MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin: MSA 05-14

Distribution: Nursing Facilities (Provider Type 60)
County Medical Care Facilities (Provider Type 61)
Hospital Long Term Care Units (Provider Type 62)
Hospital Swing Beds (Provider Type 63)
Ventilator Dependent Units (Provider Type 63)
Nursing Facilities for the Mentally Ill (Provider Type 72)

Issued: March 1, 2005

Subject: New Nursing Facility Chapter VII (Reimbursement);
Updated Nursing Facility Chapter III (Coverages and Limitations);
Nurse Aide Training and Competency Evaluation Program;
CNA Reimbursement Form

Effective: April 1, 2005

Programs Affected: Medicaid

The purpose of this bulletin is to transmit a new Medicaid Nursing Facility Provider Manual Reimbursement Chapter and an updated Coverages and Limitations Chapter.

The Coverages and Limitations Chapter has been updated to incorporate policies previously issued in policy bulletins. Changes are listed below.

The Reimbursement Chapter has been revised to incorporate new policies, previously published policy bulletins, and to clarify existing policy. Notable changes to policy are listed below. Cost reports covering cost report periods ending in calendar year 2004 must use cost allocation policies and practices in effect prior to this bulletin. Cost reports covering cost report periods ending in calendar year 2005 and beyond must use cost allocation policies and practices as outlined in this chapter.

The attached chapters, along with the Nursing Facility Certification, Survey and Enforcement Chapter (transmitted with bulletin Nursing Facilities 04-07), will be combined into the Nursing Facilities Chapter and incorporated into the April 1, 2005 version of the electronic Medicaid Provider Manual. The manual is available online at www.michigan.gov/mdch >>Providers>>Information for Medicaid Providers>>Medicaid Provider Manual.

COVERAGES AND LIMITATIONS CHAPTER CHANGES

Section 4 - Beneficiary Eligibility and Admission Process
Policy regarding admission requirements for Medicaid nursing facilities transmitted via bulletins MSA 04-15, MSA 04-17, and MSA 05-09 was incorporated.

Section 7 - PASARR Process
Language in this section was updated to clarify that PASARR is not required when a Medicaid beneficiary enters a nursing facility for the five-day respite hospice benefit.

Section 8.2 - Medicare Denial of Basic Care
Clarification was added to this section in response to inquiries from nursing facilities.

Section 8.3 - Medicaid Reimbursement for a Nursing Facility Bed Following a Qualifying Medicare Hospital Stay
Policy from bulletin MSA 04-04 was incorporated.

Section 8.22 – Provider Donations for Outstationed State Staff
Allowable costs for outstationed staff is defined.

Section 8.29 – Therapy and Pathology Services
Defined the development of maintenance plans by licensed therapists as routine nursing services.

Section 9.2 - Admission Kits
Policy related to Admission Kits was updated for consistency with policy on personal hygiene items.

Section 9.6 – Cost Finding
Defined ancillary group exclusion process.

Section 9.8 – Day Care Services Provided in the Nursing Facility
Defined when day care costs for employee dependents are allowable.

Section 9.13 – Non-Available Beds
Increased bed plan extensions.

Section 9.26.A. - Over-the-Counter Products
Policy was updated to clarify OTCs include both generic and brand name items.

Section 9.27 - Physician Services
Policy related to the initial physician examination of a resident was clarified.

Section 9.35 - Therapies
Further clarification between routine and non-routine therapy was added.

Section 9.36.A - Nonemergency Transportation
Information was added regarding the responsibility of facilities to provide nonemergency transportation to a Medicare/Medicaid beneficiary.

Section 10.2.A. - Hospital Leave Days
Policy transmitted via bulletins MSA 04-20 and MSA 05-11 was incorporated into the section.

Section 10.2.B. - Therapeutic Leave Days
This section was updated for consistency with the Reimbursement Chapter.

Section 10.5 - Memorandums of Understanding – Special Agreements for Complex Care
This section was updated to reflect information from bulletin MSA 04-14 and the Medicaid State Plan.

Section 10.6 - One-Day Stay
This section was updated for consistency with the Reimbursement Chapter

Section 11.1 - Hospital Swing Beds
This section was updated for consistency with the Reimbursement Chapter.

Section 11.3 - Ventilator-Dependent Care Units
This section was updated to reflect information from bulletin MSA 04-14 and the Medicaid State Plan.

REIMBURSEMENT CHAPTER CHANGES, UPDATES, AND REVISIONS

Section 2.2 – Ownership Changes
Defines situations where the State Medicaid Agency (SMA) must be notified, i.e., ownership changes, termination/closure.

Defines the circumstances under which the SMA will recognize a sale between related parties and how reimbursement will be determined.

Section 3 - Definitions
Expands the definition section of the chapter.

Section 4 - Cost Reporting
Clarifies the exceptions to cost reporting requirements for certain types of providers.

Clarifies cost reporting requirements for new owners and new facilities.

Outlines cost reporting requirements for home offices and related parties.

Specifies the circumstances under which a nursing facility may file a cost report under protest.

Section 5 - Plant Cost Certification
Clarifies when a provider may file a Plant Cost Certification and outlines the determination process.

Section 6 - Audit
Clarifies audit purpose and process.

Section 7 - Cost Report Reimbursement Settlements
Outlines the Cost Report Reimbursement Settlement process.

Identifies withholding of reimbursement where participation ends prior to cost reporting period end.

Section 8 - Allowable and Non-Allowable Costs
Removes appraisal pre-approval requirement.

Clarifies allowable attorney and legal fees, specifically related to regulatory actions.

Establishes policy for pass-through leases for electronic equipment and vehicles.

Specifies that Lobbying and Political Activities and Maintenance of Effort Contributions are not allowable costs.

Establishes policy for home office compensation.

Clarifies policy for owner/administrator compensation.

Section 9 - Cost Classifications and Cost Finding
Revises occupancy calculation and leave day cost reporting.

Clarifies depreciation, cost allocation policy, and policy regarding allocation of space rental costs.

Specifies allowable costs of day care for facility employee dependents.

Expands and clarifies Medicaid policy regarding reimbursement for Nurse Aide Training and Competency Evaluation Programs; specifically adds coverage for nurse aide registry renewal, increases the reimbursement limit for training costs, addresses waivers to training lockouts, and specifies that nurse aide training and testing costs are not routine.

Specifies a maximum time period for which nursing facility beds may be designated as non-available.

Section 10 - Rate Determination
Outlines Deficit Reduction Act of 1984 (DEFRA) reimbursement.

Clarifies and specifies the rate determination process for routine nursing facility services and specialized services (i.e., ventilator-dependent care units).

Incorporates all policy related to the Nursing Facility Quality Assurance Assessment Program (QAAP).

Incorporates Quality Assurance Assessment amounts into the per diem rate.

Clarifies HLTCU Variable Cost Component effective date.

Defines Medicaid payment for Rate Relief purposes.

Section 11 - Appeal Process
Clarifies the informal appeal process.

Section 12 - Medicaid Interim Payment Program
Clarifies the Medicaid Interim Payment program (MIP).

Eliminates the option for an expedited appeal and the emergency interim rate relief option.

Eliminates the Quality of Care Incentive Component, as this program no longer exists.

CHAPTER VIIA

This chapter, outlining the Medicaid reimbursement methodology for Alternative Intermediate Services for the Mentally Retarded (AIS/MR) homes, has been eliminated as there are no longer any of these homes in the state.

APPENDICES

The current Appendix G, Appraisal Guidelines, is replaced with the Appraisal Guidelines Section of the Reimbursement Chapter.

The current Appendix H, Account Descriptions for Cost Reporting, was deleted. Some contents were incorporated into the text of the chapter. The listing of cost reporting and reimbursement descriptions and classifications is contained in the Cost Reporting and Reimbursement Descriptions and Classifications Section of this chapter.

The current Appendix M, Fixed Asset Value Listing, has been incorporated into the text of the chapter. Classification of assets is covered with reference to the AHA Health Data & Coding Standards Group Estimated Lives of Depreciable Assets.

FORMS NEW AND REVISED

Form MSA-1326 (Nurse Aide Training and Competency Evaluation Program; Certified Nurse Assistant Training Reimbursement) is new. The form is intended to be used by Certified Nurse Aides to request reimbursement from their nursing facility employer for training and testing costs. A copy of the form is attached to this bulletin. It is also available in the Forms Appendix of the online version of the Medicaid Provider Manual and is on the MDCH website.

Form MSA-1324 (9-97) (Nurse Aide Training and Testing Program Interim Reimbursement Request) was updated to reflect an organizational name change to LTC Reimbursement and Rate Setting Section. A copy of the form is available in the Forms Appendix of the online version of the Medicaid Provider Manual and is on the MDCH website.

Manual Maintenance

Replace the current Long Term Care Manual Chapter VII with the attached Reimbursement Chapter. Replace the current Nursing Facilities Chapter III (dated 1/1/04) with the attached Coverages and Limitations Chapter.

The following chapters and appendices are obsolete and should be discarded:

Nursing Facilities Chapter III
Long Term Care Manual Chapter VII
Long Term Care Manual Chapter VIIA
Appendix G, Appraisal Guidelines
Appendix H, Account Descriptions for Cost Reporting
Appendix M, Fixed Asset Value Listing

The following bulletins are obsolete or have been incorporated into the attached chapters, and should be discarded:

MSA 05-11, Clarification on Hospital Leave Days (Bulletin MSA 04-20)
MSA 05-09, Second Clarification of MSA 04-15
MSA 05-05, Medicaid Reimbursement to Hospices for Quality Assurance Supplement (QAS)
Nursing Facilities 04-09 (MSA 04-20), Hospital Leave Days
Nursing Facilities 04-08 (MSA 04-17), Clarification of MSA 04-15
All Provider 04-15, FY 2004-2005 Coverage & Reimbursement Changes
Nursing Facilities 04-06 (MSA 04-15), Admission Requirements for Nursing Facilities, MI Choice and PACE
Nursing Facilities 04-05 (MSA 04-14), Ventilator Dependent Unit, Memorandum of Understanding
Nursing Facilities 04-04, Medicaid Reimbursement for a Nursing Facility Bed Following a Qualifying Medicare Hospital Stay
Nursing Facilities 04-03 (MSA 04-12), Second Revision to Nursing Facilities Bulletin 03-08
Nursing Facilities 04-01 (MSA 04-09), Revision to Nursing Facilities Bulletin 03-08, Section 2
All Provider 03-09, FY 04 Budget Reductions
Nursing Facilities 03-11, Revised Nursing Facility Chapter III; Request for Prior Authorization for a Complex Care-Memorandum of Understanding (MSA-1576); Request for Authorization of Private Room Supplemental Payment Form
Nursing Facilities 03-08, Nursing Facility Per Diem Rate Determination, Quality Programs for FY 2003-2004, Class I Rate Relief
Nursing Facilities 03-01, Executive Order 2002-22
Nursing Facilities 02-03, Quality Assurance Adjustment
LTC 00-04, Nursing Home Quality Incentive Program
LTC 00-03, Special Rate Relief
LTC 00-02, Nursing Home Quality Incentive Program
5370-90-05, Reimbursement for Newly Certified Hospital LTC Units
5370-90-03, Reimbursement for OBRA Nurse Aide Training Requirements
5370-81-05, New Medicaid Interim Payment (MIP); Program Provider Identification Numbers (MIP and Non-MIP Facilities)

The following bulletins are also obsoleted by the new Reimbursement chapter. However, Nursing Facilities should retain them until audits covering the relevant cost reporting periods are completed.

Nursing Facilities 02-05, Quality Assurance Adjustment
Nursing Facilities 03-05, Quality Assurance Adjustment for Publicly-Owned Class III Nursing Facilities
LTC 01-08, Implementation of FY 2002 Rates for Class I and Class III Providers, Executive Order 2001-9
LTC 01-02, Implementation of FY 2001 Rate Increase and Continuation of Wage Pass-Through Program for Class I and Class III Providers
LTC 99-02, Proportionate Share Pool
LTC 96-07, Wage Pass-Through
LTC 95-05, Wage Pass-Through
LTC 94-09, Wage Pass-Through
LTC 94-01, Wage Pass-Through
LTC 93-05, Nurse Aide Training

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Michigan 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

Paul Reinhart, Director
Medical Services Administration

Nursing Facilities
Coverages and Limitations

Table of Contents

SECTION 1 – GENERAL INFORMATION

This chapter discusses Medicaid nursing facility coverage which is intended to assist beneficiaries in attaining or maintaining the highest practical physical, mental, and psychosocial well-being and maximize independence and decision-making. The chapter outlines nursing facility requirements for beneficiary eligibility and admission, for providing services, and for informing beneficiaries of their rights and responsibilities.

Nursing facilities provide services to many of the state's most vulnerable citizens. Medicaid, as the primary payer for beneficiaries who reside in nursing facilities, adheres to all State and Federal regulations that govern care provided in these facilities. Governing regulations include, but are not limited to:

- Americans with Disabilities Act (ADA)
- 42 CFR §431, §438, §440, §441, § 448, § 483, § 485, § 488
- State Medicaid Operations Manual
- Medicare Catastrophic Coverage Act of 1988, Public Law 100-360
- Certificate of Need Commission §22215, §1819, §1905, §1902
- Social Security Act
- Omnibus Reconciliation Act of 1987 (Public Law 100-203), 1988, 1989, 1990, and 1994
- Michigan Medicaid State Plan

Only those services covered by the Medicaid Program, as outlined in this chapter, are reimbursable. Included is a full description of:

- Covered Services:
  - Services covered by the facility's per diem rate; and
  - Ancillary services that must be billed separately by the service provider.
- Non-Covered Services that the beneficiary may purchase with their patient-pay amount.

A Medicaid-certified nursing facility is defined as a nursing home, county medical care facility, or hospital long-term care unit with Medicaid certification. Also included are swing beds and nursing facilities for Mental Illness (MI) beds as defined in the Federal State Operations Manual (SOM) and/or State Medicaid Policy.

Beneficiary is defined as a Medicaid beneficiary, or a person legally sanctioned to make medical decisions on his behalf (i.e., guardian, conservator, activated Durable Power of Attorney).

Resident is defined as a nursing facility resident (irrespective of payer source) or a person legally sanctioned to make medical decisions on his behalf (i.e., guardian, conservator, activated Durable Power of Attorney).

Individual, as used in this chapter, means any person.

SECTION 2 – QUALITY

The Michigan Department of Community Health (MDCH) is committed to a quality long-term care system that supports people with long-term care needs, regardless of the setting in which the individual receives those services, including nursing facilities, supported living settings, and their own home. Medicaid supports a system that moves away from the traditional medical model for care to one of enhanced beneficiary participation. Nursing facilities with Medicaid certification are expected to assess and plan care with resident participation and to provide services in ways that promote and support person-centered planning and quality service delivery.

2.1 QUALITY INDICATORS

Quality is indicated by the following components:

- Regular, ongoing, and systematic monitoring and revision of individualized plans of care, progress and outcomes by the beneficiary and his support system. In order to participate, beneficiaries may require support, such as regular opportunities and assistance in reviewing key considerations. Planning results should be documented in ways that are meaningful to the beneficiary and useful to people with responsibilities for implementing the plan.
- Risk and safety concerns are considered and plans developed to minimize risk of harm while promoting independence and safety.
- Behavioral interventions and medication management are used only when necessary, and are appropriately managed and monitored.
- Care coordination must support the individual's participation in his care.
- Support for personal responsibility and community relationships that avoid the unintended and detrimental consequences of organizational involvement. Facilities should minimize the disempowerment of beneficiaries or displacement of family members by professional decision-makers and/or service providers, assume the beneficiary is competent and capable of participating in his relationships and the community, and provide assistance and support only when there are unmet needs.
- Individual freedom to exercise civic rights and decision-making authority exists to the maximum extent possible.
- Individuals are free to exercise their due process and grievance rights, and are provided the information necessary to do so.
- Individuals and their support system express satisfaction and the care leads to positive outcomes.
- Diverse cultural and ethnic backgrounds are supported.
- A system of continuous quality improvement that includes input from residents and families.

Current models that utilize person-centered planning and introduce the systems/culture change to support ongoing quality in nursing facilities include, among others, The Eden Alternative™, Wellspring™, and Gentlecare™.

2.2 Quality of Life

Nursing facilities must provide services for residents in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life. Elements of quality of life include dignity, self-determination, participation in community life and in other activities, participation in resident and family groups, and accommodation of needs through the end of life. Quality of life is defined, measured, and evaluated by residents and their support systems, and may include quality of care outcomes.

2.3 Quality of Care

Nursing facilities must meet the needs of residents in compliance with State and Federal laws, rules, codes, and established clinical guidelines and practices. (Refer to the Nursing Facility section of the Directory Appendix of the Medicaid Provider Manual for specific website links for Best Practice Information.)

Complaints regarding the quality of care in any Michigan nursing facility can be made to the Health Facility Complaint Line. (Refer to the Nursing Facility Section of the Directory Appendix for contact information.)

SECTION 3 – BENEFICIARY RIGHTS

All nursing facility residents have the right to:

- A dignified existence;
- Self-determination; and
- Communication with, and access to, persons and services inside and outside the facility.

