Mandatory Nursing Facility Medicare Certification Eliminated

Chapter 247
HF2294/SF2093
Omnibus Health and Human Services bill
Effective: July 1, 2012

Bill Summary:

In 2011, law was passed that directed the Department of Human Services (DHS) to provide recommendations to the legislature on the development of a pilot project to demonstrate a new approach to nursing facility care. The intent was to test a model of care that fell between nursing facility care levels and assisted living care levels. After interim meetings throughout the state to gather ideas, DHS staff developed a list of possible strategies/approaches. One of the strategies recommended for the legislature to consider included in the DHS Report, “Nursing Home Assisted Living Pilot Project,” was to repeal the Minnesota law requiring mandatory Medicare certification of nursing homes.

The language of the bill is included below:

Sec. 31. Minnesota Statutes 2010, section 256B.434, subdivision 10, is amended to read:
Subd. 10. Exemptions. (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.
(b) A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this paragraph that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost...
of the project. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project from seeking legislative approval of an exception to the moratorium under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the cost of the project.

(c) Notwithstanding section 256B.48, subdivision 6, paragraphs (c), (d), and (e), and pursuant to any terms and conditions contained in the facility's contract, a nursing facility that is under contract with the commissioner under this section is in compliance with section 256B.48, subdivision 6, paragraph (b), if the facility is Medicare certified.

(d) (c) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the Centers for Medicare and Medicaid Services otherwise requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.

(e) (d) A facility that is under contract with the commissioner under this section shall be allowed to change therapy arrangements from an unrelated vendor to a related vendor during the term of the contract. The commissioner may develop reasonable requirements designed to prevent an increase in therapy utilization for residents enrolled in the medical assistance program.

(f) (e) Nursing facilities participating in the alternative payment system demonstration project must either participate in the alternative payment system quality improvement program established by the commissioner or submit information on their own quality improvement process to the commissioner for approval. Nursing facilities that have had their own quality improvement process approved by the commissioner must report results for at least one key area of quality improvement annually to the commissioner.

Sec. 33. Minnesota Statutes 2010, section 256B.48, is amended by adding a subdivision to read:

Subd. 6a. **Referrals to Medicare providers required.** Notwithstanding subdivision 1, nursing facility providers that do not participate in or accept Medicare assignment must refer and document the referral of dual eligible recipients for whom placement is requested and for whom the resident would be qualified for a Medicare-covered stay to Medicare providers. The commissioner shall audit nursing facilities that do not accept Medicare and determine if dual eligible individuals with Medicare qualifying stays have been admitted. If such a determination is made, the commissioner shall deny Medicaid payment for the first 20 days of that resident's stay.

**Implications:**

Nursing facilities can now choose to withdraw from Medicare participation, just maintain their Medicaid certification, and convert their state licensure from nursing home to certified boarding care home. This option does come with additional oversight from DHS. Minnesota Statutes 256B.48 was amended to include a new section on requiring nursing facility providers that do not participate in or accept Medicare assignment to make referrals to Medicare providers. DHS will conduct audits to determine if dual eligible individuals with Medicare qualifying stays have been admitted. If such a determination is made, the commissioner shall deny Medicaid payment for the first 20 days of that resident's stay. In addition, nursing facilities considering this option should
note that conversion back from Medicaid-only (certified boarding care) to Medicaid-Medicare (nursing home/skilled nursing facility) status may be impeded due to loss of “existing construction” status. Before converting back to dual certification, a facility would need to meet “new construction” standards for the state rules.

The DHS Report, “Nursing Home Assisted Living Pilot Project,” provides the following considerations of what the repeal of the Minnesota law requiring mandatory Medicare certification of nursing homes may mean:

**Repeal the Minnesota law requiring mandatory Medicare certification – consideration** has been given to providing greater flexibility for facilities to transition between Nursing Home/SNF-NF and BCH/NF licensure/certification. For the sake of clarification, we distinguish between state licensure requirements (Nursing Home and Boarding Care Home) and the federal certification requirements (Skilled Nursing Facilities and Nursing Facilities). Skilled Nursing Facilities (SNFs) are certified to participate in the Medicare program. Nursing Facilities (NFs) are certified to participate in the Medicaid program. Many facilities are dually certified as SNF/NF. For further definition of SNF and NF status, see Appendix 10.

Nothing in current law prevents a facility from converting from Nursing Home/SNF-NF to BCH/NF. A facility that does not want to participate in Medicare, may wish to consider making this change. However, they should take into consideration that conversion back from BCH/NF to NH/SNF-NF may be impeded due to loss of “existing construction” status. Before converting back, the facility would need to meet “new construction” standards for state rules.

The goal of this flexibility can be achieved by amending Minnesota’s Mandatory Medicare Certification Law at 256B.48, subdivision 6, removing the Minnesota requirement that state licensed Nursing Homes be dually certified as SNF/NFs. As illustrated in the table in Appendix 11, and the information in Appendices 10 and 12, dropping Medicare certification opens the possibility of different nursing staff waivers. **All other federal and state regulations would still apply.** State staff does not know how the Centers for Medicare and Medicaid Services (CMS) will interpret “existing healthcare occupancies” status versus “new healthcare occupancies” status for facilities that may want to reinstate their SNF certification at a later date. The difference in this status is significant when the requirements of the federal Life Safety Code are taken into consideration.

Allowing decertification from Medicare will add costs to Medicaid if non-Medicare nursing facilities are allowed to admit individuals who would otherwise have a Medicare-qualifying stay, because Medicaid would have to pay the bill for those days of service. These costs may be eliminated by prohibiting nursing facilities that do not participate in Medicare from admitting individuals who would otherwise have a Medicare-qualifying stay and providing to DHS the resources and authority to detect when this occurs and to deny Medicaid payment.
Allowing decertification from Medicare could result in reduced access for some consumers in their local communities who may need to travel further to find a bed in a Medicare certified program. State staff does not know whether local health plans would modify their contracting arrangements with facilities that choose to decertify from the Medicare program.