MN Department of Human Services Guidance for Emergency Medicaid (sec.12A.10) expedited reimbursement and establishing temporary payments in Nursing Facilities

The Minnesota Department of Human Services (DHS) is statutorily authorized to pay expedited reimbursement to Medicaid-certified nursing facilities under Minnesota Stat. § 12A.10 for additional costs associated with a qualifying emergency. The Commissioner of Human Services has authorized the use of section 12A.10 expedited Medicaid funding to support up to 90 days of continued operations at any individual nursing facility experiencing an emergency situation arising from a staffing shortage and/ or an imminent cash flow crisis. Without this assistance, residents are at risk of poor health outcomes due to the need to transfer to another facility or hospital for adequately staffed care.

This authorization is in effect for each facility's eligible costs occurring during a 90-day coverage period beginning upon receipt of an application at DHS for 12A assistance or a date specified in the facility's application. Costs cannot have occurred prior to January 1, 2022. For applications received after March 3, 2022, the allowable coverage period will be less than 90 days as all 12A related spending must be completed by May 31, 2022.

The Commissioner reserves the right to deny a 12A.10 request and strongly encourages prior approval prior to incurring expenses being claimed under this program.

There are two categories for a facility to use to demonstrate their qualifying emergency (either/or):

Category 1 (Staffing shortage emergency)

- Staffing levels for current residents are determined to be unsafe using MDH criteria (see Attachment A) related to determining a staffing shortage emergency and facility has exhausted the resources available from other federal, state and local sources. Facilities in a Red or Orange status at the time of a 12A request will meet the criteria for a staffing shortage emergency

Category 2 (Temporary funding emergency)

- Facility demonstrates an imminent and temporary cash flow problem such as the inability to pay direct care staff and needs funding to avoid immediate resident evacuation and the associated harm to residents health and safety that cannot otherwise be resolved through technical assistance.

To determine eligibility for 12A.10 funding, DHS will consider the following criteria[1]:

- Enrolled as a MN Medicaid NF provider;
- Exhausted all available federal COVID relief funds, (e.g. PRF, PPP loans, etc.); Facility will be asked to provide statement as to use of funds. Lost revenue is allowed as use of funds only on an actual basis (not budgeted) for all payer sources for the entire period. The actual basis will compare RYE 9/30/2019 to RYE 9/30/2020 for patient care revenue only. Transfer of funds to

[1] Providers may contact Kim Brenne at kimberly.brenne@state.mn.us or 651-431-4339 for questions or concerns about facility eligibility.

non-nursing home operation not allowed as use of funds. Types of revenue **not considered** patient care revenue includes, but is not limited to; Non-Patient Care Dining Services, Fundraising, Grants or tuition, Bad Debt, Charity Care adjustments, Gift Shop Income, Beauty Shop income, contractual adjustments form all third party payers, and any gains and/or losses on investments.

- Not named on the CMS Special Focus list;
- Whether the 12A request is necessary for facility to safely admit (not under an active DoPNA);
- Current with Medicaid surcharge payments to DHS or have submitted an approved plan to become current on surcharge within 30 days or less;
- Not operating under state managed or private receivership; and
- Submitted their COVID Supplemental Cost Report Schedule to DHS.

Costs eligible for 12A.10-expedited reimbursement include one or more of the following:

- Incremental benefits, wages, bonuses, and associated payroll taxes for on-site direct care, dietary, maintenance, laundry and housekeeping staff, fringe benefits identified under section 256R.02, Subd. 22, or other employee benefits identified on Line 9080 of the DHS Cost Report form.[2] Incremental costs submitted will not include the bonus amounts paid with the January 2022 ARPA payments.
- Incremental PPE;
- Incremental SNSA costs above the statutory caps, time-limited and determined on an individual facility basis; Incremental costs to be determined by comparison of both wages and SNSA costs from the base period by category-RN/LPN, CNA and TMA. SNSA rate to be capped at 150% of current allowable rate and SNSA utilization at 40% of each categories total staffing.
- Incremental Care-related medical supply costs;
- Serial COVID testing for employees after the Federal Infection Control funds have been exhausted; and
- Any scholarship costs otherwise allowable under section 256R.37 for staff education, training and licensure.

Application, payments and reconciliation process for 12A funding

- Nursing facilities can request payment in anticipation of incremental costs that they may incur as noted above for up to a 90-day coverage period. Nursing facilities may choose to request payment after incurring incremental costs as defined above for a 90-day coverage period.
- Applications can be submitted no more than once every 30 days within the 90-day time period (up to a maximum of three applications). Each subsequent application does not extend the 90-day eligibility period to spend funds received which begins on the date specified in the first application.
- Reporting on the final uses of 12A payments must occur within 20 days following the end of the 90-day eligibility period. DHS reporting forms will be provided to nursing facilities who apply for 12A funding.

[2] Non-related party purchased services are based on a long term contract agreement, contract employee wages and benefits are not reported on the salary lines or other fringe benefits on line 9080 and are not eligible for temporary 12A funds.

- DHS will review all final uses of 12A payments and may request additional supporting documentation during the review process.
- If DHS determines that funds are not expended, or not expended on eligible costs, DHS will recover any unused funds immediately after review of the final uses of the 12A payments.
- DHS will offset the allowable 12A payments on the 9/30/2022 Cost Reports.
- Uses of 12A payments in facilities with collective bargaining agreements should be in accordance with the requirements of that collective bargaining agreement

For all requests, only those costs that are not already paid for by another source are eligible.