In accordance with Federal and State rules and regulations, nursing facilities are required to protect and promote beneficiary rights. These rights include, but are not limited to:

- The right to exercise their rights as citizens of the United States;
- The right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising their rights;
- The right to receive notice of their rights, rules and regulations, both orally and in writing, in a language that the resident understands;
- Access to their medical records and information;

  (In accordance with Federal regulations, a beneficiary [or his representative] must be allowed to inspect his records within 24 hours [excluding weekends and holidays] of such request. Also, in accordance with Michigan Public Health Code, a beneficiary [or his representative] is entitled to receive and examine an explanation of his bill or an itemized statement setting forth services paid for and services rendered, regardless of the source of payment.)
- The right to be informed about their health status;
- The right to refuse treatment;
- The right to non-discrimination, including non-discrimination based on payment source;
- Notification of covered and noncovered services, and any additional costs;
- Notification of any changes in room, policies, physician, health status, and treatment;
- Protection and appropriate management of resident funds;
- The right to covered services;
- Notification of transfer or relocation;
- The right to pain and symptom management at the end of life; and
- The right to re-admission to the nursing facility and to have their bed held during an emergency hospital stay, as defined in the Holding a Bed sub-section of this chapter.

In general, beneficiaries cannot be charged for Medicaid-covered services, except for approved patient-pay amounts, co-pays or deductibles, whether they are enrolled as a fee-for-service beneficiary, MDCH is paying their Health Maintenance Organization (HMO) premium to a contracted health plan, or services are provided under Community Mental Health Services Program (CMHSP) or Substance Abuse Coordinating Agency (CA) capitation. However, beneficiaries may be charged if they choose to obtain a service from an out-of-network or non-participating provider, as long as they have prior knowledge they will be obligated to pay the entire charge and, with that knowledge, they request the service.

Medicaid beneficiaries may not be charged the difference between the provider's charge and the Medicaid payment for a service, nor can they be charged for missed appointments.

Medicaid beneficiaries cannot be charged for the copying of medical records for the purpose of providing them to another health care provider.

SECTION 4 – BENEFICIARY ELIGIBILITY AND ADMISSION PROCESS

4.1 NURSING FACILITY ELIGIBILITY

There are five components for determining eligibility for Medicaid nursing facility reimbursement.

4.1.A. Verification of Medicaid Eligibility

Medicaid payment for nursing facility services for an individual requires a determination of Medicaid eligibility for that individual by the Michigan Department of Human Services (MDHS). When a Medicaid-eligible or potentially-eligible individual is admitted to a nursing facility, or when a resident becomes Medicaid eligible while in the facility, the nursing facility must submit the Facility Admission Notice (MSA-2565C) to the local MDHS office to establish/confirm the individual's eligibility for Medicaid benefits. A copy of the form is available on the MDCH website and in the Forms Appendix of the Medicaid Provider Manual.

A facility is considered officially notified of an individual's Medicaid eligibility when they have received the completed MSA-2565-C.

In order for Medicaid to reimburse for nursing facility services, the beneficiary must be in a Medicaid-certified bed.

4.1.B. Correct/Timely Preadmission Screening/Annual Resident Review (PASARR)

The Preadmission Screening/Annual Resident Review (PASARR) process must be performed prior to admission as described in the PASARR Process Section of this chapter.

A Level I Preadmission Screen must be performed for all individuals admitted to a Medicaid-certified nursing facility regardless of payer source. When a Level II evaluation is required, placement options are determined through the federal PASARR screening process requirements. The Level I screening form (Preadmission Screening [PAS]/Annual Resident Review [ARR]; DCH-3877) may be found at the MDCH web site. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

MDCH performs retrospective reviews, randomly and when indicated, to determine that the nursing facility has complied with federal PASARR requirements.

The nursing facility is required to ensure that the PASARR Level I screening has been completed and passed by the individual prior to admission. MDCH reviews retrospectively to determine that the Level I screening was performed, and that the Level II evaluation was performed when indicated.

MDCH is required to recover any payments made to nursing facilities for the period that a participant may have been admitted to a nursing facility when the PASARR screening process was not completed.

4.1.C. Physician Order for Nursing Facility Services

A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be dated and the physician's degree must appear with the signature. The physician must initial a rubber-stamped signature.

With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.

For an individual who applies for Medicaid while a resident in a nursing facility, the physician must reaffirm the need for long-term care not more than 30 calendar days prior to the submission of the application for Medicaid eligibility.

4.1.D. Appropriate Placement Based on Michigan Medicaid Nursing Facility Level of Care Determination

4.1.D.1 Michigan Medicaid Nursing Facility Level of Care Determination

For nursing facility admissions and readmissions on and after November 1, 2004, nursing facilities must verify beneficiary appropriateness for nursing facility services by completing an electronic web-based version of the Michigan Medicaid Nursing Facility Level of Care (LOC) Determination form. A nursing facility may not bill Medicaid for services provided if the beneficiary does not meet the established criteria identified through the Michigan Medicaid Nursing Facility LOC Determination or Nursing Facility LOC Exception Process, and may not bill the beneficiary unless the beneficiary has been advised of the denial and elects, in advance, to pay privately for services.

Services will only be reimbursed if the determination demonstrates functional/medical eligbility through the electronic web-based tool. Providers must submit the information via the web no later than 14 calendar days following the start of service.

Applicants must be evaluated prior to the start of Medicaid-reimbursable services.

The electronic web-based tool, a copy of of the Michigan Medicaid Nursing Facility LOC Determination form, Field Definition Guidelines, and other information referenced in this section are on the MDCH website. The website also contains contact information for technical support to:

- register to utilize the web-based tool
- complete the LOC Determination form

- complete the exception process
- complete the immediate review process
- transition beneficiaries

The website is located at www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Michigan Medicaid Nursing Facility Level of Care Determination.

The Michigan Medicaid Nursing Facility LOC Determination must be used by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker [BSW or MSW], or physician assistant) representing the proposed provider. Non-clinical staff may perform the evaluation with clinical oversight by a professional. The nursing facility must bill Medicaid for only those residents who meet the criteria.

For residents admitted to the facility prior to November 1, 2004, the Michigan Medicaid Nursing Facility LOC Determination must be applied no earlier than the next anniversary date of their admission to the facility. All residents admitted prior to November 1, 2004 must be evaluated no later than October 31, 2005.

Residents who are assessed at their admission anniversary date, and who qualify under only Door 7, must be offered the opportunity and assistance to transition to the community, but may not be required to do so. In applying the criteria for Door 7, it is assumed that current services provided to residents are necessary to maintain function.

When the nursing facility determines that the resident who has been in the facility for less than 12 months is not eligible for services based on functional/medical criteria, the resident must be provided an adverse action notice and referred to appropriate service programs.

The Michigan Medicaid Nursing Facility LOC Determination must be completed using the electronic web-based tool for:

- All new admissions of Medicaid-eligible applicants where reimbursement is requested beyond co-insurance and deductible amounts.
- All readmissions of Medicaid-eligible applicants where Medicaid reimbursement, is requested beyond co-insurance and deductible amounts, and a LOC Determination was not previously completed for the original admission.

  Readmissions in general do not require resubmission of the tool; this applies only if a tool was previously submitted for the resident.

  Example: If a nursing facility resident was transferred to the hospital on November 28, 2004, then readmitted to the nursing facility on December 4, 2004, the LOC Determination must be applied to that resident if he has not been previously screened.

  This protocol must be followed for readmissions from November 1, 2004 through October 31, 2005.

- Non-emergency transfer of Medicaid-eligible residents to another nursing facility, including transfers originating from a nursing facility that is undergoing a voluntary facility closure.
- Disenrollment of a beneficiary from a Medicaid Health Plan which has been paying for nursing facility services.
- Private-pay residents already residing in a nursing facility who are applying for Medicaid as the payer for nursing facility services.
- Dually eligible beneficaries who wish to return to their Medicaid nursing facility bed and refuse their Medicare SNF benefit following a qualifying Medicare hospital stay.
- Any transfer of a Medicaid-eligible resident from a nursing facility that is undergoing an involuntary facility closure due to federal or state regulatory enforcement action.

  Nursing facilities do not need to complete the entire Michigan Medicaid Nursing Facility LOC Determination critieria, but must submit the information requested on the on-line Emergency/Involuntary Transfer form by selecting "Emergency/Involuntary Transfer" from the bottom of the LOC Determination welcome screen.

  Once admitted into the facility, however, the resident must meet the functional/medical eligibility criteria on an ongoing basis, as with all other residents covered under Medicaid fee-for-service as the primary payer. A proactive discharge plan must be provided to persons who fail to qualify, and an adverse action notice must be issued if appropriate. Retrospective review of transferred residents will still apply.
- Emergency transfer of a Medicaid-eligible resident from a nursing facility experiencing a hazardous condition (e.g., fire, flood, loss of heat) that could cause harm to residents when such transfers have been approved by the State Survey Agency.

  Nursing facilities do not need to complete the entire Michigan Medicaid Nursing Facility LOC Determination criteria, but must submit the information requested on the on-line Emergency/Involuntary Transfer form by selecting "Emergency/Involuntary Transfer" from the bottom of the LOC Determination welcome screen.

  Once admitted into the new facility, however, the resident must meet the functional/medical eligiblity criteria on an ongoing basis, as with all other residents covered under Medicaid fee-for-service as the primary payer. A proactive discharge plan must be provided to persons who fail to qualify, and an adverse action notice must be issued if appropriate. Retrospective review of transferred residents will still apply.

Completion of the Michigan Medicaid Nursing Facility LOC Determination is not required for:

- Hospice beneficiaries who are being admitted to the nursing facility for any services.
- Nursing facility readmissions where a Michigan Medicaid Nursing Facility LOC Determination was previously completed for the original admission and the beneficiary met the nursing facility criteria.
- Cases where Medicare is the primary payer of the claim and the facility is only billing Medicaid for hospital leave days.

Process Guidelines define required process steps for use of the electronic web-based tool and application of the criteria, informed choice, and specific discharge planning requirements. The Process Guidelines are available on the MDCH website.

The functional/medical criteria include seven domains of need:

- Activities of Daily Living
- Cognitive Performance
- Physician Involvement
- Treatments and Conditions
- Skilled Rehabilitation Therapies
- Behavior
- Service Dependency

For residents who qualify under one of three of these domains (Physician Involvement, Treatments and Conditions, and Skilled Rehabilitation Therapies), specific restorative nursing plans and assertive discharge planning must be evident and documented within the medical record (except for end-of-life care). These requirements are specified in the Process Guidelines.

The electronic web-based Michigan Medicaid Nursing Facility Level of Care Determination must be completed only once for each admission per individual provider.

4.1.D.2 Nursing Facility Level of Care Exception Process

An exception process is available for those applicants who have demonstrated a significant level of long term care need but do not meet the Michigan Medicaid Nursing Facility LOC Determination criteria. The Nursing Facility LOC Exception Process is initiated when the nursing facility telephones the MDCH designee and requests review after the applicant has been determined ineligible using the electronic web-based tool. The Nursing Facility LOC Exception Criteria is available on the MDCH website. An applicant need trigger only one element to be considered for an exception.

4.1.D.3 Telephone Intake Guidelines

The Telephone Intake Guidelines are questions that identify potential nursing facility residents. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the nursing facility. This document is available on the MDCH website.

4.1.D.4 Annual Re-Certification

Federal regulations require annual recertification that residents meet Medicaid financial eligibility requirements. The annual recertification process is performed by the Michigan Department of Human Services. In addition, the nursing facility must ensure that residents meet the Michigan Medicaid Nursing Facility LOC Determination criteria on an ongoing basis in order for services to be reimbursed by Medicaid. Quarterly Minimum Data Set (MDS) assessments and progress notes must demonstrate that the resident has met the criteria on an ongoing basis. Medicaid suggests that the annual recertification coincide with the Annual Resident Review required under the Michigan PASARR policy.

4.1.D.5 Retrospective Review and Medicaid Recovery

At random and whenever indicated, the MDCH designee will perform retrospective review to validate the Michigan Medicaid Nursing Facility LOC Determination and the quality of Medicaid MDS data overall. If the resident is found to be ineligible for nursing facility services, MDCH will recover all Medicaid payments made for nursing facility services rendered during the period of ineligibility.

4.1.D.6 Adverse Action Notice

When the provider determines that the beneficiary does not qualify for services based on the Michigan Medicaid Nursing Facility LOC Determination, the provider must immediately issue an adverse action notice to the benefiicary or his authorized representative. The provider must also offer the beneficiary referral information about services that may help meet his needs. The action notice must include all of the language of the sample letters for long term care. These letters may be found on the MDCH website.

The beneficiary may request an administrative hearing for a benefit denial. The Administrative Tribunal Policies and Procedures Manual explains the process by which each different case is brought to completion. The manual is available for review on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information for the Administrative Tribunal.)

When a beneficiary appeals an adverse action notice to the MDCH Administrative Tribunal, the facility must notify MDCH LTC Services of the hearing. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

Immediate Review-Adverse Action Notices

The MDCH designee will review all preadmission or continued stay adverse action notices upon request by a beneficiary (or representative). When a beneficiary requests an immediate review before noon of the first working day after the date of receipt of the notice the:

- MDCH designee will request that the nursing facility provide pertinent information by close of business of the first working day after the date the beneficiary (or representative) requests an immediate review.

- MDCH designee will review the records, obtain information from the beneficiary (or representative) and notify the beneficiary (or representative) and notify the beneficiary and the provider of the determination by the first full working day after the date of receipt of the beneficiary request and the required medical records.
- Beneficiary (or representative) may still request an MDCH appeal of the Level of Care Determination.

Beneficiaries may contact the MDCH designee to request an immediate review. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

4.1.E. Freedom of Choice

When an applicant has qualified for services under the nursing facility level of care criteria, they must be informed of their benefit options and elect to receive services in a specific program. This election must take place prior to initiating nursing facility services under Medicaid.

The applicant (or representative) must be informed of services available through:

- Medicaid-reimbursed nursing facilities
- The MI Choice program
- The Program of All-Inclusive Care for the Elderly (PACE) program, where available.

If applicants are interested in community-based care, the nursing facility must provide appropriate referral information as identified in the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs. The guidelines are available on the MDCH website. Applicants who prefer a community long term care option, but are admitted to a nursing facility because of unavailable slots or other considerations, must also have an active discharge plan documented for at least the first year of care.

Applicants must acknowledge that they have been informed of their program options in writing by signing the Freedom of Choice form that is witnessed by the applicant's representative, when appropriate. A copy of the completed form for non-admissions must be retained for a period of three years. The completed form must be kept in the medical record if the applicant chooses to receive nursing facility services. The Freedom of Choice form is available on the MDCH website.

4.2 APPEALS

4.2.A. Individual Appeals

4.2.A.1 FINANCIAL ELIGIBILITY

A determination that a beneficiary is not financially eligible for Medicaid is an adverse action. Beneficiaries may appeal such an action to MDHS.

4.2.A.2 FUNCTIONAL/MEDICAL ELIGIBILITY

A determination that a beneficiary is not functionally/medically eligible for nursing facility services is an adverse action. If the beneficiary (or representative) disagrees with the determination, he has the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

4.2.B. Provider Appeals

A retrospective determination that a beneficiary is ineligible for nursing facility services based on review of the functional/medical screening is an adverse action for a nursing facility if MDCH proposes to recover payments made. If the facility disagrees with this determination, an appeal may be filed with MDCH. Information regarding the MDCH appeal process may be found on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

4.3 ADMISSION PROCESS

Prior to or upon admission, the nursing facility must provide residents and their representatives the following information. The information must be provided both orally and in a written language that the beneficiary understands. Beneficiaries must be provided copies of those items noted with ansterik (*).

- Rights as identified in federal regulations;
- All rules and regulations governing beneficiary conduct and responsibilities during their stay in the facility; *
- Rights as a Medicaid beneficiary and a list of Medicaid-covered services (services for which the resident may not be charged) as published in the Medicaid "Know your Rights" booklet; *
- Noncovered items and services, as well as the costs, for which the beneficiary may be charged (admission to a facility cannot be denied because the beneficiary is unable to pay in advance for noncovered services); *
- Facility policies regarding protection and maintenance of personal funds; *
- A description of the facility's policies to implement advance directives; *
- Facility policies regarding the availability of hospice care; *
- The name, specialty and contact information of the physician responsible for their care;
- Information about how to apply for Medicare and Medicaid; * and
- How to file a complaint.

Facilities must notify residents and their representatives (both orally and in a written language that the beneficiary understands) of any changes to the information listed above.

Receipt of the above information and any amendments must be acknowledged, in writing, by the beneficiary or his representative. Individual facilities may develop their own documentation for this process.

4.4 PREADMISSION CONTRACTS

Nursing facilities must abide by all state and federal regulations regarding preadmission contracts.

Nursing facilities are prohibited from requiring a Medicaid-eligible person or a Medicaid beneficiary, his family, or his representative to pay the private-pay rate for a specified time before accepting Medicaid payment as payment in full. Nursing facilities violating this prohibition are subject to the appropriate penalties (i.e., revocation of their Medicaid provider agreement).

SECTION 5 – MEDICAL RECORDS

Nursing facilities are required to maintain a medical record for all residents as outlined in State and Federal statutes and regulations.

Nursing facilities are required to comply with all State and Federal requirements regarding medical record confidentiality, including compliance with all Health Insurance Portability and Accountability Act (HIPAA) requirements regarding privacy.

Nursing facilities must maintain all resident assessments completed within the previous 15 months in the resident's active record. Facilities with a "paperless" system in which clinical records are electronically maintained must be able to produce a paper copy if requested for record review by State surveyors.

Nursing facilities must respect the resident's access to their medical records as required by State and Federal laws and regulations.

