F I S C A L I M P A C T R E P O R T

SPONSOR Varela **ORIGINAL DATE** 02/07/14 **LAST UPDATED** **HB** 267

SHORT TITLE Medicaid Nursing Facility Reimbursement **SB**

ANALYST Geisler

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY14	**FY15**		
	$8,000	Recurring	General
	$500.0	Nonrecurring	General

(Parenthesis ( ) Indicate Expenditure Decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY14	**FY15**	**FY16**		
	$18,264.0	$18,264 or higher, see fiscal analysis	Recurring	Federal
	$1,141		Nonrecurring	Federal

(Parenthesis ( ) Indicate Revenue Decreases)

Relates to appropriation in general appropriation act

SOURCES OF INFORMATION
LFC Files

Responses Received From
New Mexico Human Services Department (HSD)

SUMMARY

Synopsis of Bill

HB 267 would require the Human Services Department (HSD) to create and implement a new reimbursement system for Nursing Facilities by July 1, 2015. The reimbursement would include the cost of meeting the current acuity need among Medicaid recipients and the Market Basket Index (MBI) as published by the Centers for Medicare and Medicaid Services (CMS). The bill also would require HSD to increase the nursing home rates on an annual basis and includes $8 million in general fund towards that purpose. The bill also appropriates $500,000 for the establishment of the new reimbursement system.

FISCAL IMPLICATIONS

HB 267 would appropriate $8 million from the general fund to increase reimbursement rates to Nursing Facilities in SFY15. This would result in a federal match of $18,263,953 for total Medicaid payment increases of $26,263,953. The bill would also appropriate $500 thousand from the general fund for FY15 to fund the establishment of the new reimbursement system, which would result in an approximate federal match of $1,141,497 for a total amount of $1,641,497. It is assumed that this expenditure would be non-recurring.

It is important to note that HB 267's appropriation of $8 million in state general fund to increase reimbursement rates to nursing facilities in FY 15 would become part of the program's base budget in subsequent years. To this base would be added the mandatory annual reimbursement rate increase described in the bill. House Bill 2 includes $5 million for rate increases for long term care services providers. Of this amount, about $2 million would be used for nursing facility rate increases. The remaining amount, $3 million, is to increase reimbursement for personal care option services.

SIGNIFICANT ISSUES

HSD notes that HB 267 is potentially contradictory in that it requires HSD to increase nursing facility rates annually and to implement a new reimbursement system for nursing facilities that includes "the cost of meeting the current acuity of need for nursing facility care and services among Medicaid recipients" and the CMS MBI. It is possible that the new reimbursement system developed by HSD to calculate nursing facility rates may, in some years, find that for some a rate decrease could be justified. Add to that a low market basket index and HSD may find itself in a position where it cannot increase the facilities' rates. This would be in direct conflict with HB 267's provisions. Furthermore, requiring an annual rate increase in statute would limit the ability of the department to manage the budget of the Medicaid program and commit the Legislature to future appropriation increases.

HB 267 also requires that HSD determine a facility's acuity mix using audited cost reports. This is a very general way to determine acuity mix in that HSD sets acuity very broadly, using "Low Nursing Facility" (LNF) and "High Nursing Facility" (HNF). Within LNF and HNF are a wide range of acuities. The industry standard for determining acuity of nursing facility residents is Medicare's Minimum Data Set (MDS). The MDS allows for a more thorough, accurate and fair assessment of a nursing facility's acuity mix. HSD recommends that the bill not specify what method HSD uses to determine a facility's acuity mix.

OTHER SUBSTANTIVE ISSUES

<u>The New Mexico Health Care Association, which represents nursing homes, provided the following background information</u>:

Presently, non-state operated New Mexico Medicaid nursing facility rates are "negotiated" by managed care companies with facilities. However, it is generally accepted that Medicaid fee for service rates are the floor or minimum payment; also, it is widely acknowledged that the floor rate is the prevalent level of payment. Because managed care company contracts prohibit providers from releasing rate information, estimates are based on historical revenue and rate levels. The current system has two levels of care – high nursing facility level of care and low nursing facility level of care. Average weighted daily rates and costs are estimated below and include gross receipts taxes.

	High Level of Care	Low Level of Care
Cost	$246.60	$179.72
Rates	$242.62	$149.51
Shortfall	$ 3.98	$ 30.21

The current Medicaid nursing facility payment system was implemented 30 years ago and payment standards have eroded overtime. For example, no interim rate adjustments have been made for large facility capital projects like financing a new roof or building renovations and repairs above the historical base rate. The vast majority of NM nursing facilities are more than 30 years old and renovations will continue to be a growing concern.

HB 267 appropriates $8 million from the State general fund which would be matched with federal funding to increase nursing facility rates. This is critical because based on projections using 2012 Medicaid nursing facility cost reports, the industry has estimated that current underfunding is at least $34 million. In addition, on January 1, 2014 Medicaid changed the criteria for high nursing facility level of care. The change is estimated to result in an annual decrease in revenues to facilities totaling $20-30 million annually.

HB 267 also appropriates $.5 million from the State general fund to the Human Services Department to be matched with federal funding to develop a reimbursement system that recognizes acuity of patients. The new system should develop minimum rates that take into account the acuity of patients and will include annual adjustments determined by CMS' federal market basket index, a widely used annual measure of cost input factor changes. Typically, the MBI is less than a consumer price index adjustment. Acuity-based payment systems (referred to commonly as case-mix systems) are used in over 30 states, and the systems evaluate actual patient assessment information as part of the rate development process.

GG/jl