Incremental costs will be determined on a per resident day basis from the reported 2020 cost report. Known or gross reporting errors will be adjusted from both the base and emergency period but full audits are not anticipated to have been completed.

DHS will use Generally Accepted Accounting Principles on an accrual basis to determine the eligibility of 12A expenses.

256R.09 Issuing temporary payments in 2022 as a mechanism to improve cash flow in the near term

In January 2022 DHS will issue temporary Medicaid payments for nursing facilities. These temporary payments will have an effective date of January 1, 2022 and remain in effect until the Department has determined a sufficient number of 2022 rates can be generated. The temporary payments will be used to provide 2022 estimated rate increases to nursing facility providers in advance of the initial 2022 rates being available. These temporary payments will be entered into the Medicaid Management Information System (MMIS) to pay claims but will not be published on the Report Card website.
The 2022 claims will be reprocessed to remove the temporary payments from January 1, 2022 and replace it with the initial 2022 rates.
The temporary January 1, 2022 payments will consist of:

- An estimated add-on per day based on unaudited facility's direct care and other-care related costs reported on the 9/30/2020 cost report.
- The 2021 Operating per Diem (also known as "the price") plus and add-on estimated from the 9/30/2020 cost report.
- The estimated 2022 Property Rate including the property rate inflation factor and other rate increases that will occur due to bed closures, bed layaways and construction projects.
- The ECPN rate for 2022.
- The External Fixed rates from 2021, which will be updated for 2022 rate amounts for the Performance Incentive Payment Program, the Quality Improvement Incentive Payment, and previous single-bed incentives.

Attachment A - Guidelines to be Considered for Determining a Staffing Shortage Emergency

		RED	Point Value	Orange	Point Value	Yellow	Point Value	Green	Point Value
1	What is the impact to resident care? Assuming all steps as outlined in the staffing contingency plan have been taken.	Ability to provide timely meals, feeding assistance, toileting assistance, medication dispensation, medical treatments or other basic functions are significantly compromised.	10	Timely meals, feeding assistance, toileting assistance, medication dispensation, medical treatments or other basic functions are occurring, but there are impacts to scheduling efforts. You have decreased your staffing ratios (staff caring for more residents) You have consolidated services and are focusing solely on basic clinical needs	8	Timely meals, feeding assistance, toileting assistance, medication dispensation, medical treatments or other basic functions are occurring, but are currently maximizing your scheduling efforts. You have increased your staffing ratios You have consolidated services and are focusing solely on basic clinical needs	6	Resident care is occurring per service agreements or care plans. There is no need at this time to consolidate or edit service agreements.	4
2	How many shifts open?	50% or more of scheduled shifts are open	10	30-40% of scheduled shifts are open	8	10-20% scheduled shifts are open	6	Manageable number of open shifts	4
3	How long can you sustain current patterns? How immediate is the crisis?	-A significant majority of your staff are working multiple extra shifts (2-3 additional shifts per week) or more than 9 days in a row. -You are struggling today and for the forseeable future	10	-A significant majority of your staff are working multiple extra shifts (2-3 additional shifts per week) or more than 9 days in a row. -You have staff today, but are struggling to fill tomorrow and the rest of the week	8	-Some of your staff are working multiple extra shifts (2-3 additional shifts per week) or more than 9 days in a row. -You have staff for this week, but are struggling to fill next week	6	You have some gaps in staffing, but it is manageable based on census/acuity needs	4
4	What is impact to the care continuum? Ability to accept new admissions.	Unable to take admissions today and for the foreseeable future	10	Unable to take admissions today and for the foreseeable future	8	Assessing admissions based on acuity levels-only taking those with minimal care needs	6	Normal admission practices are uninterrupted	4
5	Care desert	Are you the only provider within 30 mile radius	5	It's just you and 2 other providers in 30 miles	4	It's you and 2 other provider	3	It's you and multiple providers	2
6	What internal efforts have you exhausted? Using the LTC contingent staffing plan—Red is crisis mode, orange and yellow are contingency mode, conventional green. See examples	LTC contingent staffing plan crisis status -Implementing large scale changes to business -Altered standards of care -Need for outside assistance today to meet care obligations	10	LTC contingent staffing plan contingency status-but moving to crisis in the next 3-5 days -All local resources have been exhausted -Readjusted facility schedules and redeployed non-direct care staff to focus on clinical core duties -Added incentives or bonuses -Tried to add outside staff from MOUs, sister facilities, SNSA, volunteers, other resources	8	LTC contingent staffing plan contingency status-but moving to crisis in the next 6-10 days -All local resources have been exhausted -Readjusted facility schedules to maximize in-house staff -Added incentives or bonuses -Tried to add outside staff from MOUs, sister facilities, SNSA, volunteers	6	LTC contingent staffing plan conventional status You are using your typical methods to fill open shifts	4
7	Facility staff vaccination rate	Low-below 50%	5	Low below 60%	4	75% of below	3	High above 75%	2
8	Community vaccination rate	Low-below 50%	5	Low below 60%	4	approx. 75 or below	3	High above 75%	2
		Total	65	Total	52	Total	39	Total	26

Scoring

RED	**53-65 points**
ORANGE	**40-52 points**
YELLOW	**27-39 points**
GREEN	**Less than 26**