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111TH CONGRESS
2D SESSION

H. R. 5457

To provide supplemental payments to nursing facilities serving Medicare and Medicaid patients and to amend title XIX of the Social Security Act to assure adequate Medicaid payment levels for services.

IN THE HOUSE OF REPRESENTATIVES

MAY 28, 2010

Ms. CASTOR of Florida (for herself and Mr. MURPHY of Connecticut) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To provide supplemental payments to nursing facilities serving Medicare and Medicaid patients and to amend title XIX of the Social Security Act to assure adequate Medicaid payment levels for services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Nursing Home Patient and Medicaid Assistance Act of 2010''.

SEC. 2. NURSING FACILITY SUPPLEMENTAL PAYMENT PROGRAM.

(a) TOTAL AMOUNT AVAILABLE FOR PAYMENTS.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') to carry out this section $6,000,000,000, of which the following amounts shall be available for obligation in the following years:

(A) $1,500,000,000 shall be available beginning in 2011.

(B) $1,500,000,000 shall be available beginning in 2012.

(C) $1,500,000,000 shall be available beginning in 2013.

(D) $1,500,000,000 shall be available beginning in 2014.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until all eligible dually-certified facilities (as defined in subsection (b)(3)) have been reimbursed for underpayments under this section during cost reporting periods ending during calendar years 2011 through 2014.

(3) LIMITATION OF AUTHORITY.—The Secretary may not make payments under this section

that exceed the funds appropriated under paragraph (1).

(4) DISPOSITION OF REMAINING FUNDS INTO MIF.—Any funds appropriated under paragraph (1) which remain available after the application of paragraph (2) shall be deposited into the Medicaid Improvement Fund under section 1941 of the Social Security Act.

(b) USE OF FUNDS.—

(1) AUTHORITY TO MAKE PAYMENTS.—From the amounts available for obligation in a year under subsection (a), the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall pay the amount determined under paragraph (2) directly to an eligible dually-certified facility for the purpose of providing funding to reimburse such facility for furnishing quality care to Medicaid-eligible individuals.

(2) DETERMINATION OF PAYMENT AMOUNTS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the payment amount determined under this paragraph for a year for an eligible dually-certified facility shall be an amount determined by the Secretary as re-

ported on the facility's latest available Medicare cost report.

(B) LIMITATION ON PAYMENT AMOUNT.—In no case shall the payment amount for an eligible dually-certified facility for a year under subparagraph (A) be more than the payment deficit described in paragraph (3)(D) for such facility as reported on the facility's latest available Medicare cost report.

(C) PRO-RATA REDUCTION.—If the amount available for obligation under subsection (a) for a year (as reduced by allowable administrative costs under this section) is insufficient to ensure that each eligible dually-certified facility receives the amount of payment calculated under subparagraph (A), the Secretary shall reduce that amount of payment with respect to each such facility in a pro-rata manner to ensure that the entire amount available for such payments for the year be paid.

(D) NO REQUIRED MATCH.—The Secretary may not require that a State provide matching funds for any payment made under this subsection.

(3) ELIGIBLE DUALLY-CERTIFIED FACILITY DEFINED.—For purposes of this section, the term ''eligible dually-certified facility'' means, for a cost reporting period ending during a year (beginning no earlier than 2011) that is covered by the latest available Medicare cost report, a nursing facility that meets all of the following requirements:

(A) The facility is participating as a nursing facility under title XIX of the Social Security Act and as a skilled nursing facility under title XVIII of such Act during the entire year.

(B) The base Medicaid payment rate (excluding any supplemental payments) to the facility is not less than the base Medicaid payment rate (excluding any supplemental payments) to such facility as of the date of the enactment of this Act.

(C) As reported on the facility's latest Medicare cost report—

(i) the Medicaid share of patient days for such facility is not less than 60 percent of the combined Medicare and Medicaid share of resident days for such facility; and

(ii) the combined Medicare and Medicaid share of resident days for such facil-

ity, as reported on the facility's latest available Medicare cost report, is not less than 75 percent of the total resident days for such facility.

(D) The facility has received Medicaid reimbursement (including any supplemental payments) for the provision of covered services to Medicaid eligible individuals, as reported on the facility's latest available Medicare cost report, that is significantly less (as determined by the Secretary) than the allowable costs (as determined by the Secretary) incurred by the facility in providing such services.

(E) The facility is not in the highest quartile of costs per day, as determined by the Secretary and as adjusted for case mix, wages, and type of facility.

(F) The facility provides quality care, as determined by the Secretary, to—

(i) Medicaid eligible individuals; and

(ii) individuals who are entitled to items and services under part A of title XVIII of the Social Security Act.

