Legislative Analysis

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NURSING FACILITY MEDICAID REIMBURSEMENT

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Senate Bill 1037 (H-1) as reported from House committee
Sponsor: Sen. Peter MacGregor

Senate Bill 1038 (S-2) as reported
Sponsor: Sen. Jim Stamas

Senate Bill 1039 (H-1) as reported
Sponsor: Sen. Goeff Hansen

House Committee: Families, Children, and Seniors
Senate Committee: Oversight
Complete to 12-3-18

SUMMARY:

The bills, taken together, would amend the Social Welfare Act to reinterpret existing Medicaid policy, modify eligibility for a nursing facility, and modify and create deadlines for completion of cost reports. Each bill would take effect 90 days after being enacted into law. A detailed explanation of the bills follows.

Senate Bill 1037

Currently, the Michigan Medicaid Provider Manual addresses all health insurance programs administered by the Department of Health and Human Services (DHHS). The DHHS also issues periodic bulletins as changes are implemented to the policies and/or processes described in the manual. Bulletins are also incorporated into the online version of the manual on a quarterly basis.

Senate Bill 1037 would add section 111n to the Act to stipulate that if the DHHS issues a new interpretation of existing Medicaid provider policy directly affecting nursing facility Medicaid cost reports, that change in policy must have a prospective effective date. However, a policy could have a retrospective effective date as part of a state plan amendment approval or waiver approval or if required by state law, federal law, or judicial ruling.

Medicaid Nonavailable Bed Plan Policy

By July 1, 2019, but no later than October 1, 2019, the DHHS would have to revise the Medicaid nonavailable bed plan policy to allow a nursing facility to remove beds from service for up to 10 years. All of the following would apply to the revised bed plan policy:

- A nursing facility would not be required to remove all beds from a room.
- The beds placed in a nonavailable bed plan could be from noncontiguous rooms.
- The DHHS would have to allow the entire nursing facility to be utilized during the period when the nursing facility has a bed in the bed plan, but the square footage associated with each bed would be nonreimbursable on the Medicaid cost report.

Asset Value Bed Limit and Program Enrollment Type

Beginning October 1, 2019, the DHHS would have to establish a current asset value bed limit using a rolling 10-year history of new construction. The increase to the current asset bed limit

could not exceed $13,000 per year through September 30, 2022. Beginning October 1, 2022, the current asset bed limit could not increase by more than 4% of the previous year limit.

The DHHS would also have to establish a process to automatically change the program enrollment type and managed care enrollment status in the community health automated Medicaid processing system (CHAMPS) immediately when a filing has been made by a health maintenance organization (HMO) to disenroll a nursing facility resident from an HMO and the resident has completed 45 days of skilled care at a nursing facility. The DHHS could utilize a filing to disenroll a nursing facility resident from an HMO, admission and discharge data entered by a nursing facility in CHAMPS, or automated admission, discharge, and transfer transactions to verify the 45-day limit.

Secondary Review of Denied Rate Exception

Within 60 days after receipt of a request from a nursing facility, the DHHS would have to perform a secondary review of a denied rate exception, including rate relief, or application of a classwide average rate. The secondary review would have to be performed by DHHS staff who are separate from the staff who performed the initial review determination.

DHHS Quarterly Meeting

The DHHS would also have to offer a quarterly meeting and invite appropriate nursing facility stakeholders, including at least one representative from each nursing facility provider trade association, the Long-Term Care Ombudsman, and any other representatives. In conjunction with the DHHS, individuals who participate in these quarterly meetings could designate advisory workgroups to develop recommendations on the discussion topics, which should include at least:

- Seeking quality improvement to the cost report audit and settlement process.
- Improving auditors' and providers' quality and preparedness.
- Enhanced communication between applicable parties such as DHHS staff, consultants, and providers.
- Improving Medicaid providers' ability to provide auditable documentation on a timely basis.
- Promoting transparency between providers and DHHS staff, including applying regulations and policy in an accurate, consistent, and timely manner and evaluating changes that have been implemented to resolve any identified problems and concerns.

Proposed MCL 400.111n

Senate Bill 1038

Senate Bill 1038 would add section 111m to require the DHHS to accept a Medicaid cost report filed by a nursing facility within 60 days after the facility filed the report.

The DHHS would need to ensure that an audit of a Medicaid cost report filed by a nursing facility is completed within 21 months after the final acceptance of the report. The settlement for an audit would be delivered to the provider not more than 60 calendar days after the provider accepted the final summary of audit adjustments. If a provider failed to release the records necessary to verify a specific cost report expense within 15 days of a written request, the DHHS

could disallow the cost associated with the item in question. The time period described above would not include time associated with an appeal or a charge of fraud filed against the provider.

If an audit were not completed within 21 months, the DHHS would have to accept the cost report as filed and move to settlement.

On-site Audit

An on-site audit could be performed at an individual nursing facility or at the corporate office if a home office cost report is filed. The audit could not last more than 30 calendar days per cost report year, for an individual nursing facility, or more than 180 calendar days per cost report year, for more than six commonly owned or controlled nursing facilities, unless the nursing facility agreed to an extended timeline. A limited-scope audit would need to be performed in the years an on-site audit is not performed. The time periods for an on-site audit would have to be completed within the 21-month time period described above. Additionally, a customer satisfaction survey would be provided to the nursing facilities that had completed audits in the previous quarter.

