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

Reimbursement Methodology for ICF/MR Facilities

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Title XIX Medicaid State Plan regarding *Payment Methodology for ICF/MR Facilities*. 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 November 2012 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by November 30, 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 Division of Medicaid and Medical Assistance (DMMA) has submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) to eliminate the rate freeze for Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR) facilities that has been in effect since 2009.

Statutory Authority

- "Social Security Act §1902(a)(13)(A), Public process for determination of rates of payment;
- "42 CFR §440, Subpart A, Definitions;
- "42 CFR Part 447, Payment for Services;
- "42 CFR §447.205, Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates

Background

Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)

Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR) is an optional Medicaid benefit that enables States to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. Although it is an optional benefit, all States offer it, if only as an alternative to home and community-based services waivers for individuals at the ICF/MR level of care.

IMPORTANT NOTE: Federal law and regulations use the term "intermediate care facilities for the mentally retarded". The Division of Medicaid and Medical Assistance (DMMA) prefer to use the accepted term "individuals with intellectual disability" (ID) instead of "mental retardation." However, as ICF/MR is the abbreviation currently used in all Federal requirements, that acronym will be used here.

State Variation

Need for ICF/MR is specifically defined by states, all of whom have established ICF/MR level of care criteria. State level of care requirements must provide access to individuals who meet the coverage criteria defined in Federal law and regulation.

Summary of Proposal

Based upon the Legislative Budget, the Medicaid State Plan will be amended to remove the current rate freeze for the State's ICF/MRs for State Fiscal Year 2013. Effective August 1, 2012, the rate methodology will go back to the methodology that was previously approved in the State Plan that uses reported facility costs to establish per diem rates for each level of care.

In compliance with 42 CFR §447.205, Public Notice was published before the proposed effective date of the change on July 29, 2012 in the *News Journal* and on July 30, 2012 in the *Delaware State News*.

The provisions of this state plan amendment are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

Fiscal Impact Statement

DMMA projects that Medicaid payments to the affected ICF/MR facilities will total an estimated $1,063,702.00 in State Fiscal Year (SFY) 2013 for which the State share of payments is estimated to be $335,538.00. In SFY 2014, estimated Medicaid payments will total $1,257,902.00 for which the State share of payments is estimated to be $387,261.00.

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.

First, it seems that the State "rolled back" payment rates for non-public facilities in 2009 to the rate in effect on December 31, 2008. It is now proposing to exempt private ICF/MRs from that "roll back"" for services rendered after August 1, 2012. The State projects that this will result in "leveraging" of federal funds. For example, DMMA anticipates the change will result in $51,723 in increased State payments and $194,200 in federal payments in SFY14. At 518. The Councils are aware of only one private ICF/MR in Delaware, the Mary Campbell Center. It would apparently benefit from the proposed change.

Second, other long-term care facilities subject to the "roll back" will receive additional funds based on a "Quality Assessment Rate Adjustment". That adjustment is authorized by Senate Bill No. 227 signed by the Governor on June 28, 2012. The Councils commented on the subsequent regulation defining eligibility for the adjustment. See 16 DE Reg. 38 (July 1, 2012) (proposed); and 16 DE Reg. 309 (September 1, 2012) (final).

Also, SCPD is somewhat influenced by competing considerations. On the one hand, providing more funds to facilities may result in higher quality of care and an incentive to accept "Medicaid" patients. On the other hand, SCPD questions whether the extra payments may undermine the "movement" towards promoting community-based service options.

Given the enactment of Senate Bill No. 227, and the leveraging of federal funds, both Councils endorse the proposed change since we believe that providing more funds to facilities may result in higher quality of care and an incentive to accept "Medicaid" patients. However, we would like to qualify our endorsement by stating that we hope adequate measures will be taken to ensure that the extra payments do not undermine the "movement" towards promoting community-based service options.

Agency Response: The Division appreciates the Councils' endorsement and understands its concerns. DMMA remains fully committed to promoting long term services and supports in the community.

FINDINGS OF FACT:

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

THEREFORE, IT IS ORDERED, that the proposed regulation to update the Title XIX Medicaid State Plan regarding Payment Methodology for ICF/MRs Facilities is adopted and shall be final effective January 10, 2013.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #12-60
REVISION:

ATTACHMENT 4.19-D
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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. (1) 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.~~ (2) Effective for dates of service on or after April 1, 2009, per diem rates for long term care facilities with the exception of state owned and operated 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:~~

(3) With specific regard to non-public facilities reimbursed under the payment methodologies in Section III.3 (ICF/MR facilities) of this Attachment, effective for dates of service on or after August 1, 2012, per diem rates shall not be subject to the provision of paragraph A.(2) of this section and shall be computed as described in Section III of this Attachment.

(4) With specific regard to nursing facilities reimbursed under the payment methodologies in Sections II and IX of this Attachment, 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 computed in accordance with paragraph A.(2) of this section shall be increased by a Quality Assessment Rate Adjustment Amount as described in paragraph B of this section.

B. Except as excluded in section B.(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.

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.