MDHHS Michigan Department of Health & Human Services

Medical Services Administration
BULLETIN MSA

**Bulletin Number:** MSA 18-25

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

**Issued:** August 30, 2018

**Subject:** Nursing Facility Quality Measure Initiative Bulletin Revisions

**Effective:** As Indicated

**Programs Affected:** Medicaid

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

This bulletin describes revisions to bulletin MSA 17-28 (effective October 1, 2017, pending SPA approval), regarding the nursing facility Quality Measure Initiative (QMI), to comply with CMS requirements. Excluding the changes identified in this bulletin, the provisions described in MSA 17-28 remain in effect. A copy of MSA 17-28 is included with this bulletin.

## Eligibility for QMI Payment

The following bullet is added to the provider QMI payment eligibility conditions:

- The provider must deliver at least one day of Medicaid nursing facility services at the room and board level during the state fiscal year in which they receive QMI payments and in their immediate prior year-end cost reporting period. QMI payments made to a provider found to have no days of Medicaid nursing facility services during the state fiscal year shall be recouped by the Michigan Department of Health and Human Services (MDHHS).

## QMI Payment Methodology

The Medicaid utilization rate will be determined from the immediate prior year-end cost report covering a period of at least seven months (e.g., 2016 year-end cost reports will set the utilization rate for the fiscal year beginning October 1, 2017). For the purposes of this section a cost report refers to the uniform Medicaid nursing facility cost report or a less than complete cost report. The sum of the total Title XIX patient days in the Medicaid Routine Care Unit #1 and the Medicaid Special Care Unit #1 over the sum of the total inpatient days in all nursing facility units on the cost report will set the utilization rate (e.g., if the sum of the Title XIX inpatient days in the Medicaid Routine Care Unit #1 and the Medicaid Special Care Unit #1 is 1,000, while the sum of total inpatient days in all units is 1,500, the Medicaid utilization rate

would be 66.7%). If the immediate prior year-end cost report does not cover a period of at least seven months, then the Medicaid utilization rate will be determined as follows:

- If the prior year-end cost report covers a period of less than seven months and if multiple cost reports were filed by the current or prior facility owner, then all cost reports submitted for the prior year-end will be used in calculating the Medicaid utilization rate (i.e., if the current owner and the prior owner each submitted a 2016 year-end cost report then both cost reports would be used to determine the Medicaid utilization rate).
- If no cost report was filed for the prior year-end because the current or prior owner submitted an extended period cost report, then the most recent cost report filed prior to the previous calendar year that covers a period of at least seven months will be used in calculating the Medicaid utilization rate.
- If the immediate prior year-end cost report is the only cost report the provider has ever filed, then that cost report will be used in calculating the Medicaid utilization rate even if it covers a cost reporting period of less than seven months.
- A provider that has not filed an immediate prior year-end cost report will be assumed to have no Medicaid utilization.

Per-bed QMI payment amounts are multiplied by a Medicaid utilization scale. The Medicaid utilization scale will be applied as follows:

- For nursing facilities with a Medicaid utilization rate of above 63%, the facility shall receive 100% of the QMI payment.
- For nursing facilities with a Medicaid utilization rate between 50% and 63%, the facility shall receive 75% of the QMI payment.
- For nursing facilities with a Medicaid utilization rate of less than 50%, the facility shall receive a payment proportionate to their Medicaid utilization rate.

Example: Facility A has a Medicaid utilization rate of 64% while Facility B has a Medicaid utilization rate of 35%, so Facility A would receive 100% of their QMI payment while Facility B would receive 35% of their payment.

**Public Comment**

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Attn: Ryan Tisdale
MDHHS/MSA
PO Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: TisdaleR1@michigan.gov

If responding by e-mail, please include " Nursing Facility Quality Measure Initiative " in the subject line.

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

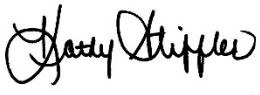
**Manual Maintenance**

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

**Questions**

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, 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**



Kathy Stiffler, Acting Director
Medical Services Administration

MSA MEDICAL SERVICES ADMINISTRATION

# Bulletin

**Michigan Department of Health and Human Services**

**Bulletin Number:** MSA 17-28

**Distribution:** Nursing Facilities, County Medical Care Facilities, Hospital Long Term Care Units

**Issued:** August 31, 2017

**Subject:** Nursing Facility Quality Measure Initiative

**Effective:** October 1, 2017

**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).**

This bulletin describes changes to the Nursing Facility Cost Reporting & Reimbursement Appendix of the Medicaid Provider Manual. Contingent upon CMS approval, a nursing facility Quality Measure Initiative (QMI) is established to provide a supplemental payment to facilities based upon their 5-star ratings from the CMS Nursing Home Compare (NHC) website at www.medicare.gov/nursinghomecompare. The QMI will be funded by an increase in the nursing facility Quality Assurance Assessment.

