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BILL ANALYSIS

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Senate Bill 1037 (Substitute S-1)
Senate Bill 1038 (Substitute S-1)
Senate Bill 1039 (Substitute S-1)
Sponsor: Senator Peter MacGregor (S.B. 1037)
Senator Jim Stamas (S.B. 1038)
Senator Goeff Hansen (S.B. 1039)
Committee: Oversight

Date Completed: 9-5-18

CONTENT

Senate Bill 1037 (S-1) would amend the Social Welfare Act to require the Department of Health and Human Services (DHHS) do the following:

-- Revise a Medicaid nonavailable bed plan policy to allow a nursing facility to remove beds from service for up to 10 years.
-- Establish a process to automatically change the program enrollment type and managed care enrollment status in the Community Health Automated Medicaid Processing System immediately.
-- Perform a secondary review of a denied rate exception within 60 days after receiving a request from a nursing facility.
-- Offer a quarterly meeting to develop recommendations for promoting transparency between providers and DHHS staff, and for seeking improvement to the cost report audit and settlement process.

The bill also would require a change to existing Medicaid provider policy directly affecting nursing facility Medicaid cost reports to have a prospective effective date.

Senate Bill 1038 (S-1) would amend the Social Welfare Act to require the DHHS to do the following:

-- Accept a Medicaid cost report filed by a nursing facility within 60 calendar days after the facility had filed the report.
-- Ensure that a Medicaid cost report audit and settlement were complete within 21 months after the report was initially filed.
-- Perform an on-site audit of a nursing facility at least once every four years, and a limited-scope audit in the years an on-site audit was not performed.
-- Accept a cost report filed by a nursing facility, if an audit or settlement were not completed within 21 months, and move to settlement.
-- Finalize all cost report audits and settlements within two years after the bill's effective date.
-- Submit to the Legislature and the Senate and House Fiscal Agencies an annual report concerning the cost report audit and settlement process, beginning two years after the bill's effective date.

The bill also would require a nursing facility to make certain documentation available to an auditor.

Senate Bill 1039 (S-1) would amend the Social Welfare Act to require the DHHS to do the following:

-- Ensure timely medical assistance eligibility determination.
-- Submit to the Legislature, nursing facility trade associations, and the Senate and House Fiscal Agencies a quarterly report containing certain information.
-- Establish a "Divestment Penalty Repayment Fund" to pay nursing facilities for care provided to residents while subject to a divestment penalty period.

The bill also would add requirements pertaining to the availability of an outstation worker, and the application of a court-ordered payment or garnishment.

Each bill would take effect 90 days after its enactment.

Senate Bill 1037 (S-1)

Medicaid Provider Policies

The Medicaid Provider Manual contains policies regarding the coverage, billing, and reimbursement for Medicaid and other health care programs administered by the Department of Health and Human Services. The Medicaid Provider Manual specifies that when considering a change in Medicaid provider policy, the DHHS consults with affected providers and other interested parties regarding the proposed change. The consultation process involves a notification of the proposed change and the reasons for the change. The DHHS distributes to interested parties a copy of the draft policy change for review and comment.

Under the bill, if the DHHS issued a new interpretation of existing Medicaid provider policy directly affecting nursing facility Medicaid cost reports, the policy change would have to have a prospective effective date. A policy could have a retroactive effective date as part of a State plan amendment approval or waiver approval, or if required by State or Federal law, or judicial ruling.

Nonavailable Bed Plan Policy

An approved nonavailable bed plan allows a nursing home to take beds out of service for purposes of Medicaid cost reporting and reimbursement rate. The plan must be approved by Medicaid.

Under the bill, 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. As part of the revised policy, all of the following would apply:

-- 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 an entire nursing facility to be used during the period when the facility had a bed in the nonavailable bed plan, but the square footage associated with each nonavailable bed would be nonreimbursable on a Medicaid cost report.

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.

CHAMPS

The Community Health Automated Medicaid Processing System (CHAMPS) is a web-based DHHS Medicaid claims processing system that allows various functions to be completed online, including provider enrollment, claims status, payment status, and eligibility verification.