(G) In the most recent standard survey available, the facility was not cited for any im-

mediate jeopardy deficiencies as defined by the Secretary.

(H) In the most recent standard survey available, the facility maintains an appropriate staffing level to attain or maintain the highest practicable well-being of each resident as defined by the Secretary.

(I) The facility complies with all the requirements, as determined by the Secretary, contained in sections 6101 through 6106 of the Patient Protection and Affordable Care Act (Public Law 111–148) and the amendments made by such sections.

(J) The facility was not listed as a Centers for Medicare & Medicaid Services Special Focus Facility (SFF) nor as a SFF on a State-based list.

(4) FREQUENCY OF PAYMENT.—Payment of an amount under this subsection to an eligible dually-certified facility shall be made for a year in a lump sum or in such periodic payments in such frequency as the Secretary determines appropriate.

(5) DIRECT PAYMENTS.—Such payment—

(A) shall be made directly by the Secretary to an eligible dually-certified facility or a contractor designated by such facility; and

(B) shall not be made through a State.

(c) ADMINISTRATION.—

(1) ANNUAL APPLICATIONS; DEADLINES.—The Secretary shall establish a process, including deadlines, under which facilities may apply on an annual basis to qualify as eligible dually-certified facilities for payment under subsection (b).

(2) CONTRACTING AUTHORITY.—The Secretary may enter into one or more contracts with entities for the purpose of implementation of this section.

(3) LIMITATION.—The Secretary may not spend more than 0.75 percent of the amount made available under subsection (a) in any year on the costs of administering the program of payments under this section for the year.

(4) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement, by program instruction or otherwise, the provisions of this section.

(5) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of—

(A) the determination of the eligibility of a facility for payments under subsection (b); or

(B) the determination of the amount of any payment made to a facility under such subsection.

(d) ANNUAL REPORTS.—The Secretary shall submit an annual report to the committees with jurisdiction in the Congress on payments made under subsection (b). Each such report shall include information on—

(1) the facilities receiving such payments;

(2) the amount of such payments to such facilities; and

(3) the basis for selecting such facilities and the amount of such payments.

(e) DEFINITIONS.—For purposes of this section:

(1) DUALLY-CERTIFIED FACILITY.—The term ''dually-certified facility'' means a facility that is participating as a nursing facility under title XIX of the Social Security Act and as a skilled nursing facility under title XVIII of such Act.

(2) MEDICAID ELIGIBLE INDIVIDUAL.—The term ''Medicaid eligible individual'' means an individual who is eligible for medical assistance, with respect to nursing facility services (as defined in sec-

tion 1905(f) of the Social Security Act), under title XIX of the such Act.

(3) STATE.—The term ''State'' means the 50 States and the District of Columbia.

SEC. 3. ASSURING ADEQUATE MEDICAID PAYMENT LEVELS FOR SERVICES.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by inserting after section 1925 the following new section:

''ASSURING ADEQUATE PAYMENT LEVELS FOR SERVICES

''SEC. 1926. (a) IN GENERAL.—A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) for a year (beginning with 2011) unless, by not later than April 1 before the beginning of such year, the State submits to the Secretary an amendment to the plan that specifies the payment rates to be used for such services under the plan in such year and includes in such submission such additional data as will assist the Secretary in evaluating the State's compliance with such requirement, including data relating to how rates established for payments to medicaid managed care organizations under sections 1903(m) and 1932 take into account such payment rates.

''(b) SECRETARIAL REVIEW.—The Secretary, by not later than 90 days after the date of submission of a plan amendment under subsection (a), shall—

''(1) review each such amendment for compliance with the requirement of section 1902(a)(30)(A); and

''(2) approve or disapprove each such amendment.

If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment that meets such requirement.''.

(b) REPORT ON MEDICAID PAYMENTS.—Section 1902 of such Act (42 U.S.C. 1396), as amended by sections 2001(e) and 2303(a)(2) of the Patient Protection and Affordable Care Act (Public Law 111–148) and section 1202(a) of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), is amended by adding at the end the following new subsection:

''(kk) REPORT ON MEDICAID PAYMENTS.—Each year, on or before a date determined by the Secretary, a State participating in the Medicaid program under this title shall submit to the Administrator of the Centers for Medicare & Medicaid Services—

''(1) information on the determination of rates of payment to providers for covered services under the State plan, including—

''(A) the final rates;

"(B) the methodologies used to determine such rates; and

"(C) justifications for the rates; and

"(2) an explanation of the process used by the State to allow providers, beneficiaries and their representatives, and other concerned State residents a reasonable opportunity to review and comment on such rates, methodologies, and justifications before the State made such rates final.".

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