SECTION 6 – CARE PLANNING PROCESS

Nursing facility care planning is a continuous and ongoing process of assessment, planning, evaluation, and revision. The purpose of the care planning process is to gather information from a variety of sources, and develop a written strategy to insure that the resident receives services and supports necessary to attain or maintain the highest practical physical, mental, and psychosocial well-being. Sources of information to support care planning include the resident, his family and friends, physicians, specialists, nurses, nurse aides, dietitians, therapists and assessment tools (including the Minimum Data Set [MDS] for Nursing Facility Resident Assessment and Care Screening). A comprehensive plan identifies and addresses all aspects of the resident's health and well-being (physical/medical, emotional, mental, spiritual), not just those services that will be provided by the facility or covered by insurance. Using the principles and essential elements of person-centered planning, facilities are expected to involve residents and their designated support system throughout the entire process.

6.1 PERSON-CENTERED PLANNING

Person-centered planning is an ongoing process that recognizes the worth and dignity of each individual and his ability to choose how supports, services and/or treatment may be used to improve his life. The following principles apply:

- **Participation in planning** – Each individual has unique strengths, abilities and preferences and is able to express preferences and make choices. Each individual can participate in planning his life, with appropriate support if needed.
- **Support for planning** – People trusted by the individual and committed to supporting the individual's choices must be involved in planning for long-term care. The process is dependent on the participation of supportive relationships, such as family members and friends, and encourages their involvement, to the extent that the choices of the individual are reflected. These relationships support the individual's right to choose, even the right to take risks.
- **Outcome orientation** - Person-centered planning is outcome-oriented. The planning should lead to positive outcomes in the individual's life, i.e., helping to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The individual determines what constitutes a positive outcome. For a younger adult with a disability, this may include building a career. For an older person near the end of life, the positive outcomes may include deciding where one dies and who is present.

Evidence of person-centered planning includes:

- An assessment process that offers the opportunity for gathering information concerning each resident's preferences, personal goals, needs and abilities, health status, and other available supports. This information should be used in developing an individualized plan of care. The individual's life plans should give direction to plans with service providers, such as discharge planning from nursing facilities into community-based settings. Nursing facilities should not exclude residents in the care planning process in order to meet facility requirements for writing care plans, obtaining signatures, and so forth.
- An assessment process that includes input from professionals and others chosen by the individual. In addition to the professionals required to participate in care planning, individuals should have support for making informed choices about the additional people and professionals they invite to their person-centered planning meetings. For example, federal guidelines require

an interdisciplinary team that includes a registered nurse who has responsibility for caring for the resident prepare care plans. In addition, the resident may choose to invite a favorite nurse aide and a former neighbor/caregiver to participate in care planning.

- A plan of care that comprehensively addresses each individual's need for health care and other services in accordance with the individual's preferences and goals.
- Services delivered in accordance with the individualized plan of care.
- Informed choice, which includes, but is not limited to, choosing among covered services and enrolled service providers, decisions about the planning process, and evaluation of the planning and its outcomes. Informed choice means knowing the options in ways that are meaningful to the individual, and having information when it is useful; not only at admission, but throughout the care process.
- Support for informed choice, which requires an organizational commitment to provide information and/or experiences that sufficiently inform an individual of their options. This commitment should be met through multiple and flexible means of providing information. These might include alternative forms of communication (e.g., Braille, sign language, audio-recorded documents), hands-on experiences with options, peer support from experienced participants, and so forth.

6.2 Assessment

In collaboration with the resident and individuals identified by the resident, appropriate facility staff must assess residents regularly and as needed to identify their preferences, wishes, goals, outcomes, capabilities, medical, and psychosocial needs. Nursing facilities should use assessment tools that are accessible (e.g., large print, verbal, appropriate language, etc.) to residents and individuals identified by the resident.

Assessment tools must include, but are not limited to, the Minimum Data Set (MDS) for Nursing Facility Resident Assessment and Care Screening. Nursing facilities are expected to use assessment tools and methods that accommodate the needs and preferences of individuals (e.g., mental health assessment tools, self-assessment tools in large print, etc.).

6.3 Minimum Data Set (MDS)

Nursing facilities must conduct a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity. The use of the current federally specified Resident Assessment Instrument (RAI), which includes the MDS, Triggers, Resident Assessment Protocols (RAPS) and utilization guidelines is mandatory. Michigan has made a determination not to have a state-specific Section-S, but reserves the right to develop and require its data collection as need arises.

The MDS assessment must be conducted:

- Promptly upon admission, but no later than 14 days of admission;
- Promptly after a significant change in the resident's physical or mental condition or within two weeks, whichever is sooner; and
- Not less than once every twelve months.

The facility must examine each resident once every three months, revising the assessment as appropriate to ensure its continuing accuracy.

Results of the MDS assessment must be used, in addition to other information gathered and in collaboration with the resident, for developing, reviewing, and revising the resident's plan of care. The assessment must be maintained in the resident's medical record and kept confidential.

Each MDS assessment must be conducted or coordinated (with the appropriate participation of other health professionals) by a licensed, registered nurse who signs and certifies the completion of the assessment. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion. Data accuracy resides with the nursing facility as the source of the data.

A facility must electronically transmit to the State, at least monthly, encoded, accurate, complete MDS data for all assessments conducted since the previous transmission. A facility that fails to transmit electronic RAI data to the State is considered out of compliance and, therefore, subject to enforcement actions. (Refer to the Nursing Facility Certification, Survey and Enforcement Chapter of this manual.)

An individual who willfully and knowingly certifies a material and false statement, or causes another individual to do so, is subject to a civil monetary penalty.

Questions about the Resident Assessment Instrument should be directed to the RAI Coordinator in the State Survey Agency. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

Federal regulations require that facilities coordinate the PASARR process and MDS. MDCH recommends that nursing facility administrators establish mechanisms to track completion dates of PAS and ARR evaluations so that, to the maximum extent practicable, they are coordinated with resident assessments and completion of the MDS.

6.4 Preadmission Screening/Annual Resident Review (PASARR)

The Preadmission Screening and Resident Review (PASARR) must be completed for all individuals seeking to enter a nursing facility regardless of payer source. Although not federally mandated, Michigan has elected to require the Annual Resident Review (ARR) for all residents in Medicaid-certified nursing facilities regardless of payer source.

The purpose of the PASARR process is to encourage community care by supporting the placement of individuals with Mental Illness (MI) or Mental Retardation (MR) in a nursing facility only when their medical needs clearly indicate that they require the level of care provided by a nursing facility. For individuals with mental illness or mental retardation, the PASARR process ensures the appropriate determination of the need for nursing facility services and the need for specialized services. The PASARR process also includes an appeals system for individuals who wish to dispute a PASARR determination.

Screening and evaluations performed under PASARR and all PASARR notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated.

(Refer to the PASARR Process section of this chapter for additional information.)

6.5 Plan of Care

Nursing facilities are required to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. A written individualized plan of care must be developed in the context of a person-centered planning process in order to specify services and activities, and to accommodate individual needs and preferences. The plan outlines the goals, strengths and needs of the resident and how those will be addressed. A comprehensive plan identifies and addresses all aspects of the resident's health and well being (physical/medical, emotional, mental, spiritual), not just those services that will be provided by the facility or covered by insurance. The plan also identifies the resident's wishes and capabilities regarding the potential of relocation to a lesser level of care and includes discharge planning.

The comprehensive plan of care must be developed with direct involvement of:

- The beneficiary, family and/or his/her representative;
- The attending physician;
- An RN who has assessed the beneficiary, or who is familiar with the assessment;
- Other appropriate staff disciplines; and
- Any other trusted individuals that the beneficiary might wish to include.

Medicaid requires that a nursing facility ensure that a licensed physician supervises a beneficiary's medical care. The physician must review the entire individualized plan of care on an on-going basis. The entire plan of care may include sections for:

- Nursing care
- Rehabilitative services (if required);
- Medication;
- Treatment;
- Restorative services;
- Diet;
- Activities;
- Special plans for health and safety;
- Continuing care, measurable objectives and timetables;
- Discharge (as appropriate); and
- Mental health services.

All services rendered must be documented and consistent with the written individualized plan of care.

6.6 Evaluation/Re-assessment/Plan Revision

Care planning is a continuous and ongoing process that requires regular re-assessment and revision of the plan of care. Federal guidelines require that the facility examine each resident not less than once every three months, and revise the resident's assessment as appropriate to ensure its continuing accuracy. Re-assessment should also occur with significant changes in the resident's condition and at the request of the resident or his representative. Once the re-assessment is completed, the current plan should be evaluated and revised to meet current goals and needs.

SECTION 7 – PASARR PROCESS

Pre-admission Screening/Annual Resident Review (PASARR) in Michigan is a two-level screening and evaluation process. The Level I screening and Level II evaluation procedures and forms are the same for Pre-admission Screening (PAS) and Annual Resident Review (ARR). The forms may be obtained from the MDCH website.

The PASARR process must be completed:

- Prior to admission to a nursing facility;
- Promptly after a significant change in a resident's physical or mental condition; and
- Not less than annually.

The PASARR process is not required in the following situations:

- When an individual is admitted to an Intermediate Care Facility for the Mentally Retarded (ICF/MR-Provider Type 65).
- When an individual is admitted to and resides in a hospital swing bed. However, the PASARR process must be completed prior to admission if the individual transfers to a nursing facility.
- When an individual is readmitted to a nursing facility after a hospital stay. If the Annual Resident Review date occurs during a period of hospitalization, the screening must be completed within 30 days of admission or readmission to the nursing facility.
- For an individual transferring from one nursing facility to another, with or without an intervening hospital stay, unless a Level I screen has not been performed previously.
- For an individual returning to the nursing facility from therapeutic leave, unless the resident's condition has changed. Therapeutic leave does not change the due date for Annual Resident Review. Advance planning may be necessary to ensure timeliness of review.
- A beneficiary receving Medicaid hospice services (LOC 16) entering a nursing facility for the five-day hospice respite benefit. A Level I screening must be completed if the beneficiary enters the facility for a length of time beyond the five-day respite period.

  The purpose of the Level I screening is to identify individuals who may be mentally ill or mentally retarded. If the patient is on antipsychotic, antianxiety, or antidepressant medicaitions for purposes of pain control/symptom relief for end of life, note that information on the DCH-3877. This allow the Community Mental Health Services Program (CMHSP) to better evaluation the need for Level II screening. If the patient is on any of the above mentioned psychotropic medication groups for a related mental illness, the MCHSP will determine the need for Level II screening.

The following table outlines screening requirements.

Pre-admission Screening (PAS)	A Level I screening is required for all individuals seeking to enter a nursing facility regardless of payer source, except as noted above. The Level I screening, and the Level II evaluation when indicated, must be completed prior to admission to a nursing facility.

Annual Resident Review (ARR)	All residents in Medicaid-certified nursing facilities must be reviewed at least annually to determine if the resident is in need of mental health services and/or continued nursing care. Annually means within every fourth quarter after the previous Level I screening or Level II evaluation, whether it was completed for admission, condition change, or annual review. The Level I screening must be completed for all residents, and a Level II evaluation must be performed if indicated. If a resident was hospitalized when an ARR was due, the Level I screening must be completed within 30 days of readmission, and any subsequent Level II evaluation must be completed within the quarter following readmission to the nursing facility.
Condition Change	A Level I screening must be completed immediately or, at most, within 14 days when there is a significant change in the resident's mental health, or a physical change that may impact the resident's mental health needs. Federal regulations defines a "significant change" as a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both. A Level II evaluation must be completed when indicated.
30-Month Rule	During the PASARR process, a nursing facility resident may be identified as no longer in need of nursing services but in need of specialized services. In this situation, if the resident has lived in a nursing facility for 30 continuous months, the CMHSP must advise the individual of their options, which may include community placement with specialized services or continued residence in the nursing facility with specialized services. Under these circumstances, no appeal needs to be filed in order to maintain nursing facility residency. The individual's status as a long-term resident must be evident in their nursing facility medical record. Individuals determined to need specialized services, who have resided in a nursing facility for less than 30 months, and who are found to no longer need nursing services must be assisted to transition to a more appropriate setting.
Transfer Trauma	Transfer trauma protections (see Transfer Trauma sub-section in this chapter) apply to mentally ill or mentally retarded individuals determined not to need nursing facility services during PASARR Level II evaluations.

7.1 LEVEL I SCREENING

The purpose of the Level I Screening is to identify individuals who may be mentally ill or mentally retarded. Level I Screening is documented on the "Preadmission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/Developmental Disability Identification)" form (DCH-3877). (Refer to the Forms Appendix of the Medicaid Provider Manual for a sample form.) The DCH-3877 must be completed and signed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or physician.

The professional who completes the Level I Screening must provide a copy of the DCH-3877 to the prospective nursing facility resident or their legal representative. Notification must also be adapted to the cultural background, language, ethnic origin and means of communication of the person being evaluated. (For the distribution of forms and documentation, refer to the Distribution of PASARR Documentation sub-section later in this section.)

The following table contains a list of psychopharmacological drugs that may indicate the presence of a mental illness. Included are examples of antidepressant and anti-psychotic medications. The list is not meant to be all-inclusive.

Antidepressant Medications	
Generic Name	**Brand Name**
Amitriptyline Hydrochloride	Elavil
Bupropion Hydrochloride	Wellbutrin
Citalopam	Celexa
Doxepin Hydrochloride	Sinequan
Fluoxetine Hydrochloride	Prozac
Fluroxamine	Luvox
Imipramine Hydrochloride	Tofranil
Mirtazapine	Remeron
Netazodone Hydrochloride	Serzone
Nortiptyline Hydrochloride	Aventyl, Pamelor
Paroxitine	Paxil
Sertraline Hydrochloride	Zoloft
Trazodone Hydrochloride	Desyrel
Venlafaxine Hydrochloride	Effexor

Anti-Psychotic Medications	
Generic Name	**Brand Name**
Chlorpromazine Hydrochloride	Thorazine
Clozapine	Clozaril
Fluphenazine Hydrochloride	Prolixin
Haloperidol	Haldol
Loxapine Hydrochloride	Loxitane
Mesorldazine Besylate	Serentil
Olanzapine	Zyprexa
Quetiapine Fumarate	Seroquel
Risperidone	Risperdal
Thioridazine Hydrochloride	Mellaril
Thiothixene	Navane
Trifluoperazine Hydrochloride	Stelazine
Ziprasidone	Geodon

Miscellaneous Products	
Generic Name	Brand Name
Lithium Citrate	Cibalith-S
Lithium Carbonate	Eskalith, Lithobid

7.2 Level II Evaluation

The purpose of the Level II Evaluation is to assess individuals who are identified as mentally ill or mentally retarded to determine the need for nursing facility services, specialized services, and/or mental health services. All individuals identified by Level I screening as possibly mentally ill or mentally retarded (a "yes" response to any question on the Level I screening form, DCH-3877) must receive a Level II evaluation, unless it is documented that they meet one of the exemption criteria outlined in the next sub-section, or the MDCH/CMHSP finds that the individual does not meet the criteria for a serious mental illness under the PASARR provisions. The CMHSP is responsible for providing the nursing facility and the individual and/or legal representative with written documentation that the individual does not meet the PASARR criteria for a serious mental illness. If the individual is seeking admission to a nursing facility, the Level II evaluation, when indicated, must be completed prior to admission.

7.3 Level II Evaluation Exemption

Level II Evaluation Exemption Form (DCH-3878) is used to claim an exemption to Level II evaluations. If the individual qualifies for an exemption to the Level II evaluation based on the criteria outlined below, the DCH-3878, "Mental Illness/Developmental Disability Exemption Criteria Certification" form must be completed. (Refer to the Forms Appendix of the Medicaid Provider Manual for a sample form.) The DCH-3878 may be completed by a registered nurse, a certified or registered social worker, psychologist, physician's assistant, or physician and must be signed by a physician.

Exemptions to the Level II evaluation may be requested based on the following criteria:

- The individual is in a coma. If the individual is in a coma at the time the Level II evaluation is to be performed, the individual may be exempted from the Level II evaluation process. A physician must certify that the individual is in a coma. The individual may then be admitted to the nursing facility without a Level II evaluation. When the individual is no longer in a coma, the nursing facility must complete a Level I screening and refer for a Level II evaluation, if indicated.
- The individual has a primary diagnosis of dementia (such as Alzheimer's disease or another dementing illness). An exemption due to dementia cannot be claimed for any individual who is also identified as being mentally retarded or having a related condition, or for any individual with another primary psychiatric diagnosis. For example, an individual with dementia alone may be exempted. An individual diagnosed with dementia and depression may not be exempted. A physician must certify that the individual meets the clinical criteria for dementia and does not have another primary psychiatric diagnosis, or mental retardation or a related condition.
- The individual is convalescing after hospitalization for an acute illness and meets all of the following conditions:
  - The individual will be admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital. Treatment in an emergency room is not considered a hospital stay. An individual who received inpatient treatment in a psychiatric facility cannot be admitted to a nursing facility claiming this exemption, nor can an individual who comes directly from home or any other community placement.
  - The individual requires nursing facility services for the condition for which they received care in the hospital.
  - The attending physician has certified before admission to the nursing facility that the individual is likely to require less than 30 days nursing facility services.

Medicaid approves payment for a hospital discharge/convalescent care stay up to 30 days only. If the individual needs nursing care beyond 30 days, the nursing facility must notify the local CMHSP at least five working days before the end of the 30-day stay that a Level II evaluation is needed. The local CMHSP completes the Level II evaluation within 14 days of the date of notification and forwards the evaluation to MDCH. The entire determination process must be completed within 40 days of the individual's admission from the hospital. If MDCH determines that the individual no longer requires nursing facility services, Medicaid reimburses up to five days beyond the date of the determination to allow for appropriate discharge planning. It is expected that a nursing facility will begin discharge planning for residents at the time of admission from the hospital and discontinue this planning only when a determination is made that the resident will not be discharged from the nursing facility.

