MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA-11-46

Distribution: Nursing Facilities

Issued: October 31, 2011

Subject: Nursing Facility Rate Relief

Effective: December 1, 2011

Programs Affected: Medicaid

The purpose of this bulletin is to address Medicaid policy for nursing facilities requesting rate relief by:

- Clarifying the criteria through which rate relief can be permitted;
- Further defining the circumstances under which accelerated rebasing may occur;
- Revising the "Worksheet to Establish Criteria for Nursing Facility Class I Rate Relief" to reflect these changes; and
- Defining "Net Quality Assurance Supplement (QAS)" and "Non-Medicare Nursing Facility Day".

Information in this bulletin will be applied to policy found in the Cost Reporting & Reimbursement Appendix of the Medicaid Provider Manual.

POLICY CHANGES

Eligibility Criteria

A nursing facility must meet one of five criteria in order to qualify for rate relief under current Medicaid policy. The following changes are being made to existing policy as shown in **bold print** below:

First Criterion: The sum of the provider's Variable Rate Base, Economic Inflation Update, and other associated rate add-ons (excluding Nurse Aide Training and Testing reimbursement), plus the Net Quality Assurance Supplement, must be less than the provider's audited Medicaid variable cost per resident day **for the provider's two fiscal cost reporting periods (not rate setting periods) of not less than seven months immediately prior to the first period of rate relief.**

Second Criterion: The provider is required, as a result of a survey by the State Survey Agency (SSA), to correct one or more substandard quality of care deficiencies to attain or sustain compliance with Medicaid certification requirements. The survey must have occurred within six months prior to the provider's request for rate relief. The provider must submit **to the Reimbursement and Rate Setting Section (RARSS)** a copy of the citation and an approved Plan of Correction outlining the action being taken by the provider to address the **deficiencies**. **A copy of facility staffing levels before and after the survey citation must be provided to RARSS to demonstrate the staffing increase is sustained and is not for short-term training purposes only.**

Third Criterion: The provider has experienced a significant change in the level of care needed for current Medicaid residents in the nursing facility. Significant change is defined as an increase of ten minutes per patient day, as demonstrated by Minimum Data Set (MDS) data, **which results in a corresponding increase in direct care staffing equal to or greater than the increase in patient minutes per day.** The provider must submit an analysis comparing resident acuity levels from the rate base year to current resident acuity levels. MDS data must be used for this comparison. The data is subject to a clinical review by Medicaid. The analysis must also include a comparison of the previous and current nurse staffing levels required **based on actual residential census or actual patient days** and other nursing-related costs or requirements likely to increase the operational costs. This does not include nursing administration staff.

Fourth Criterion: The provider is new in a Medicaid-enrolled facility, and the facility's most recent cost report submitted to Medicaid was incomplete, undocumented or had unsubstantiated cost data by the previous provider. Inadequate cost reporting includes non-payment of accrued liabilities due to the previous provider's bankruptcy, as determined by Medicaid auditors or their designees in accordance with Medicaid allowable costs, or inadequate records to support the filed cost report. Proof of the change of ownership must be submitted, along with an explanation of why the cost report data is inadequate to calculate the provider's reimbursement rate.

Fifth Criterion: Rate relief is needed to prevent closure of a Medicaid-enrolled facility due to a regulatory action by the State Survey Agency (SSA) where the facility's closure would result in severe hardship for its residents and their families due to the distance to other nursing facilities, and no new provider would operate the facility at its current reimbursement rate. A facility would meet this hardship criteria only if a new owner has agreed to take over its operation and it is either the only nursing facility in the county or the facility has at least 65 percent of the Medicaid nursing facility (Class I, III and V) certified beds in that county.

Rate Relief Methodology

Example: The provider's cost report for the period ending December 31, 2010 could be used to set the October 1, 2010 rate if approved for rate relief under **the criteria established in the Eligibility Criteria Section of this Appendix.** The provider would be allowed to participate in any add-on reimbursement programs at their election.

The cost reporting is based on the provider's established fiscal year and must not cover a time period of less than seven months. The cost report period used for the accelerated rebasing must have a reporting period end date prior to January 1 of the State rate year. **This example is applicable to the third and fourth criteria for rate relief qualification as stated in the Eligibility Criteria Section of this Appendix of this chapter.**

Example: A cost report time period ending after January 1, **2010** could not be used for accelerated rebasing of a rate effective during the State rate year October 1, **2009** through September 30, **2010**.

DEFINITIONS

The definition of Net Quality Assurance Supplement is being clarified to state that it is "The Quality Assurance Supplement minus the **Medicaid share of the** assessment, based on non-Medicare nursing facility days."

Non-Medicare Nursing Facility Days are any nursing facility days for which Medicare (Part A [Fee for Service] and Part C [Medicare Advantage]) is not the primary source of reimbursement.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Steven Fitton, Director
Medical Services Administration

Michigan Department of Community Health

Worksheet to Establish Criteria for Nursing Facility Class I Rate Relief

A Class I provider applying for rate relief must meet one of five rate relief criteria. This worksheet is applicable to the first criterion found in the Eligibility Criteria Section of the Nursing Facility Cost Reporting & Reimbursement Appendix of the Medicaid Provider Manual.

The sum of the provider's Variable Rate Base, Economic Inflation Update, and other associated rate add-ons (excluding Nurse Aide Training and Testing reimbursement), plus the Net Quality Assurance Supplement, must be less than the provider's audited Medicaid variable cost per resident day for its two fiscal cost reporting periods (not rate setting periods) of not less than seven months immediately prior to the first period of rate relief. Costs for Nurse Aide Training and Testing are not included in the Medicaid variable costs.

The cost analysis from the provider's immediate prior two fiscal periods (of at least seven months) must be in the following format:

			Costs of 1st period prior to rate relief	Costs of 2nd period prior to rate relief
A. Variable Costs Incurred on a Per Resident Day (From Worksheet 2-H Costs of Provider Cost Report)			$	$
			Costs of 1st period prior to rate relief	Costs of 2nd period prior to rate relief
B. Variable Cost Reimbursement				
Variable Rate Base			$	$
Economic Inflationary Update			$	$
Net QAS			$	$
Other Add-ons			$	$
C. Total			$	$
Variable Costs Incurred in Excess of Variable Cost Reimbursement (A-B)			$	$

Example: Provider has a December 31 fiscal period end. On January 1, 2009, provider determines that their allowable variable costs have exceeded their Medicaid reimbursement for fiscal years 2008 and 2007. Provider would be eligible under this criterion for rate relief effective January 1, 2009 using the fiscal year ended December 31, 2008 cost report.

This analysis, along with other required items identified in the Medicaid Provider Manual, Nursing Facility, Cost Reporting & Reimbursement Appendix, Rate Relief for Class I Nursing Facilities Section, must be submitted to:

LTC Reimbursement and Rate Setting Section
Bureau of Medicaid Financial Management
Medical Services Administration
P.O. Box 30479
Lansing, MI 48909–7979