MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-42

Distribution: Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Ventilator Dependent Care Units

Issued: October 1, 2014

Subject: New Class I Nursing Facility Rate Relief Criterion

Effective: November 1, 2014

Programs Affected: Medicaid

NOTE: Implementation of this policy is contingent upon approval of a State Plan Amendment by the Centers for Medicare & Medicaid Services (CMS).

The purpose of this bulletin is to describe changes to the Rate Relief for Class I Nursing Facilities Section within the Nursing Facilities and Reimbursement Appendix of the Medicaid Provider Manual. A new condition under which rate relief is available will be added to enable facilities that meet this condition to provide better services to Medicaid beneficiaries. A new section will also be added to describe the methodology and documentation required for the criterion.

Eligibility Criteria

Facilities seeking rate relief will continue to be required to demonstrate the three basic criteria defined in the Eligibility Criteria section as well as one additional criterion from the list included in the section. That list would expand from five to six options.

The Eligibility Criteria section will be changed to include the following additional criterion:

- The nursing facility provider must also meet at least one of the following six criteria:
    - The provider's current Variable Rate Base is less than or equal to 60 percent of the corresponding rate year's Variable Cost Limit. A facility is not eligible under this criterion if an owner or administrator's compensation is above the current compensation limit. A provider with non-allowable related party transaction costs or non-allowable related party lease costs cannot be eligible under this criterion.

Rate Relief Methodology and Documentation

The following sub-section will be added to the Rate Relief for Class I Nursing Facilities Section:

Rate Relief for a Current Provider in a Medicaid Enrolled Nursing Facility with a Variable Rate Base Less Than or Equal to 60 Percent of the Variable Cost Limit

A current provider in a Medicaid enrolled nursing facility with a Variable Rate Base of less than or equal to 60 percent may request rate relief.

A new Variable Rate Base of the rate is calculated that will be no more than 50 percent of the difference between the Class I Average Variable Cost and the existing Variable Rate Base for the current rate year. The resulting new Variable Cost Component will thereby adjust the facility's per diem rate. This Variable Rate Base will remain in effect through the current State fiscal year rate period ending September 30.

Example: A nursing facility has a current Variable Rate Base of $96, the Variable Cost Limit is $160, and the Class I Variable Cost Average is $150 (none of the figures are based on actual data, they are used for example purposes). Based on the facility's request for rate relief they are found eligible for the maximum 50 percent of the difference between their current Variable Rate Base and the Variable Cost Average. Their Variable Base Rate will then increase from $96 to $123.

The provider receiving rate relief in this category must utilize the standardized data to file a Class I Rate Relief Interim Cost Statement at the time of application for relief. The Interim Cost Statement excerpted worksheets from the Medicaid annual cost report (Medicaid cost reporting formats identified below) must reflect actual or expected costs incurred by the nursing facility for the provider's cost reporting period. A facility with less than seven months remaining in its Cost Reporting period may file a second Interim Cost Statement at the end of that fiscal year.

The Rate Relief Interim Cost Statement must contain the following completed schedules of the cost report in the Michigan Department of Community Health (MDCH) required electronic format:

- Checklist
- Worksheet A
- Worksheet B
- Worksheet 1
- Worksheet 1-C (only if claiming allocated related party costs)
- Worksheet 2

The Interim Cost Statement is used to determine the interim rate for the remainder of the rate period. The interim rate is revised when the acceptable annual cost report is submitted and used for accelerated rebasing.

Effective October 1 of the following State fiscal year rate period, MDCH determines the Variable Rate Base using accelerated rebasing. The accelerated rebasing utilizes the provider's first cost reporting period that reflects at least seven months of nursing facility operation after rate relief. The cost reporting time period is based on the provider's established fiscal year. The nursing facility allowable variable cost is indexed to October 1 of the year that is one year prior to the new rate year being calculated by applying the appropriate cost index.

The subsequent rate year calculation is in accordance with standard reimbursement methodology.

Example 1, Request Received with Less Than Seven Months in the Cost Reporting Period: A provider has a cost reporting period ending on December 31 of each year. The provider is approved for rate relief for rate year October 1, 2014 to September 30, 2015. The facility per diem rate is set using a new Variable Rate Base of no more than 50 percent of the difference between the Variable Rate Base and Class I Average Variable Costs effective for the rate year beginning October 1, 2014. The provider must complete an Interim Cost Statement for variable costs for their cost report period that must be filed with their rate relief request. In this instance they may submit a revised Interim Cost Statement for the provider's cost reporting period January 1, 2015 through December 31, 2014. The rate year beginning October 1, 2015 would then utilize the accelerated rebasing to determine the rate for that period based on the December 31, 2015 fiscal year.

Example 2, Request Received with Seven Months or More in the Cost Reporting Period: A provider has a cost reporting period ending December 31 of each year. The provider is approved for rate relief and submits their Interim Cost Report ending on February 1, 2014. The facility per diem rate is set using a new Variable Rate Base of no more than 50 percent of the difference between the Class I Variable Cost Average and the Variable Base Cost effective for the rate period February 1, 2014 through September 30, 2014. The rate relief would be effective through the end of the rate relief period of September 30, 2014. The rate year beginning October 1, 2014 would then utilize the accelerated rebasing to determine the rate for that period based on the December 31, 2014 fiscal year.

Rate relief is subject to audit and settlement with reimbursement adjustment using the principles and guidelines outlined in Medicaid policy. Rate relief reimbursement cannot exceed the appropriate cost and rate limitations. The provider is reimbursed by Medicaid for any underpayment, and the provider must reimburse Medicaid for any overpayment. If the interim Variable Rate Base determined for rate relief reimbursement to the provider exceeds the audited Variable Rate Base reimbursement by more than three percent, the provider will be assessed a penalty equal to 10 percent of the total overpayment amount.

A nursing facility provider receiving rate relief is allowed to participate in any other add-on reimbursement programs at their election. These programs are defined under the Medicaid policy applicable to the program. The costs associated with these add-on programs are not included in the cost settlement of the variable costs for rate relief as previously described.

Rate Relief Documentation

It is the provider's responsibility to submit supporting documentation with the rate relief petition. A petition from the provider must include:

- Identification of the criteria under which rate relief is requested.
- Supporting documentation for the criteria.
- Detail of the circumstances causing the need for the rate relief request.
- A requested effective date (the actual effective date of the rate relief is based on the date that the petition is received by Medicaid). The earliest effective date would be the first day of the next month (i.e., a petition received on August 31 may be effective as soon as September 1).
- The services time period that is the basis for which rate relief is requested.
- Detail of the expenses that are not in the base period for the current or subsequent fiscal year Medicaid rate and how these expenditures relate to the provision of resident care.
- Plans on how these changes will ensure the required level of resident care.

Public Comment

This bulletin is being issued for public comment of the policy promulgation process concurrently with the implementation of the changes noted in this bulletin. Any interested party wishing to comment on the changes may do so by submitting comments in writing to:

Michigan Department of Community Health
Ryan Tisdale, Long Term Care Policy Section
Bureau of Medicaid Policy and Health System Innovation
Medical Services Administration
PO Box 30479
Lansing, MI 48909
E-mail: TisdaleR1@michigan.gov

If responding by e-mail, please include “New Class I Nursing Facility Rate Relief Criterion” in the subject line.

Comments received will be considered for revisions to the changes implemented by this bulletin.

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

Stephen Fitton, Director
Medical Services Administration