## Cost Reporting

### Nursing Facility Quality Measure Initiative Special Cost Reporting Requirements

The Quality Assurance Assessment levied for the QMI and the payment amount of the QMI are to be reported on the cost report the year they are applicable and in the following manner:

- The tax assessed on a facility is to be reported on the “Quality Incentive Initiative Assessment – Long Term Care” line of the cost report under the Administrative & General cost center.
- The amount of QMI payment is to be reported on the “Quality Incentive Initiative Payment – Long Term Care” line of the cost report under Routine Services Revenue.

The tax assessed is adjusted from the cost report in accordance with the Quality Assurance Assessment Tax subsection of the Allowable and Non-Allowable Costs section of the Nursing Facility Cost Reporting & Reimbursement Appendix. An adjustment is also made to the cost report to remove the QMI payment amount net of the QMI tax assessment amount. The QMI payment adjustment may not exceed zero (i.e., the adjustment is either a negative amount or zero), and the adjustment amount is made to “Miscellaneous – Base” in the Medicaid Routine Care Unit #1 line of the cost report.

## Rate Determination

### Nursing Facility Quality Measure Initiative

Eligible nursing facilities may receive a supplemental QMI payment. Payments to individual nursing facilities will be determined by their average 5-star quality measure rating on the CMS NHC website, Medicaid utilization rate, number of licensed beds, and resident satisfaction survey data as described in this section. In cases of a change of ownership, the new owner's QMI payment will continue to be calculated based off of the prior owner's average quality measure rating, Medicaid utilization rate, number of licensed beds and resident satisfaction survey data.

The average 5-star quality measure rating will be based upon the average rating from July of the prior calendar year to June of the current calendar year (e.g., for the rate year beginning October 1, 2017, the average 5-star quality measure rating would be based on the average rating between July 1, 2016 to June 30, 2017).

### Eligibility for QMI Payment

To be eligible to receive a QMI payment, a provider must meet the following conditions:

- The provider must be a Class I or III nursing facility.
- The provider must have a 1, 2, 3, 4 or 5-star quality measure rating on the NHC website.
- The provider must be a Medicaid-certified nursing facility.
- The provider must not be closed for business. That includes a voluntary closure, or an action by MDHHS, CMS or LARA to decertify or delicense a provider.
- The provider must not be designated as a Special Focus Facility (SFF) by CMS.
- If the provider has an average quality measure rating below 2.5 stars, they must submit an action plan to the Long Term Care Policy Section as described in this section.

MDHHS will generally check in August prior to the beginning of a rate year and approximately every three months thereafter to see which facilities are designated as SFFs or have closed. A provider designated as a SFF will not be eligible to receive any QMI payments until they graduate from the SFF list. An SFF that graduates after the rate year begins will only be eligible for prorated QMI payments for the balance of the remaining months of the rate year (e.g., a provider that graduates from the SFF list would not receive reimbursement equal to what they would have received had they been eligible for the entire rate year). If a provider has closed or graduated from the SFF list, MDHHS may recalculate some or all QMI payments depending on the amount of available funds.

## QMI Action Plan

A provider with an average quality measure rating below 2.5 stars must file an acceptable QMI action plan with the Long Term Care Policy Section to be eligible for a QMI payment. The action plan will need to provide specific details reflecting how a provider intends to use QMI funds to increase quality outcomes. The Long Term Care Policy Section will provide written notice to providers with a rating below 2.5 stars and will provide the expectations for the action plan. A plan that does not provide the specific details required in the notice will not be accepted by the Long Term Care Policy Section.

The Long Term Care Policy Section will set a due date in the notice for a provider to submit the action plan. A provider that fails to submit an action plan by the due date cannot receive payment until an action plan is sent to and accepted by the Long Term Care Policy Section. If a provider fails to submit an acceptable action plan within 30 days of the due date, they will be unable to receive a QMI payment for the remainder of the fiscal year. Unless directed otherwise by the Long Term Care Policy Section, the action plan must be sent electronically as specified in the notice.

## QMI Payment Methodology

QMI payments will be calculated near the beginning of the state fiscal year unless otherwise specified by MDHHS. The NHC quality measure rating will determine a per-bed QMI amount based on available funding. The per-bed amount will be larger for higher quality measure ratings (i.e., a 5-star rating will result in a higher per-bed QMI amount than a 4-star rating, etc.). The QMI amount is further adjusted to factor in Medicaid utilization and, for rate years on or after October 1, 2018, the submission of resident satisfaction survey data will be used to further adjust the amount. The adjusted QMI amount is multiplied by the number of licensed nursing facility beds to determine the QMI payment for the year. The yearly QMI payment is distributed as a monthly gross adjustment.

