Government Operations Handout

Skilled Nursing Facility Assessment Program

Pertaining to: HB 397 10.28(a) "Medicaid Assessment Program for Skilled Nursing Facilities"
Under: 42 CFR Subpart B Section 68
Subject to: GS 12-3.1 – Fees and Charges by Agencies. Government Operations Requirement on Fees

DHHS is directed by HB 397 10.28(a) to impose a provider assessment on skilled nursing facilities effective October 1, 2003 and to use the funds generated from the assessment to institute a new nursing reimbursement methodology. Although the assessment was provided for in HB 397, Chapter 12, Section 3.1 of the General Statutes provide for a consultation with the Joint Legislative Commission on Governmental Operations on the amount and purpose of the fee.

The new nursing home reimbursement system modernizes the existing system and is a patient specific model that offers higher reimbursement to higher need Medicaid patients. Nursing facilities serving higher need Medicaid patients receive greater reimbursement. High need Medicaid patients receive greater access to care as a result of the acuity adjustment that reimburses needy patients at a higher level.

Under the new model, North Carolina transitions towards a purchaser of services (i.e., nursing care) as opposed to a reimburser of cost. Nursing facilities that serve identically needy patients receive increased reimbursement. Medicaid funding follows patient needs, not facility costs. North Carolina has communicated with the NC Not-for-Profit Homes for the Aging, the NC Health Care Facilities Association, and the NC Hospital Association in the development of this new reimbursement model and has achieved broad consensus and mutual goals.

Financial requirements for the case-mix price based model are projected from a rebase of the existing reimbursement model. With state and local budget neutrality for fiscal year 2004, the additional expense of the new reimbursement program is funded federally through the Provider Assessment, as provided for under 42 CFR 433 subpart B. The provider assessment funding supplants the state and local share of the Medicaid funding (up to a 6% threshold of total estimated nursing revenue). The estimated assessment collection for SFY04 is $65.8mm dollars from nursing facilities which result in $125.9mm additional federal funds. Facilities receive a net increase of 12% based on current funding levels.

On a monthly basis, providers will remit an occupied bed fee, based on all non-Medicare days. Assessment brackets are based on Medicaid utilization, as outlined below. Funds received from the assessment will be used to provide for the additional expense of a case-mixed reimbursement system as well as provide for the associated administrative requirements of the system. As directed in HB 397, 100% of the funds are used the new reimbursement system. Assessment brackets may be adjusted annually to ensure adequate funding levels. Note that the top ten Medicaid facilities receive lower assessments to meet CMS redistribution requirements for their uniformity waiver.

Medicaid Utilization	Assessment Fee*
0.0% - 10.0%	$0.00
10.01% - 30.0%	$2.75
30.01% & up	$8.25
Top 10 Facilities	$1.00

**On all non-Medicare occupied days.*

A waiver is being reviewed by CMS to approve the proposed assessment structure. While the North Carolina General Assembly has provided for an October 1, 2003, implementation of the new reimbursement structure and provider assessment program, the federal funds associated are contingent on waiver approval, which was submitted in July 2003. Until CMS approval, existing reimbursement rates and procedures remain in place.