MARYLAND Department of Health

Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

October 12, 2017

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401 – 1991

The Honorable Michael E. Busch
Speaker of the House of Delegates
H-101 State House
Annapolis, MD 21401-1991

Re: Nursing Home Quality Assessment Implementation Annual Report – Health - General §19-310.1(f)

Dear President Miller and Speaker Busch:

I am pleased to submit the report required by SB 101, enacted during the 2007 regular session of the General Assembly, which required the Department to report by March 1, 2008 and annually thereafter on the implementation of a quality assessment on specified Maryland nursing facilities. SB 101 established in law this quality assessment on Maryland nursing facilities (with the exception of facilities with fewer than 45 beds, and those operated by continuing care retirement communities, or CCRCs), to be applied to all non-Medicare days of care provided by the facility in the previous quarter of the State fiscal year.

HB 67, enacted during the 2015 session of the General Assembly, changed the date of the required annual report to September 1 of each year, in recognition that the March 1 date fell before the current fiscal year's final expenditures were known, and before the budget allocation for the next fiscal year's allocation was finalized by the General Assembly.

This report will update the General Assembly on the implementation of the quality assessment during FY 2017, and provide the specific information required by Health-General Article §19-310.1 (f). For the FY 2017 assessment, the Department established two per-diem payment rates for the nursing facilities subject to the assessment on non-Medicare days of care. These rates were $25.00 for most nursing facilities, and, for the five facilities providing the highest number of Medicaid days of care in the previous year, $5.50 per non-Medicare day of care.

Information Specified by Health-General §19-310.1(f) Reporting Requirement

Health-General §19-310.1(f) requires the Department to report by September 1 each year on its implementation of the quality assessment. This section of statute specifies that this report include the following information:

(1) The percentage and amount of the assessment charged to each nursing facility subject to [the assessment];
(2) The number of nursing facilities subject to [the assessment] with a net loss; and

(3) A comparison of the total amount provided in the Medicaid budget for nursing home reimbursement in the current fiscal year to the actual amount received in the immediately prior fiscal year.

In response to the first section, the percentage and amount that each nursing facility will pay is projected in the statistical model submitted to Centers for Medicare and Medicaid Services each year by dividing the amount of revenue to be collected via the quality assessment — in FY 2017, $152,763,470 — by multiplying the per diem assessment rate, either $25.00 or $5.50, by that facility's non-Medicare days of care projected for FY 2017, from a statewide total of 7,293,491 days projected for FY 2017.[1]

Pinpointing the exact amount of revenue earned by each nursing facility — since the quality assessment program generates funds that both repay each provider in part for the amount of assessment paid for each Medicaid day of care, and augment the overall Medicaid reimbursement rate — is complicated by the complexities of the methodology with which the Department sets nursing facility rates. The variation between facilities along the four cost centers — nursing, other patient care, administrative and routine, and capital costs — make head-to-head benefit versus cost comparisons approximate at best. The factors that contribute to a net loss with regard to the payment of the quality assessment are a relatively low number of Medicaid days of care, and relatively high numbers of private pay days, for which these facilities will pay the per-diem but receive neither a refunded per-diem nor an enhanced Medicaid rate. The facility with the highest net loss resulting from the payment of the quality assessment is the only privately-owned, non-CCRC nursing facility that does not participate at all in the Medicaid Program.

The following chart shows the 18 nursing facilities that the statistical model developed for the FY 2017 quality assessment projected would pay more for their non-Medicare days of care than they would benefit by being reimbursed for the assessment paid for Medicaid days and also by receiving the higher Medicaid rates partially financed by the assessment.

[1] The actual total number of assessable days for FY 2017 will have been provided to the Department by mid-May 2018, a compilation of fiscal year-end cost reports from all facilities. The Department's audit contractor uses these reports to verify the number of days for which each facility has reported and paid a per diem.

Nursing Facilities with Projected Net Loss from Payment of FY 17 Quality Assessment

Facility	Quality Assessment paid in FY 2017	Repayment of QA for Medicaid days of care	Addition to Medicaid daily rate from QA payment	Total benefit of QA (repay MA perdiem + rate subsidy)	Net fiscal impact from payment of QA
Carriage Hill Bethesda (not a Medicaid provider)	$663,525	$0	$0	$0	($663,525)
Homewood at Crumland Farms	$893,475	$265,906	$225,232	$491,138	($402,337)
Rockville Nursing Home	$664,600	$158,509	$134,857	$293,366	($371,234)
Charlotte Hall Veterans Home	$2,354,875	$1,217,608	$842,157	$2,059,765	($295,110)
Genesis Powerback Rehab Brightwood Center	$210,900	$582	$1,791	$2,373	($208,527)
Potomac Valley Nursing and Wellness Center	$1,249,500	$582,717	$478,000	$1,060,717	($188,783)
Crofton Convalescent and Rehab Center	$933,850	$359,334	$393,040	$752,374	($181,476)
Kensington Nursing and Rehab Center	$1,105,325	$530,908	$416,224	$947,132	($158,193)
St. Joseph's Ministries	$694,800	$277,664	$259,357	$537,021	($157,779)
Hillhaven	$429,775	$138,099	$138,991	$277,090	($152,685)
Manor Care Potomac	$858,575	$339,631	$366,476	$706,107	($152,468)
NMS Healthcare Hyattsville (St.Thomas More)	$1,399,750	$531,498	$761,787	$1,293,285	($106,465)
Mid-Atlantic of Fairfield	$442,800	$180,179	$221,591	$401,770	($41,030)
Genesis Waugh Chapel Center	$439,225	$164,211	$242,974	$407,185	($32,040)
Solomons Nursing Center	$539,000	$277,182	$241,034	$518,216	($20,784)
Heartland Hyattsville	$1,065,725	$581,073	$464,760	$1,045,833	($19,892)
Genesis Spa Creek	$643,500	$286,100	$345,713	$631,813	($11,687)
Restore Health Rehab Center (three months of FY 17)	$16,000	$460	$6,528	$6,988	($9,012)

This means that the large majority of nursing facilities subject to the assessment — a total of 183 during FY 2017 — derived at least some level of benefit from the assessment, and those with high percentages of Medicaid recipients benefitted most.

The enabling legislation also requires a comparison of the Medicaid budget for nursing home reimbursement for the previous and the current fiscal years, shown below.

FY 2017 reimbursement	$1,174,483,756
FY 2018 (appropriation)	$1,193,157,994

If you have any questions about this report, or would like additional information, please contact Mark A. Leeds, Director of Medicaid's Long Term Services and Supports Administration, at (410) 767-1443 or Webster Ye, Deputy Chief of Staff, at (410) 767-6480 or webster.ye@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

cc: The Honorable Edward J. Kasemeyer, Chairman
Senate Budget and Taxation Committee

The Honorable Thomas M. Middleton, Chairman
Senate Finance Committee

The Honorable Maggie McIntosh, Chairman
House Appropriations Committee

The Honorable Shane E. Pendergrass, Chairman
House Health and Government Operations Committee

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