Availability of Documentation

A nursing facility would need to make available to an auditor documentation required under the Medicaid state plan, the Medicaid Provider Manual, and the Code of Federal Regulations relating to Medicare and Medicaid. A nursing facility would have to enhance utilization of electronic documents and correspondence to exchange information to reduce time and travel required for nursing facility audits.

Auditor Education

The DHHS would need to provide auditor education and include an ongoing discussion of all audit adjustments to ensure consistency in applying DHHS policy and to identify and eliminate any inconsistencies between offices.

External Review

Within one year after the effective date of the bill, an external review by a third party of the DHHS Office of Audit's practices related to nursing facility providers' filing of Medicaid cost reports and audits and settlements would have to be completed.

The purpose of the external review would be to compare the efficiency and cost-benefit effectiveness of existing DHHS audit practices with contracting functions of audits or settlements to a third party. The DHHS would be responsible for obtaining the external review and providing the completed review to the legislature. The third party would need to be independent from the DHHS, Medicaid providers, provider trade association members, and nursing facility cost report preparers or consultants.

No later than two years after the effective date of the bill, the DHHS would have to finalize all audits and settlements for cost reports that have been filed since before the bill's effective date. A cost report not completed by the DHHS within two years of that date would have to be accepted by the DHHS as filed by the nursing facility, and a cost report settlement would have to be issued within 60 calendar days after acceptance.

Annual Report

Beginning two years after the effective date of the bill, the DHHS would have to provide an annual report to the appropriate stakeholders, including at least one representative from each nursing facility provider trade association, on the implementation and results of the cost report audit and settlement process established by the bill. The report would need to include at least the following:

- The number of limited-scope audits, on-site audits, and any other type of audit performed during the reporting period.
- Results of the audit satisfaction surveys and how the DHHS responded to those surveys.

Proposed MCL 400.111m

Senate Bill 1039

Senate Bill 1039 would add section 105g to require the DHHS to ensure timely medical assistance eligibility determinations by doing all of the following:

- Allocating specific staff caseloads of nursing facility residents applying for medical assistance to ensure compliance with the federal standard of promptness (not more than 90 days for a disabled individual and not more than 45 days for a nondisabled individual). Staff allocated to receive caseloads could also receive caseloads for applications in setting other than nursing facilities.
- Collaborating with the nursing facility trade associations to provide periodic training on eligibility processes and requirements.
- Beginning October 1, 2019, reporting quarterly to the nursing facility trade associations on compliance with the federal standard of promptness timelines for medical-assistance-eligible nursing facility residents. The report would have to list compliance by county and identify measures necessary to meet the standard.

Annual Eligibility Redetermination

Beginning October 1, 2019, the DHHS would have to do all of the following:

- Implement an asset detection and verification process for a medical-assistance- eligible nursing facility resident.
- Provide to the recipient a prepopulated form reflecting information from the most recent Medicaid application and allow him or her to attest to the information to provide an accelerated redetermination process.
- Collaborate with the nursing facility trade associations to provide periodic training on medical assistance eligibility redeterminations.

Divestment Penalty Report

The DHHS would have to request, with the filing of the Medicaid cost report disclosure to the provider, the amount of debt incurred due to Medicaid divestment penalties. The DHHS would have to annually report the debt incurred by providers due to Medicaid divestment penalties to appropriate nursing facility stakeholders.

Outstation Worker

Under the bill, the DHHS would have to make available an outstation worker to facilitate Medicaid eligibility determination to a nursing facility that requests an outstation worker.

Recipient Court-Ordered Payment/Garnishment

If a recipient residing in a nursing facility had a court-ordered payment or garnishment, the DHHS would have to automatically apply the payment or garnishment before determining the patient-pay amount.

Proposed MCL 400.105g

HOUSE COMMITTEE ACTION:

The House Committee on Families, Children, and Seniors reported the Senate-passed version of Senate Bill 1038 without amendment and reported H-1 substitutes for Senate Bills 1037 and 1039. The H-1 substitute for Senate Bill 1037 added a provision capping increases to the current asset value bed limit, as described above. The H-1 substitute for Senate Bill 1039 removed a provision that would have required the DHHS to establish a Divestment Penalty Repayment Fund of $3.0 million to pay nursing facilities for care provided to residents while subject to a divestment penalty period. It added the provisions described under **Divestment Penalty Report**, above.

FISCAL IMPACT:

These bills would increase DHHS information technology costs by an unknown amount to prepopulate Medicaid eligibility redetermination forms and to automatically change a Medicaid recipient's "program enrollment type" when a Medicaid recipient is disenrolled from a Medicaid managed care organization after residing in a skilled nursing facility for 45 days. The bill could also increase DHHS personnel costs related to allocating specific staff for Medicaid recipients who reside in a nursing facility and related to additional training costs for nursing facility trade associations on Medicaid eligibility.

Lastly, these bills could increase Medicaid nursing home costs related to the changes to the nonavailable bed policy and to the changes in accepting cost reports. If Medicaid nursing home costs were to increase, the federal share of the increase would be 64.45% and the state share would be 35.55%.

POSITIONS:

The Health Care Association of Michigan testified in support of the bills. (11-29-18)

The Michigan County Medical Care Facilities Council indicated support for the bills. (11-29-18)

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