The person completing the Level II evaluation exemption must provide a copy of the DCH-3877 to the prospective nursing facility resident or their legal representative. Notification must also be adapted to the cultural background, language, ethnic origin and means of communication of the person being evaluated. (Refer to the Distribution of PASARR Documentation subsection.)

7.4 Level II Evaluation Completion

Individuals who are identified on the Level I screening as having a mental illness or mental retardation, and who do not meet exemption criteria outlined previously must be referred to the local CMHSP for a Level II evaluation. Level II evaluations are conducted by mental health professionals through the local CMHSP, under contract with MDCH. The evaluation involves an interview with the individual, review of medical records, and consultation with nursing facility and/or hospital staff. The mental health professional must conduct the Level II evaluation in accordance with the MDCH OBRA Operations Manual. A copy of this manual may be requested from the MDCH OBRA office or the local CMHSP.

When a Level II Evaluation is required, it must be completed prior to nursing facility admission.

When a Level II evaluation is indicated for an Annual Resident Review (ARR), the nursing facility must notify the local CMHSP of the need for the Level II evaluation at least 30 days prior to the due date of the ARR by sending them a new DCH-3877 (Level I screening form). For example, if the initial Level II evaluation was completed on April 15, 2004, the ARR is due April 15, 2005, and the facility must notify the local CMHSP that a new Level II is due by March 15, 2005. The local CMHSP is responsible for timely completion of Level II evaluations and for providing facilities with written documentation of PASARR determinations in a timely manner.

Once completed, the CMHSP forwards all documentation of the Level II evaluation to MDCH. Based on this documentation, MDCH determines whether the individual requires nursing facility services or can be served in an alternate setting. MDCH also determines whether specialized services or other mental health services are needed to treat the individual's mental illness or mental retardation.

MDCH's decision regarding the need for nursing facility services and the need for specialized services is forwarded to the referring CMHSP. It is the responsibility of the CMHSP to explain the evaluation and determination to the individual and his legal representative within 30 days. The CMHSP must provide a copy of the evaluation and the MDCH determination letter to the individual and his representative and explain the appeal rights to the individual and their legal representative. This information must also be adapted to the cultural background, language, ethnic origin and means of communication of the individual being evaluated.

The local CMHSP notifies the attending physician, nursing facility, and discharging hospital of the results of the evaluation and the MDCH determination in writing within 30 days of the review. A copy of this notification must be retained in the individual's record. (Refer to the Distribution of PASARR Documentation sub-section.)

Given that all other admission criteria outlined in this chapter are met, a nursing facility may admit an individual on the basis of a verbal Pre-admission Screening determination from MDCH. This determination may be communicated to the nursing facility by the CMHSP.

If the facility does not receive a written determination as follow-up to a verbal determination within 30 days of an admission, the facility must send a written reminder to the CMHSP and the MDCH OBRA Office within 45 days of the admission. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

The nursing facility is responsible for verifying that required PAS and ARR processes are completed and documented in the resident's record. The nursing facility medical record must include the determinations of the level of care, the need for specialized services, the original DCH-3877 and DCH-3878 forms, and the Level II evaluation report and supporting documents.

7.5 Distribution of PASARR Documentation

The following chart shows the correct distribution of copies of PASARR forms (DCH-3877, DCH-3878) and Level II evaluation documentation. All originals must be fully completed and signed.

Level I Screening Documentation (DCH-3877)		
Original	Nursing facility record	All nursing facility admissions
Copy	Individual or their representative	All nursing facility admissions
Copy	CMHSP	If "yes" answer(s)
Copy	MDCH via local CMHSP	If "yes" answer(s) and no exemption criteria met

Documentation of Exemption to Level II Evaluation (DCH-3878)	
Original	Nursing facility record
Copy	Individual or their representative
Copy	CMHSP
Copy	MDCH via local CMHSP

Level II Evaluation Documentation	
Original	MDCH OBRA Office
Copy	CMHSP
Copy	Individual or their representative
Copy	Nursing facility
Copy	Hospital, attending physician

MDCH Determination	
Original	CMHSP
Copy	MDCH
Copy	Individual or their representative
Copy	Hospital, attending physician
Copy	Nursing facility

7.6 Compliance

Failure of a nursing facility to comply with OBRA PASARR requirements will result in the loss of Medicaid reimbursement to the facility for services provided for that resident for any period during which a correct and timely screening or review was not completed for that resident. A claim should not be submitted for dates of services provided during periods for which required Pre-admission Screening or Annual Resident Review has not been completed.

The resident or parties responsible for the resident cannot be charged for the loss of reimbursement caused by the facility's failure to meet PASARR requirements.

The Level I screening is considered completed when the DCH-3877 has been filled out, signed, and distributed or, if exemption criteria are met, both the DCH-3877 and DCH-3878 have been filled out, signed, and distributed. The Level II evaluation process is completed when the CMHSP has completed the evaluation and the individual has been notified of the MDCH determination.

For a screening or evaluation to be correct, the completed forms must contain information consistent with documentation in the resident's nursing facility medical record.

Compliance is monitored through the survey process, complaint investigations, and audits. Retrospective payment adjustments through interim gross adjustments and/or final settlements are made to recover funds as necessary. A nursing facility is not penalized for failures to meet PASARR provisions for which it is not responsible and/or could not prevent.

7.7 Appeals of PASARR Determinations

Individuals adversely affected by PASARR determinations may appeal the determination or another person may appeal the determination on their behalf. Examples may include the determination that the individual no longer requires specialized services when they have received those services in the past and wish to continue. An individual may decline nursing facility admission or specialized services without appeal.

Information regarding the MDCH administrative hearing (appeal) process is available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

7.8 Complaints

Complaints or concerns regarding a nursing facility's implementation of the PASARR regulations should be directed to the Health Facility Complaint Line. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

Complaints or concerns about local CMHSP implementation of PASARR policy should be sent to the MDCH OBRA Office. (Refer to the Directory Appendix for contact information.)

SECTION 8 – MEDICAID COVERED AND NON-COVERED SERVICES

Determination of medical necessity and appropriateness of Medicaid services is the responsibility of the attending physician (M.D. or D.O.) and is subject to MDCH review. Services must be within the scope of currently accepted medical practice, limitations of the Medicaid Program, and State and Federal requirements.

8.1 MEDICARE-COVERED SERVICES

For Medicare-covered services, MDCH only pays up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance and deductibles), or the Medicaid fee screen, whichever is less. This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare. In addition, Medicaid covers the coinsurance and deductible amounts on any Medicare-covered service not normally covered by Medicaid.

If the beneficiary has a Medicare benefit available, that benefit must be utilized before Medicaid pays any portion of the claim. If a beneficiary who has Medicare coverage is receiving services under CMHSP or CA capitation, the CMHSP/CA assumes the MDCH payment liability described in this section.

For Medicare coinsurance days billed to Medicaid, the beneficiary may be in either a Medicare certified or Medicare/Medicaid dually certified bed.

Prior authorization is not required for billing the Medicare deductible and coinsurance amounts, even if the service would require prior authorization if Medicaid were the payer. However, if the facility is uncertain of Medicare coverage, prior authorization from Medicaid should still be obtained. This allows the facility to render the service, bill Medicare and then, if appropriate, bill Medicaid for its share of the service. If Medicare Part B covers an item or service that is included in the Medicaid per diem, the nursing facility is responsible for any coinsurance or deductible, even when billed by an ancillary provider.

Services for which Medicare has made a payment may not be used to offset the patient-pay amount. Coinsurance amounts are charged to the patient-pay amount, and Medicaid reimburses any applicable difference between the patient-pay amount and the coinsurance rate.

If a beneficiary has Medicare Part B coverage, and Medicare does not cover a service, Medicaid considers the service to be included in the Medicaid reimbursement for routine nursing care.

8.2 MEDICARE DENIAL OF BASIC CARE

Medicare covers only skilled care. Medicaid covers both basic and skilled care. In the event a dually eligible Medicare/Medicaid beneficiary requires basic care, Medicaid will cover the service if all other admission criteria are met (e.g., physician order for nursing facility care and beneficiary meets the Medicaid Nursing Facility LOC Determination for NF Care).

8.3 MEDICAID REIMBURSEMENT FOR A NURSING FACILITY BED FOLLOWING A QUALIFYING MEDICARE HOSPITAL STAY

A dually eligible beneficiary who resides in a Medicaid-only certified bed and is admitted to a hospital for actue care services, may be eligible for Medicare-reimbursed Skilled Nursing Facility (SNF) benefits at the time of hospital discharge. If that beneficiary wants to return to the Medicaid NF bed he originally occupied, he may refuse his Medicare SNF benefit and Medicaid will reimburse for all medically necessary

nursing facility days and other medically necessary services. The days billed to Medicaid must be included in the Medicaid census statistics.

The nursing facility must advise beneficiaries of their right to refuse their Medicare SNF benefit in order to return to their Medicaid NF bed. This notice must be in a manner that the beneficiary, family member, or beneficiary's level representative can understand or be clearly explained to them as needed.

8.3.A. Required Documentation

The facility must maintain, in the beneficiary's clinical and fiscal record, documentation that supports the beneficiary made the choice to forego Medicare-reimbursed services and return to his Medicaid-only certified bed. This documentation must be signed and dated by the beneficiary (or his authorized representative) and a nursing facility representative.

8.3.B. Medicare Part B

Required outpatient physical or occupational therapy, or outpatient speech pathology for NF beneficiaries must be provided and billed under Medicare Part B where applicable, even if no payments are made under Medicare Part A for the nursing facility stay.

8.4 Other Insurance

Many Medicaid beneficiaries have insurance coverage (either traditional health insurance or an HMO) through private and/or employer-based commercial policies. That insurance is always primary, and the rules of that insurer must be followed. This includes, but is not limited to, prior authorization requirements, qualifications of providers, and providing services through the insurer's provider network. MDCH does not pay for services denied by the primary insurer because the primary insurer's rules were not followed.

MDCH pays appropriate copays and deductibles up to the beneficiary's financial obligation to pay or the Medicaid fee screen, whichever is less. If the primary insurer has negotiated a rate for a service that is lower than the Medicaid fee screen, MDCH cannot be billed more than the negotiated rate. Medicaid-covered services not included in the primary insurer's plan are reimbursed by MDCH up to the Medicaid fee screen if all MDCH coverage rules are followed. If a beneficiary with other insurance coverage is enrolled in a MHP, or is receiving services under CMHSP or CA capitation, the MHP/CMHSP/CA assumes the MDCH payment liabilities described in this section.

8.5 Payment for Non-covered Services

For necessary medical or remedial care recognized under the State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows nursing facility beneficiaries to access their patient-pay amount to pay for these services. If Medicare covers the medical service, then Medicaid will continue to cover the Medicare deductible and coinsurance in the event it does not exceed the Medicaid fee screen.

SECTION 9 - MEDICAID SERVICE DESCRIPTIONS

The following table outlines those services that are included in the facility's per diem rate or are an ancillary service that may be provided to beneficiaries in a nursing facility. Following the table is a more detailed description of each service.

All services required as a condition of licensure/certification are included in the per diem rate.

The nursing facility should contact the ancillary provider or Medicaid Provider Inquiry Line to confirm Medicaid coverage of ancillary services.

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Administrative Services	X		
Admission Kits (Limited to routine personal hygiene items (See Personal Hygiene Items description)	X		
Alcohol Abuse Treatment (See Substance Abuse Services and Treatment description)		X	
Ambulance Services – Emergency and non-Emergency (See Transportation description)		X	
Ancillary Services			X (Some)
Beauty and Barber Services			X
Chiropractic Services		X	
Daily Oral Hygiene and Supplies (See Dental Services description)	X		
Dental Services		X	
Dietary Services and Food (including enteral tube feeding formula, supplies and equipment)	X		
Drug Dependency Treatment (See Substance Abuse Services and Treatment description)		X	
Dry Cleaning (See Laundry Services description)			X
Durable Medical Equipment – customized equipment		X	
Durable Medical Equipment – standard equipment	X		
End of Life Care	X		
Enrichment Programs	X		
Family Planning Services		X	
Food (See Dietary Services and Food description)	X		
Foot Care – Routine (See Podiatry Services description)	X		

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Hearing Services		X	
Hospice Services – Nursing Facility Responsibility	X		
Hospice Services – Hospice Responsibility		X	
Hospital Services (Inpatient and Outpatient)		X	
Housekeeping and Maintenance	X		
Intravenous Therapy – nursing supplies, equipment (including IV infusion pump, but not drug infusion pump)	X		
Intravenous Therapy – pharmaceuticals		X	
Laboratory Services – routine	X		
Laboratory Services Requiring Special Laboratory and Professional Laboratory Staff		X	
Laundry Services	X		
Medically-Related Social Services	X		
Medication Reviews (See Pharmacy description)	X		
Mental Health Services – facility provided	X		
Mental Health Services – local CMHSP and referrals		X	
Nurse Aide Attendance for Medical Appointments (See Transportation description)	X		
Nursing Care – routine	X		
Orthotics		X	
Oxygen - intermittent and infrequent	X		
Oxygen – daily use		X	
Personal Comfort Items			X
Personal Hygiene Items	X		
Pharmacy – Medicaid Covered Over-the-Counter Drugs		X	
Pharmacy – Routine Over-the-Counter Drugs	X		
Pharmacy— Prescription Drugs		X	
Physician Services		X	
Podiatry Services		X	
Private Duty Nursing in a Nursing Facility			X
Private Room (if medically necessary)	X		
Private Room (no medical necessity)			X
Prosthetics		X	
Radiology		X	
Supplies and Accessories	X		
Therapies – Routine maintenance	X		
Therapies – Non-routine		X	

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Total Parenteral Nutritional Formula, Equipment and Supplies (See Dietary Services and Food description)		X	
Transportation Services - non-emergency	X		
Vaccines	X		
Vision Services		X	
Wound Dressings (see Supplies and Accessories)	X	X (some)	

9.1 Administrative Services

Nursing facilities must be administered in a manner that effectively and efficiently uses its resources to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in compliance with all applicable State and Federal licensure and certification laws, codes and regulations. Services rendered in the general administration of the facility are included in the facility's per diem rate. Services include, but are not limited to:

- Arranging appointments;
- Building, equipment, and grounds maintenance;
- Development, adoption, and posting of patient rights;
- Development of disaster plans;
- Development of patient councils;
- Infection control;
- Insect and vermin control;
- Management of patient trust funds;
- Nursing care determinations;
- Quality control;
- Record keeping; and
- Utilization control.

9.2 Admission Kits

Routine personal hygiene items in an admission kit are included in the per diem rate. Nonroutine personal hygiene items in an admission kit are not reimburseable and are not allowable costs.

9.3 Ancillary Services

Ancillary services (i.e., services other than daily care services) must be ordered and documented, in writing, by the beneficiary's attending physician, and the documentation must be retained in the beneficiary's medical record. The physician's signature on prior authorization forms, treatment plans, etc., certifies the necessity of ancillary services. The physician must review the beneficiary's progress resulting from the ancillary service not less than every 60 days and summarize the progress resulting from the ancillary service provided.

The orders must be for a specific beneficiary (no blanket orders) and prior to the service being rendered. Orders may be received by telephone but must be written in the beneficiary's medical record. Such services must be provided and billed by the appropriate enrolled provider. It is suggested that the facility contact the ancillary provider or the Medicaid Provider Inquiry Line to ascertain whether the service is covered prior to arranging for the provision of the service. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

The facility is responsible for arranging all ancillary and non-covered medical services. Arranging appointments and transportation for these services is included in the per diem rate.

The beneficiary or beneficiary's representative may choose to purchase non-covered services directly from an ancillary provider. The beneficiary pays the ancillary provider directly for the services provided. The nursing facility must retain, in the beneficiary's fiscal record, receipts showing that the beneficiary paid for the particular non-covered service. Medicaid post-payment reviews will be conducted to assure that the beneficiary's fiscal record contains the receipts.

Nursing facilities may not bill Medicaid for ancillary services except for therapies, oxygen, pharmacy, and the Medicare coinsurance or deductible for ancillary services. Otherwise, the ancillary provider must bill for the service. Some nursing facilities are exempt from billing certain ancillary services (e.g., only a Provider Type 62-Hospital Long Term Care Unit can bill for pharmacy). The Billing & Reimbursement for Institutional Providers Chapter contains the allowable nursing facility provider types that can bill for ancillary services.

Therapies may be billed by the facility regardless of coverage by Medicare. However, Medicaid remains the payer of last resort.

Ancillary services (e.g., physical therapy) provided to a beneficiary on the day of discharge may be billed to Medicaid, even if the beneficiary was admitted and discharged on the same date.

9.4 Beauty and Barber Services

Services of a professional beautician or barber are not included in the per diem rate and are not covered by the Medicaid Program. The beneficiary may purchase such services from personal funds. A beneficiary's patient-pay amount may not be used to cover these costs.

9.5 Chiropractic Services (Medically-necessary)

Chiropractic services, such as x-rays and treatment, are an ancillary service and are not included in the facility's per diem rate.