Unless determined otherwise by MDHHS, licensed beds will be determined using the number of beds licensed by the Department of Licensing and Regulatory Affairs and identified in the Long Term Care Reimbursement and Rate Setting Section's Long Term Care Application system as of August 1 prior to the rate year. Home for the aged, assisted living, adult daycare, apartment, non-long term care, etc. beds do not count towards the licensed bed count.

The Medicaid utilization rate will be determined from the immediate prior year-end cost report covering a time period of at least 7 months (e.g., 2016 year-end cost reports will set the utilization rate for the fiscal year beginning October 1, 2017). The sum of the total Title XIX patient days over the sum of total inpatient days in the Medicaid Routine Care Unit #1 and Medicaid Special Care Unit #1 on the cost report will set the utilization rate (e.g., if the sum of the Title XIX inpatient days in the Medicaid Routine Care Unit #1 and Medicaid Special Care Unit #1 is 1,000 while the sum of total inpatient days is 1,500 the Medicaid utilization rate would be 66.7%). A nursing facility that did not file a cost report in the prior year or a cost report covering a period of at least 7 months will be assumed to have a Medicaid utilization rate of below 50%.

Per-bed QMI payment amounts are multiplied by a Medicaid utilization scale. The Medicaid utilization scale will be applied as follows:

- For nursing facilities with a Medicaid utilization rate of above 63%, the facility shall receive 100% of the QMI payment.
- For nursing facilities with a Medicaid utilization rate between 50% and 63%, the facility shall receive 75% of the QMI payment.
- For nursing facilities with a Medicaid utilization rate of less than 50%, the facility shall receive 50% of the QMI payment.

Effective for rate years beginning on or after October 1, 2018, an adjustment is made for the submission of resident satisfaction survey data from recently performed surveys. The Long Term Care Policy Section will provide notice to facilities prior to the fiscal year on how to submit the data, what documentation is necessary, and where to submit resident satisfaction survey data by a due date specified in the notice. Per-bed QMI payments will be multiplied by 100% for facilities that submit acceptable resident satisfaction survey data and documentation, but payments will be multiplied by a percentage set by MDHHS for facilities that do not submit the data and documentation. The resident satisfaction survey must have been conducted no more than 12 months before the submission of the notice, and survey data submitted for prior year QMI payments will not be accepted.

The following formula demonstrates the monthly adjusted QMI payment (for rate years prior to October 1, 2018 the resident satisfaction survey factor is not included in the formula):

- QMI Gross Adjustment = (([NHC Per-Bed Amount]*[Medicaid Utilization Scale]*[Resident Satisfaction Survey Factor])*[Number of Licensed Nursing Facility Beds])/[Number of Eligible Payment Months]

**Examples:**

- For rate year October 1, 2017, Nursing Facility A has an average NHC rating of 5 stars, a Medicaid utilization rate of 55%, 100 licensed nursing facility beds and meets all the payment eligibility requirements. The NHC per-bed amount for a 5 star rating is $2,000, so the QMI Gross Adjustment = (($2,000)*(75%)*(100))/12 = $12,500/month.
- For rate year October 1, 2017, Nursing Facility B has an average NHC rating of 2 stars, a Medicaid utilization rate of 32%, 45 licensed nursing facility beds and meets all the payment eligibility requirements. The NHC per-bed amount for a 2 star rating is $1,250, so the QMI Gross Adjustment = (($1,250)*(50%)*(45))/12 = $2,343.75/month.
- For rate year October 1, 2018, Nursing Facility C has an average NHC rating of 3 stars, a Medicaid utilization rate of 78%, 200 licensed nursing facility beds, has not submitted resident satisfaction survey data and meets all the payment eligibility requirements. The NHC per-bed amount for a 4 star rating is $1,750 and the resident satisfaction survey factor for facilities with no survey is 85%, so the QMI Gross Adjustment = (($1,750)*(100%)*(85%)*(200))/12 = $24,791.67/month.

- For rate year October 1, 2018, Nursing Facility D has an average NHC rating of 1 star, a Medicaid utilization rate of 61%, 150 licensed nursing facility beds, has submitted resident satisfaction survey data and meets all the payment eligibility requirements. The NHC per-bed amount for a 1 star rating is $1,000, so the QMI Gross Adjustment = (($1,000)*(75%)*(100%)*(150))/12 = $9,375/month.

All values in the examples above are for example purposes only and do not reflect actual rates.

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Attn: Ryan Tisdale
MDHHS/MSA
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Or
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**Approved**

Chris Priest, Director
Medical Services Administration