected to increase the average per diem by $3.18.

The fiscal impact is $2.3 million for 2011. MD had considerable UPL room (more than $30/day) based on their most recent submission. Non-Federal share is from an approved provider tax, which is also increasing provider costs and therefore the per diem by an average of $3.92. MD provided public notice in the June 25, 2011 issue of The Baltimore Sun.

The State has demonstrated public process and provided public notice. MAC meetings in October 2008 discussed the proposal. Because the fiscal impact is not substantial - $3 million for 2010 and $13 million for 2011 – and MD had considerable UPL room (more than $30/day) based on their most recent NF SPA submission, we did not request an updated UPL. Non-Federal share is from an approved provider tax. MD consulted with the UIO on September 15, 2011.

Other Considerations:

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

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National Institutional Reimbursement Team