9.6 Dental Services

The facility's per diem rate includes providing assistance with, and supplies for, daily oral hygiene. Dental supplies include, but are not limited to:

- Dental floss
- Mouthwash
- Mouthwash cups
- Denture adhesive
- Denture cleaner
- Denture cups
- Toothbrushes
- Toothpaste

Routine and emergency dental services are an ancillary service and are not included in the facility's per diem rate.

9.7 Dietary Services and Food

Residents must be provided nourishing, palatable, well-balanced meals that meet their daily nutrition and special dietary needs. Dietary services must also meet the preferences of residents and offer substitutes of similar nutritional value.

Nutrition appropriate for each resident's condition is included in the facility's per diem rate. This includes, but is not limited to:

- Daily nutritious meals and snacks
- Reasonable food substitutes of a similar nutritive value
- Dietary supplements
- Enteral formulas, supplies, equipment, and associated nursing services
- Infant formulas
- Nursing services associated with total parenteral nutrition (TPN) *
- Special diets
- Therapeutic diets
- Water solutions

* *The formula, equipment, and supplies required for the TPN feedings are an ancillary service and are not included in the facility's per diem rate.*

Medicaid reimburses non-profit nursing facilities that incur costs resulting from the purchase of raw food and food preparation associated with special dietary needs for religious reasons. (Refer to the Nursing Facility Reimbursement chapter of this manual for more information.)

9.8 Durable Medical Equipment

9.8.A. Standard Equipment

Standard, non-customized durable medical equipment is included in the facility's per diem rate. The durable medical equipment supplier and the nursing facility must make arrangements for purchasing or renting required equipment. Standard durable medical equipment includes, but is not limited to:

- Adaptive ADL equipment
- Air mattresses
- Autoclaves
- Bed boards
- Bed cradles
- Bed pans
- Bed rails
- Beds (including hospital beds)
- Bedside safety rails
- Bedside stands
- Blood pressure apparatus
- Canes
- Comfortable cushioned chair
- Commodes
- Crutches
- Emesis basins
- Food pumps
- Foot boards
- Foot rails
- Foot stools
- Freestanding trays for meals
- Geriatric chairs
- Infrared lamps
- Lifts
- Oxygen equipment and supplies
- Positioning pillows
- Reading lights
- Sitz baths
- Splints
- Suction machines
- Traction equipment
- Trapeze equipment
- Tub lifts
- Urinals
- Walkers
- Wash basins
- Wheelchairs

Such equipment must be available for all the residents demonstrating need. Previously acquired equipment should be adapted to meet the beneficiary's needs, if appropriate.

The facility is required to repair/maintain standard, non-customized equipment, and this expense is included in the per diem rate. This may not be billed separately to Medicaid, the beneficiary, his family, or representative.

Replacement, repair and maintenance of standard equipment owned or rented by the beneficiary is not a Medicaid-covered benefit.

9.8.B. Customized Equipment

For customized equipment, the durable medical equipment provider must request prior authorization. Once purchase or rental of the equipment is authorized, the DME/Medical Supply provider may provide the service and bill Medicaid directly.

Prior authorization is approved if the following conditions are met:

- The attending physician (M.D. or D.O.) must order the equipment in writing. These orders must be signed by the attending physician and retained in the beneficiary's medical record. The orders must include the estimated period of months that the beneficiary will need such equipment, the medical/functional need, and an explanation of why standard, non-customized equipment is not suitable. A copy of the physician's orders must be attached to the durable medical equipment provider's prior authorization request.
- The equipment is medically necessary and specifically customized for the exclusive use of the beneficiary.
- The equipment offers physical/restorative function to the beneficiary.
- The facility is not the direct supplier of durable medical equipment.

Repairs to customized equipment by the durable medical equipment provider are covered only when it is necessary to make the equipment serviceable. Extensive repairs and maintenance by authorized technicians are covered if the warranty has expired. The durable medical equipment provider may bill for authorized repairs. Routine periodic servicing, such as cleaning, testing, regulating, and checking of the equipment, is not separately reimbursable.

9.9 End of Life Care

Facilities are expected to have systems and policies in place to address appropriate advance care planning and end of life care. Facilities must notify residents at admission of their policies regarding the implementation of advance directives and the availability of hospice care. Residents are entitled to adequate and appropriate pain and symptom management as a basic and essential part of their medical treatment. Best Practice Information for end-of life care and pain management for nursing homes and hospital LTC units is available on the Michigan Department of Consumer & Industry Services website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

9.10 Enrichment Programs

Facilities are required to provide or arrange for an ongoing program of activities designed to meet the interests and physical, mental and social well-being of each resident. An individualized program may be developed as part of the person-centered care planning process. Programs designed to maintain the resident's quality of life are included in the facility's per diem rate. Such services include, but are not limited to:

- Social services;
- Books;
- Current periodicals (e.g., newspapers, magazines) [If the beneficiary personally subscribes to a periodical (e.g., newspaper, magazine) for his own use, he is responsible for payment of that subscription.];
- Diversional programs;
- Motivational programs;

- Reality-oriented programs; and
- Recreational programs.

9.11 Family Planning Services

Family planning services are an ancillary service and are not included in the facility's per diem rate.

9.12 Hearing Services

Hearing evaluations are an ancillary service and are not included in the facility's per diem rate.

A Medicaid co-payment is not required for nursing facility beneficiaries.

9.13 Hospice Services

Upon admission to a nursing facility, residents must be advised of the facility's policies regarding the availability of hospice care.

Nursing facility beneficiaries [including Memorandum of Understanding (MOU) Special Agreements for Complex Care cases] are eligible for Medicaid hospice services if determined by a hospice provider to meet hospice level of care. Additionally, in certain situations (such as lack of a caregiver in the home), a hospice beneficiary, in consultation with the hospice provider, may elect to enter a nursing facility to receive end of life care. Medicare beneficiaries receiving or eligible for the 100-day skilled nursing benefit have the right to choose hospice instead. This decision should not be influenced by differences between hospice and Medicare skilled nursing facility reimbursement rates.

If the beneficiary is enrolled in a MHP and is admitted to the nursing facility with the hospice benefit, the MHP is responsible for reimbursement of hospice services.

For nursing facilities that elect to contract with hospice providers, MDCH encourages a written contract between the hospice provider and the nursing facility that specifically outlines the responsibilities of each. Additionally, the contract must specify how the hospice provider will reimburse the nursing facility for room and board.

Nursing facilities **cannot** bill Medicaid directly for room and board or any other services for hospice beneficiaries. A hospice is responsible for all costs for a person receiving hospice care. The hospice bills Medicaid for room and board, then reimburses the nursing facility at the rate specified in the contract between the providers.

MDCH reimburses the hospice for its daily rate and for room and board for beneficiaries in Medicaid or Medicaid/Medicare certified beds. The room and board rate is 95% of the facility's Medicaid per diem rate, which is the minimum established by Centers for Medicare and Medicaid Services (CMS). Although the rate paid to the hospice by Medicaid is set, it is not necessarily the rate that the hospice must pay the facility. It is expected that some services may be purchased or traded between the facility and the hospice, so the negotiated room and board rate must be stipulated in the contract.

Because Medicaid is making a payment for room and board (even though it is paid to the hospice), beneficiaries must be treated as all other Medicaid beneficiaries. For example, the facility cannot seek or accept additional or supplemental payment from the beneficiary, his family, or representative in addition to the amount paid for the covered service, even when a beneficiary has signed an agreement to do so.

9.13.A. Nursing Facility Responsibilities

Nursing facilities must adhere to all State licensure requirements, even though some of the components of care are provided by the hospice rather than the nursing facility. An example of a licensure component completed by the hospice is that, upon admission, the hospice provides the facility with copies of the beneficiary's history and physical, interdisciplinary assessment, and plan of care. For purposes of licensure, these copies are accepted as appropriate.

If a beneficiary is already receiving hospice services and elects admission to a nursing facility, the nursing facility should note that the beneficiary has elected hospice on the Facility Admission Notice (MSA-2565-C) sent to the local MDHS office. This should result in a Level of Care 16 on the beneficiary's **mihealth card**. If the **mihealth card** does not indicate a Level of Care 16, the beneficiary or their designated representative should contact the local MDHS office to request a correction.

Hospice staff cannot be utilized to meet staffing patterns required for licensure (i.e., the facility cannot include hospice staff on staffing reports).

Although the hospice is responsible for developing the coordinated plan of care, the nursing facility, as well as the beneficiary, must be an active participant in its development.

If the hospice beneficiary in a nursing facility has a patient-pay amount, it is the hospice's responsibility to collect that amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

Services that must be provided by the nursing facility include:

- Room and board;
- Laundry (including facility items as well as personal items); and
- All other non-terminal illness-related services afforded other Medicaid beneficiaries (e.g., services included in the per diem rate).

Hospice covered beneficiaries residing in the nursing facility must not experience any lack of nursing facility services or personal care due to their status as a hospice beneficiary. Facilities must offer the same drugs, services, medical supplies and equipment to all beneficiaries who have elected the hospice benefit in the same manner that services are provided to other beneficiaries in the facility who have not elected hospice care. If a service is normally furnished as part of the facility's per diem rate, the service must also be provided to hospice beneficiaries. If services are provided for needs associated with a non-terminal illness and are normally furnished and billed by another provider, that practice would continue.

9.13.B. Hospice Responsibilities

Hospice must certify/re-certify the beneficiary's need for hospice care.

If a beneficiary already living in a nursing facility elects the hospice benefit, it is the responsibility of the hospice to submit to MDCH, Enrollment Services Section, a Hospice Membership Notice form (DCH-1074). MDCH will assign a Level of Care code 16 on the Eligibility Verification System (EVS).

The hospice, in collaboration with the beneficiary and/or family and nursing facility, will establish a coordinated plan of care for the beneficiary. The plan must specify the overall care to be provided and indicate, in detail, which services will be provided by the hospice and which will be provided by the facility.

If the hospice beneficiary has a patient-pay amount, it is the hospice's responsibility to collect that amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

9.13.C. Service Provision

The following is intended for use as a guideline only. It identifies services for which the hospice is responsible, services that the hospice may arrange, and services that are "negotiable."

9.13.C.1. SERVICES THAT HOSPICE MUST PROVIDE (RELATED TO THE TERMINAL ILLNESS)

- A coordinated plan of care outlining the responsibilities of each provider;
- Intermittent (i.e., less than eight hours per day) nursing care of the hospice beneficiary;
- Counseling (defined as bereavement, nutritional, and spiritual); and
- Social work services.

9.13.C.2. SERVICES THAT HOSPICE MAY ARRANGE (RELATED TO THE TERMINAL ILLNESS)

- Spiritual care; and
- Home health aide/homemaker services. This applies only for services not provided during the facility's normal provision of care. For example, if the facility normally provides baths five times a week but the hospice plan of care calls for a bath each day, the hospice aide would provide baths on the days the facility does not.

9.13.C.3. NEGOTIABLE SERVICES

Services that must be available for hospice beneficiaries but appropriate contracted providers may render, as related to the terminal illness and as included in the patient plan of care, include the following. These services are the responsibility of the hospice, and **cannot** be billed to Medicaid by the contracted provider.

- Inpatient care for acute episodes of pain and symptom control;
- Inpatient respite care (not available for beneficiaries residing in a nursing facility);
- Laboratory;
- Pharmacy;
- Durable medical equipment;
- Radiology;
- Medical;
- Up to 24 hours of continuous care (at least eight hours of which must be nursing care) during periods of crisis;
- Physical therapy;
- Occupational therapy;
- Speech/language pathology; and
- Emergency ambulance transportation (if the service is included as part of the hospice plan of care).

9.14 HOSPITAL SERVICES

A nursing facility must have in effect a transfer agreement with one or more hospitals.

9.14.A. Planned Inpatient Hospital Admission

When a hospital admission is planned, the beneficiary must be discharged from the nursing facility. The nursing facility must not count the day of discharge as reimbursable by Medicaid. This day is included on the hospital's claim when billing. The facility may not bill Medicaid for hospital leave days for a planned admission. (See the Holding a Bed [Hospital Leave and Therapeutic Leave] sub-section of this chapter for more information.)

9.14.B. Emergency Inpatient Hospital Admission

When a resident is admitted to the hospital on an emergency basis, the nursing facility may receive Medicaid reimbursement for holding their bed. (See the Holding a Bed [Hospital Leave and Therapeutic Leave] sub-section of this chapter for more information.)

9.14.C. Outpatient and Emergency Room

Outpatient and emergency room services are an ancillary service and are not included in the facility's per diem rate.

A beneficiary who goes to the hospital for outpatient or emergency room services is not discharged from the nursing facility because the beneficiary is not admitted to the inpatient hospital. The beneficiary should be included in the census of the nursing facility, even if the beneficiary was being treated at midnight in the hospital outpatient or emergency room.

9.15 Housekeeping and Maintenance

Facility and room/bed maintenance necessary to maintain a sanitary, orderly, and comfortable environment are a required service and included in the nursing facility's per diem rate.

9.16 Intravenous Therapy

Intravenous therapy nursing services, supplies and equipment (including IV infusion pump, but not drug infusion pump) are included in the facility's per diem rate.

Pharmaceuticals used in IV therapy are an ancillary service and are not included in the facility's per diem rate.

9.17 Laboratory Services

Any nursing facility that performs laboratory services must be certified/accredited under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Laboratory tests that are listed as waived tests under CLIA are included in the facility's per diem rate (e.g., Testrip). A list of these tests and the instrumentation needed to perform them can be found on the FDA website: www.fda.gov/cdrh/CLIA.

Laboratory services that can only be performed with special laboratory equipment by professional laboratory staff may be provided and billed by the appropriate enrolled ancillary provider (e.g., independent laboratory, outpatient hospital). Such services are not included in the facility's per diem rate.

Drawing, collecting and delivery of laboratory specimens are routine nursing services. As such, they are included in the facility's per diem rate regardless of who actually performs the service (i.e., nursing facility or ancillary provider).

9.18 Laundry Services

Facilities are responsible for general laundry services (e.g., bedding) and the beneficiary's personal laundry (e.g., clothing). Such services are included in the facility's per diem rate.

Dry cleaning services may be billed to the beneficiary if the beneficiary requests the service in writing, he has prior knowledge that the service is not covered by Medicaid, and he agrees to accept the cost. A beneficiary's patient-pay amount may not be used to cover these costs.

9.19 Medically-Related Social Services

Nursing facilities must provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. These services may include, for example, information and referral, resident and family support, discharge planning, and are included in the facility's per diem rate.

9.20 Mental Health Services

Nursing facilities are required to have a written agreement with the local CMHSP outlining their working relationship to provide screening, evaluation and specialized services to nursing facility residents. The agreement must include a description of the process to be used to ensure the annual review of residents previously identified as mentally ill or mentally retarded. The agreement must also specify the means through which the facility and the CMHSP will deliver mental health services for nursing facility residents.

Completion of required Pre-admission Screening and Annual Resident Review is included in the facility's per diem rate. Prior to admission to a nursing facility, all individuals, regardless of payment source, must receive the Level I Pre-admission Screening (PAS) to identify the need for mental health and specialized services. Additional screening for mental health and specialized services is done as an Annual Resident Review (ARR), or more frequently in response to a change in a beneficiary's condition. (See the PASARR Process section of this chapter for more information.)

Mental health services provided by the nursing facility staff, as specified in the resident's plan of care, are included in the facility's per diem rate. Nursing facilities must provide mental health and/or mental retardation services that are of lesser intensity than specialized services to all residents who need such services.

9.20.A. Specialized Services

Specialized services are those identified by the PASARR Level II and are provided or arranged by the CMHSP. These services must be available to nursing facility individuals regardless of whether they are identified and required by the PASARR process, or whether the individual is determined to require additional services to be provided or arranged for by the State as specialized services. Individuals with a primary diagnosis of dementia are also covered by this requirement, even though the PASARR process exempts individuals with a primary diagnosis of dementia.

The PASARR Level II evaluation may provide recommendations regarding the specialized services and programs needed by the resident. Recommendations are based on evaluation of the resident's impairment in functional skills and the severity of those deficits. Nursing facilities must meet the responsibilities as outlined in this section for providing specialized services.

"Specialized Services" are defined as those mental health services for residents who are mentally ill or mentally retarded which are:

- Of greater intensity than those normally required from a nursing facility;
- Provided in conjunction with usual nursing facility services;

- Determined through the PASARR process;
- Provided or arranged for by the local CMHSP acting on behalf of the State; or
- Result in the continuous and aggressive implementation of an individualized plan of care.

Specialized services for residents with **mental illness** may include, for example, individual, group and family psychotherapy, crisis intervention services, and formal behavior modification programs.

Specialized services for residents with **mental retardation** include specialized professional involvement because the service need is related to the resident's mental retardation. Evaluators must carefully distinguish between those service needs that require the involvement of a mental retardation professional, and those which are "generic" and do not require specifically-trained professionals. For example, administering medication is a "generic" service, while teaching a resident to self-administer may be a "specialized service" because it requires the involvement of a mental retardation professional to design and monitor the program.

For residents with **multiple diagnoses**, such as mental retardation and mental illness or mental retardation and dementia, evaluators may recommend either specialized services or other mental health services, depending on the interrelationship of the two diagnoses.