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

Denied Rate Exception Secondary Review

Under the bill, within 60 days after receiving 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. Department staff who were independent from the staff who performed the initial review determination would have to perform the secondary review.

Quarterly Review

The bill would require the DHHS to offer a quarterly meeting and to invite appropriate nursing facility stakeholders, including at least one representative from each nursing facility provider trade association, the State long-term care ombudsman, and any other representative. Individuals who participated in the meetings, in conjunction with the DHHS, could designate advisory workgroups to develop recommendations on the discussion topics that should include at least the following:

-- Promoting transparency between providers and DHHS staff, including applying regulations and policy in an accurate, consistent, and timely manner and evaluating changes that had been implemented to resolve any identified problems and concerns.
-- Seeking quality improvement to the cost report audit and settlement process, including clarification to process-related policies and protocols that would include the following: a) improving the auditors' and providers' quality and preparedness; b) enhanced communication between applicable parties such as DHHS staff, consultants, and providers; and c) improving Medicaid providers' ability to provide auditable documentation on a timely basis.

Senate Bill 1038 (S-1)

Medicaid Cost Report

The bill would require the Department of Health and Human Services to accept a Medicaid cost report filed by a nursing facility within 60 calendar days after the facility had filed the report.

"Medicaid cost report" or "cost report" would mean the cost of care reports submitted annually by a nursing facility that is participating in the Medicaid program at a utilization rate on average of at least six Medicaid residents, on DHHS cost reporting forms. A nursing facility provider with fewer than six Medicaid residents per day would have to file a "less than complete" cost report and would not be subject to audit.

Audit & Settlement

The bill would require the DHHS to ensure that an audit of a Medicaid cost report filed by a facility performed by the DHHS was completed within 21 months after final acceptance of the report. The settlement for an audit would have to be finalized within 60 calendar days after the completion of the audit. The 21-month period would not include time associated with any appeal.

"Audit" would mean a review of the financial records used to complete a Medicaid cost report for compliance with allowable cost principles and other policy contained in the Medicaid Provider Manual. The term would include a limited-scope audit or an on-site audit. An audit could be of limited or full scope.

"Settlement" would mean the process of reconciling a nursing facility's interim payments based on filed cost report data to audited cost report data. A final settlement would be computed after the cost report had been audited.

The Department would have to perform an on-site audit of a nursing facility at least once every four years. An on-site audit could not last more than 30 calendar days per cost report year for an individual facility, or more than 180 days per cost report year for more than six commonly-owned or controlled facilities, unless the nursing facility agreed to an extended timeline. A limited-scope audit would have to be performed in the years an on-site audit was not performed.

A customer satisfaction survey would have to be provided to the nursing facilities that had completed audits in the previous quarter.

A nursing facility would have to make available to an auditor documentation required in accordance with the Medicaid State Plan, the Medicaid Provider Manual, and the Code of Federal Regulations relating to Medicare or Medicaid. A nursing facility would have to enhance use of electronic documents and correspondence to exchange information to reduce time and travel required for nursing facility audits.

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

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

Within two years after the bill's effective date, the DHHS would have to finalize all audits and settlements for cost reports that had been filed since before the bill's effective date. A cost report that the DHHS had not completed within the two-year period 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.

External Review

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

responsible for obtaining the external review and would have to provide the completed review to the Legislature. The third party would have to be independent from the DHHS, Medicaid providers, provider trade association members, and nursing facility cost report preparers or consultants.

Report to Legislature

Beginning two years after the bill's effective date, the DHHS would have to provide to the Senate and House of Representatives Appropriations subcommittees on the DHHS budget, the Senate and House standing committees having jurisdiction over issues involving senior citizens, and the Senate and House Fiscal Agencies an annual report on the implementation and results of the cost report audit and settlement process established under the bill. The report would have to include all of the following:

-- The number of limited-scope audits, on-site audits, and any other type of audit performed during the reporting period.
-- How the DHHS had met the one-time-every-four-years on-site audit requirement.
-- Results of the audit satisfaction surveys and how the DHHS had responded to them.