9.20.B. Nursing Facility Responsibilities

Responsibilities of the nursing facility include:

- Providing all of the usual and customary services (see Medicaid Covered Services sub-section) and as required by licensing and certification. This includes specialized mental health rehabilitation services as defined in 42 CFR 483.120.
- Monitoring the need for PASARR evaluations and ensuring that they are completed on time (see the PASARR Process section). The nursing facility must notify the CMHSP when a Level II evaluation is indicated.
- Collaborating with the resident or his legal representative and the CMHSP to develop an individualized plan of care for specialized services based on the needs identified during the PASARR Level II evaluation. The plan of care must outline the responsibilities of each provider for the specialized services.
- Coordinating the identified services (which may be obtained from the local CMHSP) and implementing and monitoring the services recommended in the individualized plan of care. Nursing facilities must also provide interventions which complement, reinforce and are consistent with any specialized services the individual is receiving or is required to receive by the State through the CMHSP. The individualized plan of care must specify how the facility will integrate relevant activities throughout all hours of the day at the facility to achieve consistency and enhancement of the goals identified in the individualized plan of care.

9.20.C. CMHSP Responsibilities

Responsibilities of the CMHSP include:

- Performing the comprehensive evaluation (Level II evaluation) when required by the PASARR Screening.
- Collaborating with the resident or his legal representative and the nursing facility to develop an individualized plan of care for specialized services based on the needs identified during the PASARR Level II evaluation. The plan of care must outline the responsibilities of each provider for the specialized services.
- Providing specialized services to nursing facility residents who have been determined to need them through the PASARR process. MDCH has allocated funds to local CMHSPs for this purpose.
- Providing training to nursing facility direct care staff to implement and monitor the programs as designed, and participating in the evaluation and modification of the plan of care as needed.
- Providing services to nursing facility residents on the same basis as to all other persons in the region. A nursing facility may use the local CMHSP as a mental health service provider in order to fulfill the nursing facility's obligation to provide specialized mental health rehabilitation services. Services for residents with a primary diagnosis of dementia are also available from a local CMHSP on the same basis.

In 1991, funds were made available to local CMHSPs to provide specialized services and other mental health services to individuals residing in nursing facilities. Priority for use of these funds is for individuals with the most severe mental health problems who need specialized services. To the extent there are funds remaining after this priority group is served, MDCH has given local CMHSPs authorization to serve individuals who need mental health services other than specialized services.

Ancillary providers of mental health services may bill Medicaid directly.

9.21 NURSING CARE

Nursing facilities must have nursing staff sufficient to provide nursing and other related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Nursing care includes the responsibility for development, implementation and oversight of a plan of care that remains consistent with on-going observation, assessment and intervention by licensed nurses. The following are examples of custodial and rehabilitative nursing care that may be performed by, or under the supervision of, licensed nurses and are included in the per diem rate. Nursing services include, but are not limited to:

- Observing vital signs and recording the findings in the beneficiary's medical record;
- Administration of topical, oral, or injectable medications, including monitoring for proper dosage, frequency, or method of administration, including observation for adverse reactions;
- Treatment of skin irritations or small superficial or deep skin lesions requiring application of medication, irrigation, or sterile dressings;

- Routine changing of dressings in chronic, non-infected skin conditions and uncomplicated postoperative incisions;
- Nursing observation and care of beneficiaries with unstable or complex medical conditions which can only be provided by, or under the immediate direction of, licensed nursing personnel;
- Proper positioning in bed, wheelchair, or other accommodation to prevent deformity and pressure sores;
- Provision of bed baths;
- Routine prophylactic and palliative skin care (e.g., application of creams and lotions) for the prevention of skin irritation and pressure sores;
- Administration of intravenous solutions on a regular and continuing basis;
- Administration of tube feedings;
- Nasopharyngeal aspiration required for maintenance of a clear airway;
- Care of a colostomy or iliostomy during early postoperative period, on an on-going basis, and conducting colostomy training;
- Use of protective restraints, bed rails, binders, and supports (if ordered by a physician and in compliance with state and federal regulations) provided in accordance with written patient-care policies and procedures;
- Use of intermittent positive pressure breathing equipment and nebulizers;
- Care of catheters;
- Care of tracheostomies, gastrostomies, and other indwelling tubes;
- Administration of oxygen or other medicinal gases on a regular and continuing basis in the presence of an unstable medical condition or when nursing assessment is required to determine frequency and necessity of administration;
- Identifying the need for, and insuring arrangements for, prompt and convenient clinical, laboratory, x-ray, and other diagnostic services;
- Use of heat as a palliative and comfort measure, such as whirlpool and hydrocolator;
- Training and assistance in transfer techniques (bed to wheelchair, wheelchair to commode, etc.);
- Training, assistance, and encouragement of self-care as required for feeding, grooming, toileting activities (including toilet routine to encourage continence), and other activities of daily living;
- Normal range-of-motion exercises as part of routine maintenance nursing care; and
- Pain assessment and management.

9.22 Orthotics

Orthotics are an ancillary service and are not included in the facility's per diem rate.

9.23 Oxygen

The administration of oxygen and the related nursing services are included in the per diem rate.

Oxygen gas, equipment, and supplies for intermittent and infrequent use are included in the facility's per diem rate.

If a beneficiary requires frequent or prolonged oxygen on a daily basis (i.e., at least 8 hours per day):

- As a resident in the Nursing Facility (Provider Type 60), the oxygen gas, equipment, and supplies must be billed by an enrolled medical supplier, not the nursing facility.
- As a resident in a County Medical Care Facility (Provider Type 61) or a Hospital Long Term Care Unit (Provider Type 62), the oxygen gas, equipment, and supplies are billable by the facility.
- (Refer to the Billing and Reimbursement for Institutional Providers Chapter in this manual for billing instructions.)

Oxygen services (i.e., gas, equipment, and supplies) are not covered by Medicaid if **Medicare** is paying for the stay. Medicare's per diem reimbursement rate includes the oxygen services.

9.24 Personal Comfort Items

Medicaid does not cover individual personal comfort items (e.g., telephone, television, radio, guest trays). Such services are not included in the facility's per diem rate. Beneficiaries may purchase individualized services with personal funds. A beneficiary's patient-pay amount may not be used to cover these services.

If the facility provides personal comfort items to all its beneficiaries (e.g., a television in the recreation room), the service is included in the facility's per diem rate.

9.25 Personal Hygiene Items

Items needed for personal hygiene are included in the facility's per diem rate. Such items include, but are not limited to, the following:

- Bacteriostatic soaps
- Body lotions
- Combs and brushes
- Cotton swabs
- Deodorant/antiperspirant
- Facial tissues
- Hair conditioners (as appropriate)
- Incontinence supplies
- Medicine cups
- Oral hygiene supplies
- Patient gowns
- Personal hygiene preparations
- Safety razors
- Sanitary napkins
- Shampoo
- Shaving cream
- Soaps

9.26 Pharmacy

Nursing facilities must provide pharmaceutical services to meet the needs of each resident.

Prescriptions must be ordered and documented, in writing, in the beneficiary's medical record by the attending physician.

A Medicaid co-payment is not required for prescription pharmaceuticals for nursing facility beneficiaries.

The Michigan Pharmaceutical Product List (MPPL) contains the over-the-counter and prescription pharmaceutical products covered by Medicaid and any restrictions placed on those products, including when prior authorization is required. The prior authorization process is outlined in the MPPL and may be obtained by the physician or their designee. The Michigan Pharmaceutical Products List is available online. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

Only Hospital LTC Units may bill Medicaid directly for pharmacy items. Pharmaceuticals dispensed in all other types of nursing facilities must be billed through a pharmacy (unless pharmacy is included in the per diem rate, i.e., ICF/MR).

9.26.A. Over-the-Counter Products (OTC's)

- The MPPL designates when an OTC drug is included in the facility's per diem rate. It is the responsibility of the facility to provide these products. Examples of OTCs in the per diem include mouthwash, topical antiseptics, analgesics, cough and cold preparations, ointments (both generic and brand name [e.g., Vaseline, Gold Bond]), and vitamins and minerals. The pharmacy or supplier must make arrangements with the nursing facility for reimbursement.
- OTCs not included in the per diem rate that may be billed to Medicaid, as outlined in the MPPL, are reimbursable to Pharmacy (Provider Type 50) for nursing facility beneficiaries. Examples include Diphenhydramine and Insulin.

9.26.B. Medication Reviews

Medication reviews, as required by federal regulations, are the responsibility of the facility and are included in the per diem rate. The pharmacist must make arrangements with the facility for reimbursement of such services.

9.27 Physician Services

Physician services must be provided and are an ancillary service. Such services are not included in the facility's per diem rate. In accordance with federal requirements, residents have the right to choose an attending physician.

A physician must initially examine a resident within 48 hours of admission to the nursing facility, unless the resident has been examined by a licensed physician within five days before admission and a copy of that examination is available in the facility at the time of the resident's admission. If the admission occurs on a Friday, the exam must be completed within 72 hours.

A physician must evaluate a beneficiary every 30 days for the first 90 days after admission. The resident must then be evaluated every 60 days unless otherwise justified and documented by the physician. At a minimum, the resident must be evaluated at least once every 90 days on an ongoing basis.

A physician visit is considered timely if it occurs no later than ten days after the required visit. After the initial visit, the physician may alternate personal visits between the physician and a physician assistant or nurse practitioner.

9.28 Podiatry Services

Palliative treatment and routine foot care (e.g., trimming of the nails, removal of corns and calluses) are included in the facility's per diem rate.

Medically necessary podiatry physician services are an ancillary service and are not included in the facility's per diem rate.

9.29 Private Duty Nursing

Private duty nurses are not covered in a nursing facility by the Medicaid Program nor are they included in the facility's per diem rate. The beneficiary may use personal funds to purchase private duty nursing services. A beneficiary's patient-pay amount may not be used to cover the cost of private duty nursing.

9.30 Private Room

When a Medicaid beneficiary requires a private room due to medical necessity, the nursing facility is reimbursed at the usual per diem rate. Private rooms required for medical necessity are included in the facility's per diem rate. Written documentation of medical necessity must be part of the beneficiary's medical record.

Medical necessity is defined as a documented medical condition that creates the need to isolate the resident for his safety and/or the safety of others (i.e., infection control). This also includes behavioral conditions related to a medical condition (i.e., aggression related to dementia). The medical necessity must be documented, as well as addressed, in care planning and treatment.

If a beneficiary requests a private room and there is no medical necessity, the beneficiary may elect to pay privately. The nursing facility must advise the beneficiary that a private room is not a Medicaid-covered service unless it is medically necessary, and that the beneficiary or family is responsible for paying the difference between the cost of a semi-private and private room. The facility may only charge the difference between what it would normally charge a private-pay resident for a semi-private and a private room. Facilities may not charge beneficiaries the difference between the Medicaid per diem rate and the rate charged a private-pay resident for a private room. For example, if the facility charges $98.00/day for semi-private room and $112.00/day for a standard private room, the charge is $14.00/day. The beneficiary's patient-pay amount may not be used for this purpose.

If the beneficiary agrees to pay the difference between the semi-private and private room rate, the beneficiary or family member must request permission, in writing, from the MDCH. The Request for Authorization of Private Room Supplemental Payment for Nursing Facility form (MSA-1580) is used to obtain the permission. The MSA-1580 is completed by the beneficiary or family member. (Refer to the Directory Appendix of the Medicaid Provider Manual for downloading the MSA-1580 and other contact information.) Requests to supplement the cost of a private room are reviewed for cost and reason for request on a case-by-case basis. A response will be sent to the requestor, the beneficiary (if different), and the facility within ten working days.

This response must be retained as part of the beneficiary's medical record. Subsequently, these charges are subject to audit by MDCH, CMS or designated representatives of either of those entities. These charges must be reported by the nursing facility as revenue received. This response, however, does not guarantee that the beneficiary will be provided a private room. The agreement to provide a private room is given by the nursing facility.

9.31 Prosthetics

Prosthetic services are an ancillary service and are not included in the facility's per diem rate.

9.32 Radiology

Radiology services are an ancillary service and are not included in the facility's per diem rate.

9.33 Substance Abuse Services and Treatment

Services rendered for the treatment of alcohol and drug abuse are an ancillary service are not included in the facility's per diem rate.

9.34 Supplies and Accessories

Supplies, accessories, and equipment necessary to achieve the goals of the beneficiary's plan of care are included in the facility's per diem rate and must be available to the beneficiary. Medical supplies, accessories, and equipment include, but are not limited to:

- Atomizers
- Bandage products
- Bed linens
- Bib or protective cover
- Catheters/accessories and irrigation solution
- Cloth diapers
- Cotton balls
- Cotton swabs
- Deodorizers
- Diagnostic agents (e.g., Testape, Kyotest)
- Disposable diapers
- Disposable gloves
- Dressings (e.g., surgical pads, cellulose wadding, tape)

  Note: Some supplies for complex wound care are not included in the per diem rate and must be obtained through a medical supplier or pharmacy (Provider Type 87 and 50). Supplies that must be billed by a medical supplier, including information for interpreting the list of supplies, are on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for additional information.)

- Elastic hose
- Enema kits

- Finger cots
- First aid trays
- Flameproof cubicle curtains
- Foot soaks
- Hot water bottles
- Hypodermic needles/syringes
- Ice bags
- Incontinence pads, pants, and liners
- IV supplies and equipment; related supplies (including IV infusion pump)
- Minor medical/surgical supplies
- Miscellaneous applicators
- Nebulizers (hand-held or used with a compressor)
- Ostomy supplies
- Plastic waste bags
- Recreational/therapeutic equipment and supplies to conduct ongoing activities
- Safety pins
- Sheepskin, devices and solutions for preventing/treating decubiti
- Slings
- Stethoscopes
- Straws
- Syringes/needles
- Thermometers
- Tongue blades (depressors)
- Towels/washcloths
- Tracheostomy care kits and cleaning supplies
- Trochanter rolls
- Water carafes/glasses

Note: This list is not complete. Generic equivalents and products in the same family (i.e., same general use) are also included in the facility's per diem rate.

9.35 THERAPIES

Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care.

Routine maintenance therapy consists of the repetitive services required to maintain function. The development of the therapy and treatment are included in the per diem rate. Such therapy does not require the therapist to perform the service, nor does it require complex and sophisticated procedures.

Non-routine occupational therapy (OT), physical therapy (PT) and speech/language/ pathology (ST) are ancillary services that are covered if prior authorization is obtained and the following conditions are met:

- The therapy must be billed by the facility;
- There must be a written order by the attending physician for each calendar month of therapy; and
- The written orders must be signed by the attending physician and retained in the beneficiary's medical record.

Non-routine ancillary therapy is therapy that requires the skills of a qualified technical or professional health personnel such as physical therapists, occupational therapists, speech pathologists or audiologiests, and are directly provided by or under the general supervision of these skilled personnel to assure the safety of the beneficiary and achieve the medically desired results as ordered by the beneficiary's physician.

Federal regulations require the facility to have a valid contract with the OT, PT, or ST provider. A valid contract allows the facility to retain professional and administrative control over the services provided. Therefore, an agreement that stipulates only the use of facility space does not constitute a valid contract.

If Medicaid funds have inappropriately been paid to a facility for OT, PT, or ST services when a facility did not possess a valid contract, the funds may be recovered by gross adjustment or at the time of cost settlement, as appropriate.

The following clarifies the professional responsibilities of the nursing facility, the physician, and the therapist in the provision of OT, PT or ST services for Medicaid beneficiaries.

- The facility has administrative and professional responsibility for the management of the total health care needs of the beneficiary as outlined in the plan of care. The facility must assure that appropriate OT, PT, or ST services are available to the beneficiary as needed. In situations where the therapist is not an employee of the facility, the facility must establish a valid contract with a therapist/speech pathologist who meets applicable licensure/certification/accreditation requirements.
- The attending physician is responsible for determining the medical necessity and appropriateness for services and preparing the written orders for OT, PT or ST evaluation and treatment. These are reviewed and approved/disapproved by the MDCH Prior Authorization Division.
- The therapists are responsible for evaluating the beneficiary's needs; developing a written plan of treatment, including goals and objectives; and providing or overseeing the appropriate services. A copy of the treatment plan must be retained in the beneficiary's medical record.

The facility's responsibilities, as described above, are not meant to conflict in any way with the professional responsibilities of OTs, PTs or STs in the evaluation and treatment of the beneficiary.

The cost of supplies and equipment (e.g., plate guards) used as part of the therapy program is included in the reimbursement for the therapy/speech pathology.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital. ST may also be provided by a hearing and speech center. Prior authorization must be obtained by the facility regardless of where the service is to be provided.

Note: Therapy provided by a physician (M.D. or D.O.) is not a covered benefit for beneficiaries in a nursing facility.

9.35.A. Occupational Therapy (OT)

Occupational therapy (OT) must be active and restorative. A registered occupational therapist or a certified occupational therapy assistant must render the services. If the assistant renders the service, the therapist must be on the premises when the service is provided.

The following are examples of occupational therapy services that may be covered by Medicaid:

- Training in activities of daily living;
- Fabrication of adaptive equipment;
- Perceptual motor training;
- Splinting;
- Testing;
- Therapeutic exercises; and
- Prosthetic and orthotic training.

OT services that are provided and billed simultaneous with PT are not covered. Also, diversional OT, reality orientation, and restorative nursing functions are considered part of the per diem rate, and not separately reimbursable.

9.35.B. Physical Therapy (PT)

Active, restorative, or specialized maintenance physical therapy (PT) programs, as explained below, are benefits of the Medicaid Program. There must be the expectation that the beneficiary's condition will improve significantly in a reasonable and generally predictable period of time.

A licensed physical therapist (temporary permit is acceptable), physical therapy assistant, or physical therapy aide must provide the services. If the assistant or aide renders the services, the therapist must be on the premises when services are provided.

The following are examples of restorative PT services which may be covered by Medicaid:

- Hot pack, ice pack, infrared treatment, or whirlpool bath is covered when provided as a prerequisite to a skilled physical therapy procedure;
- Gait training is covered when provided to a beneficiary whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;
- Prosthetic and orthotic training is covered when instructing the beneficiary in using the prosthetic or orthotic device; and
- Range of motion exercises are covered when provided as part of the treatment of a specific disability which has resulted in a loss or restriction of mobility.

For specialized maintenance physical therapy, the therapist's initial evaluation of the beneficiary's needs and designing of the program are covered. The program must be appropriate to the beneficiary's capacity, tolerance, and treatment objectives. The instructions to the beneficiary or to other members of the health team (e.g., nursing personnel) in carrying out such an individualized treatment plan and infrequent re-evaluations, as may be required, are also covered.

9.35.C. Speech Pathology/Therapy (ST)

The services must be for active, restorative treatment and must be rendered by a speech pathologist certified by, or possessing a "Letter of Equivalency" from, the American Speech and Hearing Association. For speech pathology evaluations, a copy of the speech pathologist's certification or "Letter of Equivalency" must accompany the first prior authorization request for that pathologist.

The following are examples of conditions that may warrant speech pathology services:

- Cerebral vascular accident (CVA) or trauma;
- Neurological disease, such as Parkinsonism or multiple sclerosis;
- Laryngectomy;
- Voice disorders caused by conditions such as nodules, polyps, papilloma, ulcers, cysts, or cord damage (the exact diagnosis must be included in the physician's order); or
- Maxillofacial abnormalities with traumatic or surgical excision of the tongue, lips, or hard or soft palate.

When properly documented, other diagnoses and conditions may be covered if they meet the above requirements and are prior authorized.

Since the purpose of speech pathology services is restorative rather than habilitative, these services are not covered for:

- Speech problems due to symptoms of organic brain syndrome or chronic brain syndrome; or
- Speech problems due to mental retardation.

Medicaid does not cover ST when another public agency (e.g., local or intermediate school district special education program) can assume the responsibility of services for the beneficiary.

9.35.D. Prior Approval for Therapies

The Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization (MSA-115) is used to request prior authorization. The MSA-115 must be reviewed and signed by the attending physician. When making the initial request for therapy, the facility must attach a copy of the initial evaluation and written treatment plan.

Initial prior authorization is valid until the end of the calendar month in which treatment begins. Prior authorization to continue therapy must be obtained for every calendar month thereafter.

The initial evaluation does not require prior authorization and cannot be provided more often than twice in a 12-month period (and at least six months apart).

Exception: Evaluation of oral pharyngeal swallowing cannot be provided more than four times in a 12-month period.

The therapist or speech pathologist must keep appropriate notes that include the date of treatment, the name of the therapist, the type and length of treatment, and the resident's response to treatment. These notes must be maintained in the beneficiary's medical record.

Prior authorization requests for group therapy require documentation that group therapy is in the best interest of the beneficiary's treatment.

9.35.D.1. INITIAL REQUEST

When making the initial request for prior authorization of therapy, the facility must attach a copy of the initial evaluation and the written treatment plan. The initial evaluation and treatment plan must include the following information:

- Statement of the problem (i.e., the specific physical entity and functional incapacity involved or the specific speech and/or language diagnosis based upon results of formal/informal testing);
- Baseline condition at initial evaluation, measured in units appropriate to the problem (for speech pathology, this would include the baseline description of clinical and functional performance in all language modalities);
- Short-term goals appropriate to the beneficiary's diagnosis, level of severity, prognosis, and functional needs;
- Proposed technique for reaching goals, including the planned progression from the baseline condition to the goal; and
- Method by which progress will be measured.

This and any other supplemental documentation must include the beneficiary's name and Medicaid ID Number, the date, and the facility's name and ID Number.

The MSA–115 is used to obtain authorization for therapy prior to the provision of the service.

9.35.D.2. CONTINUED REQUEST

Authorization of the initial service does not guarantee authorization of continued service. The therapist must submit the MSA-115 for continued therapy with documentation of the most recent progress. The progress notes must be concise and refer to the baseline established in the initial evaluation. Progress must be objective and measurable.

9.35.D.3. DISTRIBUTION OF FORM

The prior authorization form is a four-part, snap-out form. The original, first, and second copies of the form must be submitted to the MDCH Prior Authorization Division. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

The facility should retain a copy for its records until the approved or disapproved form is returned by the MDCH. If the facility does not receive a response regarding the original prior authorization form within 15 days of the date of its submission, a new request should be submitted. (The reason a second prior authorization form is being submitted should be included, i.e., no response to the first request.) The facility must not bill until authorization is received and the services are rendered.

9.35.D.4. PROCESS

The MDCH consultant will make a determination and assign a prior authorization number to approved requests. The originals will be returned to the facility. If a portion of the request is denied, Medicaid will only reimburse for the authorized services. The nine-digit Prior Authorization Number must be entered on the claim when billing. The facility must retain a copy of the approved request as part of the beneficiary's medical record.

Approval of the request confirms that a beneficiary is in need of services that can be covered by the Program. It does not verify beneficiary eligibility, level of care, nor guarantee the fee charged. The facility is responsible for verifying the beneficiary's Medicaid eligibility prior to providing the service.

Whenever a beneficiary is admitted to the facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, the name of that facility and the date of discharge from that facility should be included on the prior authorization request. In order to assure continuity of the treatment regimen in such instances, retroactive authorization may be requested if the request is filed within ten days following admission. Retroactive authorization may be granted when the service is rendered within Program guidelines for coverage (e.g., is restorative in nature).

Facilities participating in Medicare are not required to obtain prior authorization for the deductible and/or coinsurance amounts when Medicare approves the services.

9.35.D.5. BILLING

The Invoice Processing System is programmed to match the services authorized with the services billed. Services billed must not exceed the services authorized.

Completion Instructions

The following instructions pertain to the completion of the MSA-115. All prior authorization forms must be typewritten to facilitate processing.

Item 1 - Control Number

The control number is used by MDCH for identification purposes. The facility must **NOT** mark in this item.

Item 2 through Item 4 - Consultant's Use Only

These items are for the MDCH Consultant's use only. These items are not to be completed by the facility.

Item 5 - Prior Authorization Number

If all or part of the service is authorized, a nine-digit Prior Authorization Number will be entered in this item. The facility must enter this number on the claim when billing.

Note: In the event the facility is approved for both an MOU and therapy services, one prior authorization number will be issued for both the MOU and therapy.

If the service is disapproved, no number will be assigned.

Item 6 through Item 8 - Facility Identification Data

The facility's name, provider type code, and seven-digit identification number must be entered as they appear on the Medical Assistance Provider Enrollment Turn-around Form, page 2.

Item 9 - Facility Reference Number

The facility may enter a reference number or the beneficiary's name, not to exceed 10 alpha and/or numeric characters, to comply with its individual filing system.

Item 10 through Item 11 - Facility Identification Data

The facility's mailing address (including an attention line if appropriate) and telephone number (including area code) assists the Consultant in resolving inquiries and returning the prior authorization form to the facility.

Item 12 through Item 15 - Client Identification Data

The beneficiary's name (last, first, and middle initial), sex (M or F), ID Number, and birth date (in the six-digit format: month, day, year) must be entered exactly as they appear on the mihealth card.

Item 16 - Admission Date

This is the date the beneficiary was most recently admitted to the facility.

Item 17 through Item 18 - Diagnosis and Onset Date

The diagnosis for which the beneficiary requires the services and the onset date of the diagnosis indicate the primary reason the beneficiary requires the requested services must be entered.

If the beneficiary has a chronic disease (e.g., arthritis) and recently suffered an exacerbation, the approximate date of such exacerbation must be cited.

Item 19 through Item 21 - Therapist Identification Data

The therapist's/pathologist's name, office telephone number (including area code), **address**, and certificate number identifying the therapist/pathologist must be entered. (Speech pathologists must attach a copy of the Certificate of Clinical Competency or Letter of Equivalency to the first prior authorization involving an individual speech pathologist.)

The therapist/pathologist wishing to add any comments may do so by attaching a separate sheet which must contain the beneficiary's name and identification number, date, and the facility's name and identification number.

Item 22 - Treatment Authorization Request

The Treatment Authorization Request must be checked to indicate whether this is the initial prior authorization request for this beneficiary for this treatment plan, a continuing request for an additional calendar month of service, or a revision of a previously authorized treatment plan.

Item 23 - Service Given By

This indicates who is to provide the service: therapist/ pathologist, assistant, or aide (this does not refer to a nurse's aide).

Item 24 - Treatment Month

The calendar month(s) in which treatment is to be rendered must be shown in a two-digit format (e.g., April should be shown as 04).

Item 25 - Date Started

The date treatment was started for the given diagnosis must be entered.

Item 26 - Last Authorized

The date the MDCH Consultant signed the last approved prior authorization request for the given diagnosis must be entered.

Item 27 - Number Sessions

This is the number of sessions rendered up to the date the form was completed for the given diagnosis. The facility must not indicate the number of sessions previously authorized for a different diagnosis.

Item 28 - Rehabilitation Potential

This is a brief assessment of the beneficiary's rehabilitative potential and factors that contribute to this determination (e.g., "good potential, patient's attitude is positive and persistent, progress depends upon the reduction of pain").

Item 29 - Line Number

The line number is to be used as a reference.

Note: A separate Line Number must be used for each different CPT/HCPCS Code that is used.

Item 30 - Number per Month

This is the number of times the service is to be provided. Services may be prior authorized on a weekly basis.

Item 31 - Procedure Code

This is the CPT/HCPCS code(s) as listed in the Medicaid Provider Manual, Billing & Reimbursement for Institutional Providers Chapter, Nursing Facility Section which describes the service(s).

Note: For each different CPT/HCPCS code, a separate Line Number must be used.

Item 32 - Consultant Use Only

The facility is not to complete this item. The MDCH Consultant will use this area to indicate any amendments on approved services. The facility should always review this area to see if any changes are necessary for delivery of services and/or accurate billing.

Item 33 - Goals

The **expectations** for the beneficiary's ultimate achievement and the length of time it will take must be stated (e.g., ambulation unassisted for 20 feet, able to dress self within 15 minutes, oral expression using 4-5 word phrases to express daily need).

Item 34 - Progress Note/Discharge Plan

This is the documentation of the beneficiary's progress from the prior month to the current time in reference to the measurable and functional goals stated in the treatment plan. Documentation of beneficiary nursing and family education may be included. The final month of anticipated treatment should include the discharge plan for the carry-over of achieved goals to supportive personnel.

Item 35 - Complications Causing Extension of Treatment

Any condition or complication that might require an extension of service**s** (e.g., decubiti, urological complications, or fractures) should be fully described.

Item 36 - Physician Certification

The attending physician must indicate if this is an initial certification or a recertification and sign and date the prior authorization form. The attending physician's signature is required each time a request is made.

Item 37 - Provider Certification

The facility's certification is required to validate the form. This is accomplished by the facility's authorized representative's signature on the form and the form must be dated. All unsigned requests will be returned to the facility for signature.

Item 38 through Item 43 - Consultant Use Only

These items will be completed by the consultant. The consultant will indicate that the service is approved as presented, approved as amended, or disapproved. If all or part of the plan is authorized, the consultant will assign a nine-digit Prior Authorization Number in Item 5.

The therapist/speech pathologist must keep progress notes. Such notes include the:

- date of treatment,
- name of the individual who rendered treatment,
- type and length of treatment, and
- beneficiary's response to the treatment.

The progress notes must be included in the beneficiary's medical record.

The cost of supplies and equipment (e.g., plate guards) used as part of the therapy/speech pathology program is included in the reimbursement for the therapy/speech pathology.

The following illustrates an MSA-115 as it might be completed in a usual situation.

OCCUPATIONAL/PHYSICAL THERAPY - SPEECH PATHOLOGY
PRIOR APPROVAL - REQUEST/AUTHORIZATION
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

NOTE: FOR INITIAL AND REVISED REPORTS ONLY, YOU **MUST** ATTACH A COPY OF THE INITIAL EVALUATION AND TREATMENT PLAN.

1. CONTROL NUMBER

CONSULTANT USE ONLY 2. 3. 4.

5. Prior Authorization Number

6. TREATMENT SITE	7. TYPE	8. I.D. NUMBER	9. PROVIDER'S USE ONLY	
Hills Nursing Home	60	6143500	Good	
10. ADDRESS (NUMBER, STREET, CITY STATE, ZIP)			11. PHONE NUMBER	
5 Main Street, Ada, Michigan 49441			(616) 243-9170	
12. RECIPIENT NAME (LAST, FIRST, MIDDLE INITIAL)	13. SEX	14. I.D. NUMBER	15. BIRTHDATE	16. ADM. DATE
Good, Sam	M	11000047	04/01/37	02/01/02
17. DIAGNOSIS TO BE TREATED/EVALUATED				18. ONSET DATE
CVA with resultant left hemiparesis				
19. THERAPIST/PATHOLOGIST NAME (LAST, FIRST, MIDDLE INITIAL)		20. OFFICE PHONE NUMBER	21. LICENSE/CERTIFICATION NUMBER	
O'Malley, Sue R.		(616) 432-7620	843714	

22. TREATMENT AUTHORIZATION REQUEST	23. SERVICE GIVEN BY	24. TREATMENT MO.	25. DATE STARTED	26. LAST AUTH.	27. NO. SESSIONS
☐INITIAL ☐CONTINUING ☒ REVISED	THERAPIST/ ☒ PATHOLOGIST ☐ ASST ☐ AIDE	08	12/01/02	11/24/02	1

28. REHABILITATION POTENTIAL

33. GOALS
Gait Training

ESTIMATED TIME

34. PROGRESS NOTE/DISCHARGE PLAN

Patient is exhibiting some hesitation in moving outside the Parallel bars. Does two lengths with stand-by assistance before rest. Trying to get outside of bars within next week.

29. LINE NO.	30. NUMBER PER MONTH	31. PROCEDURE CODE	32. CONSULTANT USE ONLY
01	20	97116	
02			
03			
04			
05			
06			

35. COMPLICATIONS CAUSING EXTENSION OF TREATMENT

36. PHYSICIAN CERTIFICATION
I certify ☐, re-certify ☒ that I have examined the patient and determined that therapy is necessary; that service will be furnished on an in/out-patient basis while the patient is under my care; that I approve the above treatment plan or evaluation and will review it every 30 days or more often if the patient's condition requires.

James P. Pike, M.D. (PHYSICIAN NAME (TYPE OR PRINT)) — James P. Pike M.D. (PHYSICIAN SIGNATURE) — 01/03/02 (DATE)

37. PROVIDER CERTIFICATION
The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and if approved, and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

Pete Reese (PROVIDER SIGNATURE) — 08/03/02 (DATE)

CONSULTANT USE ONLY

38. CONSULTANT REMARKS

39. APPROVED AS	40. DISAPPROVED	41. CONSULTANT SIGNATURE	42. DATE	43. MONTH
PRESENTED ☐ AMENDED ☐	☐			

9.36 TRANSPORTATION

9.36.A. Non-emergency Transportation

The nursing facility is responsible for all non-emergency transportation for all Medicaid beneficiaries, including Medicare/Medicaid beneficiaries when Medicare is covering the cost of the care. Non-emergency transportation includes transport to medical appointments/treatment not available in the facility (i.e., dialysis treatment). The facility must either arrange or provide transportation. Reimbursement for non-emergency transportation is included in the facility per diem rate. The per diem rate also includes transportation for newly-admitted beneficiaries from a hospital or another residence.

Travel to out-of-state medical providers (other than Michigan Medicaid-enrolled "borderland" providers as defined in the General Information for Providers chapter of this manual) is not the responsibility of the facility and must be prior authorized by MDCH.

The facility must select the most appropriate, cost-effective mode of transportation. Whenever possible, a facility-owned vehicle should be used. This vehicle must comply with the Americans with Disabilities Act (ADA).

In rare situations, the condition of a beneficiary needing non-emergency transport requires an attendant in addition to the driver. In such cases, it is appropriate for a nurse aide to accompany the beneficiary and this cost should be reflected in the annual cost report as "staffing costs associated with providing needed medical care." Sending a nurse aide or other staff member with the beneficiary being transported must not negatively impact the care of residents remaining in the facility.

The need for a nurse aide to accompany a beneficiary must not be confused with the responsibility of the family or legal guardian "to attend the beneficiary if escort is needed to sign consent forms, decide treatment options, sign insurance forms, provide histories, etc." A nurse aide is not to be responsible for these legal and medical decisions and knowledge.

9.36.B. Emergency Ambulance

Nursing facilities must have contractual arrangements for ambulance services for emergencies. When there is an emergency, an ambulance provider renders the service and bills Medicaid.

9.36.C. Non-emergency Ambulance

When a physician issues a written order for non-emergency ambulance transportation, usually due to the need for a stretcher or other emergency equipment, the ambulance provider may bill Medicaid directly and must maintain the physician's order as documentation of medical necessity. If non-emergency ambulance transport is not ordered by the beneficiary's physician, arrangements for payment must be between the facility and the ambulance provider, and cannot be charged to the beneficiary, beneficiary's family or used to offset the patient-pay amount.

9.37 Vaccines

Reimbursement for any vaccination ordered by the attending physician and administered in the nursing facility is included in the per diem rate. The invoiced purchase cost of the vaccine should be included as an allowable medical supply expense on the facility's cost report.

9.38 Vision

Vision services (examinations and glasses) are ancillary services and are not included in the facility's per diem.

A Medicaid copayment is not required for nursing facility beneficiaries.