Senate Bill 1039 (S-1)

Eligibility Determination

The Social Welfare Act requires the Department of Health and Human Services to establish a program for medical assistance for the medically indigent (commonly called Medicaid).

Under the bill, consistent with Federal regulations, the standards of promptness for establishing medical assistance eligibility for individuals in nursing facilities could not be more than 90 days for a disabled individual, and not more than 45 days for a nondisabled individual. To ensure timely eligibility determination, the DHHS would have to do all of the following:

-- Establish staff dedicated to specialized caseloads for nursing facility residents applying for medical assistance in order to ensure compliance with the standards for promptness.
-- Collaborate with the nursing facility trade associations to provide periodic training on medical assistance eligibility processes and requirements.
-- Beginning October 1, 2019, report quarterly to the nursing facility trade associations, Senate and House or Representatives Appropriations subcommittees, Senate and House standing committees having jurisdiction over issues involving senior citizens, and the Senate and House Fiscal Agencies on compliance with the standard of promptness timelines for medical-assistance-eligible nursing facility residents.

The report would have to list compliance with the standard of promptness by county and identify measures necessary to meet that standard.

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.
-- Allow the recipient or his or her representative to attest to any change in assets or income to provide an accelerated redetermination process.
-- Collaborate with the nursing facility trade associations to provide periodic training on medical assistance eligibility redeterminations.

Divestment Penalty Repayment Fund

The Department would have 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. If the total divestment penalty debt claimed by all nursing facilities in the State exceeded $3.0 million, the money would have to be dispersed to each facility claiming debt at a percentage covered by the Fund. If the total divestment penalty debt claimed by all nursing facilities in the State were less than $3.0 million, General Fund money remaining could not lapse to the General Fund, but would have to remain available in the next fiscal year.

The Department would have to make available an outstation worker to use to facilitate Medicaid eligibility determination to a nursing facility that requested an outstation worker.

Beginning October 1, 2019, 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 400.111n (S.B. 1037)
Proposed MCL 400.111m (S.B. 1038)
Proposed MCL 400.105g (S.B. 1039)

Legislative Analyst: Stephen Jackson

FISCAL IMPACT

The bills would lead to an increase in General Fund/General Purpose (GF/GP) costs, largely due to the creation of a $3.0 million Divestment Penalty Repayment Fund and indeterminate increases in DHHS staffing and information technology costs needed to meet new nursing facility eligibility promptness standards. There also would be the potential for cost increases if the nonavailable bed plan policy increased the occupancy rate for low occupancy nursing homes, thus potentially increasing the per diem payments for such homes.

Senate Bill 1037 (S-1) would allow nursing facilities to remove beds from service for up to ten years. The nonavailable bed plan policy could result in low occupancy nursing homes, which would receive lower per diem rates, increasing their occupancy rate by removing beds from service and receiving greater per diem rates. The impact of this policy change would be indeterminate but potentially significant.

Senate Bill 1038 (S-1), which addresses nursing facility audits, would have a minor fiscal impact. There likely would be some marginal administrative savings for nursing facilities, including Medical care facilities. There would be the potential for further increased costs if the 21-month acceptance timeline outlined in subsection (7) expired and cost reports that otherwise would continue to go through a settlement process instead would have to be accepted as filed.

Senate Bill 1039 (S-1) would create a standard of promptness for Medicaid eligibility for those in nursing homes (90 days for disabled and 45 days for nondisabled individuals) and would outline procedures and practices to ensure timely eligibility determination. These would include additional staff dedicated to Medicaid nursing facility eligibility determination, implementation of an asset detection and verification process, and creation of a $3.0 million Divestment Penalty Repayment Fund. The staffing increase would cost about $55,000 GF/GP per FTE added. There also would be information technology costs related to the fund disbursement process. The implementation of an asset detection and verification process also would likely lead to marginal increases in administrative costs. The Fund would cost a

maximum of $3.0 million GF/GP per year (if the Fund were not fully claimed in a given year, the GF/GP costs could be lower in subsequent years as surpluses would carry over).

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