SECTION 10 – SPECIAL PLACEMENTS AND AGREEMENTS

10.1 DEMENTIA UNITS

A nursing facility may elect to designate beds or units to address the special needs of beneficiaries with Alzheimer's disease or other dementing illnesses. Care for Medicaid beneficiaries in dementia specialty beds is reimbursed as defined for any other nursing facility bed.

10.2 HOLDING A BED (HOSPITAL LEAVE AND THERAPEUTIC LEAVE)

Medicaid reimburses the nursing facility for holding a bed while the beneficiary is admitted to a hospital for emergency medical treatment (hospital leave) or takes a therapeutic leave from the facility for non-medical reasons.

Prior to therapeutic leave or transfer to a hospital, providers must give written notice of the facility's bed hold and readmission policy to the beneficiary and a family member or legal representative. This must include information about Medicaid coverage for therapeutic and hospital leave. In an emergency, notice must be given to the resident and family or legal representative within 24 hours. If the beneficiary refuses to have a family member notified, this must be documented in the beneficiary's record.

The written notice must specify:

- The Medicaid bed hold policy under which the beneficiary is permitted to return and resume residence in the facility; and
- The facility's written policy under which a beneficiary is readmitted to the facility when their absence is in excess of the Medicaid-reimbursed leave days.

The beneficiary must be readmitted immediately to the first available bed (if the beneficiary still requires nursing facility services and is still Medicaid eligible.

10.2.A. Hospital Leave Days

Medicaid reimburses a nursing facility to hold a bed for up to ten days during a beneficiary's temporary absence from the facility due to admission to the hospital for emergency medical treatment only when the facility's total available bed occupancy is at 98 percent or more on the day the beneficiary leaves the facility. "On the day" is defined as the facility's census at midnight on the day that the beneficiary leaves. Note that calculation of available bed occupancy for purposes of Medicaid reimbursement for hospital leave days is different than calculation of occupancy for cost reporting purposes.

Facilities at 97.5 percent occupancy or more may roundup to 98 percent.

Occupancy includes all licensed beds (e.g., Medicaid-certified, dual Medicare/Medicaid certified, licensed only). The 98 percent or more occupany does not include beds held open for hospital or therapeutic leave day(s).

In cases where a facility's available bed occupany is below 98 percent on the day the beneficiary leaves for an emergency admission to the hospital, but rises to 98 percent or more during his hospital stay, no hospital leave days can be billed for the beneficiary. Hospital leave days are only billable for a beneficiary if the occupancy rate is 98 percent or more on the day the beneficiary leaves the hospital.

In cases where the available bed occupancy is at 98 percent on the day the beneficiary leaves and drops below 98 percent during his hospital stay, the facility may bill up to 10 hospital leave days.

In instances where a facility is enrolled with Medicaid and has more than one Provider ID number, the available bed occupancy must be calculated separately for each Provider ID number.

Examples of Worksheet for Determining % of Occupancy

	Example 1	Example 2
Total Licensed Beds (exclusing beds in an approved non-available bed plan)	179	140
Number of Total Licensed Beds Not Occupied	2	7
Beds for Residents on Hospital Leave (Medicaid or private pay is paying to hold the bed)	6	8
Beds for Residents on Overnight Therapeutic Leave	0	10
Total Residents on Leave	6	18
Adjusted Licensed Beds	173	122
Number of Residents Physically in Facility (total occupancy minus total residents on leave)	177 – 6 = 171	133 – 18 = 115
Occupancy (number of residents physically in facility divided by adjusted bed capacity)	177 / 173 = 99%	115 / 122 = 94%

Facilities billing for Hospital Leave Days, must document in the beneficiary's medical (clinical) record what the facility's census was at the time the beneficiary left the facility for a hospital leave.

The facility must hold the bed and may bill Medicaid if there is reasonable expectation by the attending physician at the point of admission to the hospital that the beneficiary will

return to the nursing facility by the end of the tenth day. The hospital admission must be for emergency medical treatment, as documented by the attending physician in the beneficiary's medical record.

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the beneficiary (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The beneficiary must return to the nursing facility in ten or fewer days in order for the nursing facility to bill Medicaid for hospital leave days.

If the beneficiary is in the hospital for more than ten days, the nursing facility is released from its obligation to hold the bed and cannot bill Medicaid for **any** hospital leave days. The resident may be charged to hold the bed for those days if they agree in advance. (See Medicaid Non-Covered Leave Days sub-section.) The facility is encouraged to monitor the resident during the hospital stay to determine the likely length of hospitalization.

If the resident is expected to be in the hospital for ten days or fewer and dies while in the hospital, the nursing facility may bill Medicaid for the hospital leave days up to the day before the resident died.

If the resident returns to the nursing facility under Medicare coverage, and was Medicaid eligible prior to the emergency admission, the facility may bill Medicaid for the hospital leave days if the emergency hospitalization was for ten days or fewer.

A resident is counted in the facility census if they are in the facility at midnight. If the resident is out of the facility on hospital leave at midnight, that day must be counted as a hospital leave day. If the resident returns to the nursing facility from the hospital, then is re-admitted to the hospital for the same condition that they were hospitalized for previously, the 10-day period of Medicaid reimbursed hospital leave days continues if the resident was not counted in the facility census for that day. If, given the circumstances above, the resident was counted in the facility census, a new 10-day period of Medicaid reimbursed hospital leave days may begin.

The resident need not be shown on the Medicaid claim as discharged from the nursing facility unless the hospital admission was a planned admission (not an emergency) or was longer than 10 days.

Patient-pay amounts and billing methods are not affected by this hospital leave day policy. The nursing facility should continue to collect any patient-pay amount, typically on the first day of the month, and indicate the amount collected on the Medicaid claim. The Medicaid Claims Processing System automatically deducts the patient-pay amount and reimburses the provider for the balance. If the facility bills Medicaid for hospital leave days that occur at the beginning of the month, then the nursing home should collect the patient-pay amounts as usual. The facility should charge the amount against the patient-pay that Medicaid will pay for that day. For example, if a resident has a

patient-pay of $200 and is in the hospital for an emergency condition for the first 5 days of the month (the stay is 10 days or fewer), the nursing facility should collect the patient-pay amount from the resident, then submit a Medicaid claim. Medicaid would reimburse the facility the hospital leave day per diem rate, minus the patient-pay amount. Using 2002 figures, the facility reimbursement would be $150.30 [($70.06 x 5)-$200].

There is no limit to the number of hospital leave days per resident that may be billed to Medicaid annually as long as there are no more than 10 consecutive leave days per hospital stay.

Hospital leave days are not included in the Medicaid census statistics.

10.2.B. Therapeutic Leave Days

If the beneficiary has a temporary absence from the nursing facility for therapeutic reasons as approved by a physician, Medicaid reimburses the facility to hold the bed open for up to a total of 18 days during a 365-day period. Therapeutic leave is for non-medical reasons, such as overnight stays with friends or relatives. A resident is counted in the facility census if they are in the facility at midnight. If the beneficiary is out of the facility on therapeutic leave at midnight, that day must be counted as a therapeutic leave day.

The Medicaid Program covers up to 18 therapeutic leave days in a 365-day period for each beneficiary if:

- The facility reserves the bed for the beneficiary during his absence; and
- The beneficiary's written plan of care provides for out-of-facility visits; and
- The beneficiary returns to the facility.

There is no limit to the number of therapeutic leave days that may be reimbursed at one time as long as the total does not exceed 18 days in a 365-day period (not the calendar year). For example, if a resident goes on a 5-day family vacation beginning April 10, 2003, that resident has 13 therapeutic leave days remaining until April 9, 2004.

If a beneficiary does not return from a therapeutic leave, the beneficiary must be discharged on the date he left the facility. The date of admission and the date of discharge may not be billed as therapeutic leave days.

Therapeutic leave days must be included in the Medicaid census statistics if the therapeutic leave day is being paid by the beneficiary or Medicaid.

10.2.C. Medicaid Non-Covered Leave Days

Medicaid does not reimburse providers to hold a bed for reasons other than emergency transfer to a hospital (10-day maximum per hospital admission), or therapeutic leave (18-day maximum per 365-day period). However, the facility may hold the beneficiary's bed for other reasons and for leave days not covered by Medicaid, and bill the beneficiary if the beneficiary:

- Has prior knowledge that the service is not a Medicaid benefit; and
- Desires to have the bed reserved; and
- Agrees, in writing, to pay the facility to hold the bed at a specified rate. (The beneficiary's patient-pay amount may not be used for this purpose.)

If the beneficiary elects to not pay privately, the beneficiary has the option to return to the next available, equivalent bed. A beneficiary cannot be involuntarily transferred/discharged after a temporary absence, including discharge to obtain acute care in an inpatient hospital, unless the appropriate criteria are met and the appropriate regulations, policies, and procedures are followed.

Except for Medicaid-covered leave days and when beneficiaries have paid to hold a bed, the beneficiary must be discharged from the facility, then readmitted upon return to the first available bed.

10.3 Involuntary Transfer or Discharge

10.3.A. Conditions

A nursing facility must not involuntarily transfer or discharge a beneficiary unless:

- It is necessary for the welfare of the beneficiary, and the beneficiary's needs cannot be met in the facility; *
- The beneficiary's health has improved sufficiently so the beneficiary no longer needs the services provided by the facility; *
- It is necessary to protect the safety of individuals in the facility;
- It is necessary to protect the health of individuals in the facility; *
- The beneficiary has failed, after reasonable and appropriate notice, to pay (or to initiate payment under Medicaid) for a stay at the facility; or
- The facility ceases to operate.

The facility must include documentation in the beneficiary's clinical record for any of the above circumstances.

* *Items require documentation of medical necessity by the attending physician.*

10.3.B. Transfer Trauma

For certain residents (defined below), transfer trauma must be considered when that resident may be moved due to a change in the level of nursing need.

Transfer trauma is defined as "any adverse psychological and/or physical effects occasioned by the transfer of a nursing home patient that would be materially detrimental to the physical or mental health of the patient."

Residents for whom transfer trauma must be considered include all those who have resided in the current nursing facility for at least one year, or who have been involuntarily transferred within the previous year. (A discharge to obtain acute care in an inpatient hospital, followed by an immediate readmission within three weeks to the same nursing facility, does not interrupt the continuity of a resident's stay).

The State Survey Agency evaluates transfer trauma. This evaluation considers the social, mental and emotional adjustment of the resident, including the length of time that the resident has been in the nursing facility and the relationships that the resident has formed in the facility. This evaluation may also consider the resident's age, history and success of previous placements, and history of adapting to change. Consideration must also be given to the opinion of the attending physician regarding the resident's social and emotional adjustment and the physical effects of the proposed transfer.

Transfer trauma must be considered before the resident is notified of a nursing level of care change. When Medicaid is the payer source, Medicaid payment at the current level continues while transfer trauma is being considered.

If Medicaid was not the payer source immediately prior to the transfer trauma issue being raised, then Medicaid payment is not made until a decision is reached.

If the transfer trauma decision upholds the beneficiary' s medical need to remain in a bed not certified for his present level of care, then the beneficiary's prior level of care will be retained to provide for continued Medicaid coverage.

If it is determined that there is no issue of transfer trauma, the beneficiary must be transferred to a bed or setting appropriate for the new level of care. MDCH will change the level of care code. The beneficiary or representative can appeal the level of care decision.

Concerns about involuntary transfer and/or transfer trauma should be reported to the Health Facility Complaint Line. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

10.3.C. Beneficiary Notification

Nursing facilities must give beneficiaries a 30-day written notice regarding transfer unless:

- The transfer or discharge is a health care emergency;

- The safety or health of beneficiaries or staff is endangered;
- The beneficiary agrees to the transfer/discharge.
- The beneficiary's health has improved sufficiently so the beneficiary no longer needs the services provided by the facility; or
- The facility ceases to operate.

The notice must include:

- The reason for the transfer or discharge;
- The effective date of the transfer or discharge;
- The location to which the beneficiary will be transferred or discharged;
- The name, address, and (toll-free) telephone number of the State Long Term Care Ombudsman;
- For beneficiaries with developmental disabilities (DD), the mailing address and telephone number of the agency responsible for the protection and advocacy of DD individuals, established under the Developmental Disabilities Assistance and Bill of Rights Act;
- For nursing facility beneficiaries with mental illness (MI), the mailing address and telephone number of the agency responsible for the protection and advocacy of MI individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act; and
- Appeal rights.

The facility must also provide:

- Sufficient preparation and orientation to beneficiaries to ensure safe and orderly transfer or discharge from the facility, as required by state and federal regulations; and
- Notice of the facility's bed-hold and re-admission policy, including the Medicaid bed-hold policy.

If a nursing facility elects to discontinue operations (voluntary closure) or withdraw from the Medicaid program, the facility must provide notice to the beneficiary as outlined above not less than 30 days before the closure or withdrawal. The notice must be sufficient to allow for suitable relocation arrangements.

10.4 Married Couples

When married beneficiaries or blood relatives live in the same Medicaid nursing facility, they may share a room if both spouses or their relatives consent. (This policy applies only to beneficiaries who both require nursing facility services. It does not apply when one beneficiary does not require nursing facility services. For example, if a husband and wife wish to share a room in a nursing facility, in order for Medicaid to cover both of them in the facility, they must both require nursing facility services. If only one of them requires nursing facility services, Medicaid only covers services for that person.)

10.5 Memorandums of Understanding (MOU) - Special Agreements for Complex Care

The Request for Prior Authorization for a Complex Care Memorandum of Understanding form (MSA-1576) is used to request prior approval (PA) for the placement of a Medicaid beneficiary for whom placement from a hospital has been, or could be, hindered due to the cost and/or complexity of nursing care or special needs. The PA covers an individually negotiated reimbursement rate for the placement. Special individualized placement requests and payment arrangements are based on medical necessity and/or service/supply needs exceeding those covered by Medicaid reimbursement for routine nursing facility care.

Examples include, but are not limited to:

- Ventilator dependent care (for nursing facilities not contracted with MDCH to provide ventilator dependent care)
- Multiple skin decubiti utilizing several treatment modalities
- Tracheostomy with frequent suctioning needs
- Beneficiaries who require intensive nursing care or treatment.

Program requirements:

- Referrals may come from either the acute care hospital or the nursing facility.
- Hospitals must document that at least ten (10) Medicaid certified nursing facilities within a 50 mile radius of the hospital refused to admit the beneficiary due to the complexity of the patient's care needs.
- Nursing facilities may request a MOU after admitting a beneficiary if the hospital failed to accurately document the beneficiary's condition and needs prior to transfer to the nursing facility. The nursing facility must request the MOU within 30 days from the date of admission to the nursing facility.

The following information must be submitted:

- A completed MSA-1576, including any requests for additional nursing, CENA, supplies or equipment. An electronic copy of the form is available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.) The Michigan Medicaid Nursing Facility Manual contains information regarding what services are to be provided by the NF as part of the daily per diem reimbursement.
- The beneficiary's medical background, including current medical status, treatment/nursing care plan, and justification for any additional nursing hours and/or special equipment requested. (This information should be included on the MSA-1576).
- Recent (within the past 30 days) lab, x-ray, and diagnostic/therapeutic test results and/or reports.
- A list of nursing facilities within a fifty (50) mile radius that have denied admission due to the complexity of care the beneficiary required, including:
  - Name and address of the nursing facility
  - Contact person's name and title

- Date of contact
- Reason for denial

- Documentation of the financial resources available to the beneficiary, including:
  - Medicaid coverage
  - Medicare Parts A and B
  - Other commercial insurance coverage.
  - Name and telephone number of a contact person at the nursing facility requesting the MOU.

It may take up to three weeks for the MOU to be processed. If it appears that a beneficiary, upon discharge, will require intensive nursing care, the hospital's discharge planning coordinator should initiate the prior authorization process for the MOU as early in the beneficiary's hospital stay as possible to ensure a smooth transition to the nursing facility. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

The hospital or nursing facility will be contacted by telephone regarding Medicaid's ability to assist with the beneficiary's placement. If approved, the NF will receive a prior authorization number to be used when billing. The Directory Appendix of the Medicaid Provider Manual contains contact information.

10.6 One-Day Stay

A nursing facility is reimbursed for a one-day stay if a Medicaid beneficiary is admitted to the facility and, the same day, is discharged from the facility due to death, return home, or transfer to another institution that is not a Medicaid-enrolled provider. The one-day stay does not apply to a beneficiary admitted to a nursing facility if, later that day, the beneficiary is discharged and transferred to another nursing facility or an inpatient hospital and, at midnight, the second facility or hospital claims the beneficiary in its daily census.

A one-day stay must be included in the Medicaid census statistics.

10.7 Religious Non-medical Health Care Center

Religious Non-medical Health Care Centers may be licensed as nursing facilities and certified for Medicaid. Beneficiaries in Medicaid-certified facilities, under the care of a practitioner, may be determined to be in need of nursing care and, therefore, covered by Medicaid.

SECTION 11 – SPECIAL PROVIDER TYPE COVERAGES AND LIMITATIONS

11.1 HOSPITAL SWING BEDS (PROVIDER TYPE 63)

In order to address the shortage of rural nursing facility beds, federal requirements allow rural hospitals to provide post-hospital extended care services. Such a hospital, known as a swing bed hospital, can "swing" beds between hospital and nursing facility levels of care on an as-needed basis. In order to receive Medicaid reimbursement, hospital swing beds must meet all applicable state and federal requirements and provide all required services.

Providers of hospital swing bed services may bill Medicaid for hospital swing bed days only when the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid inpatient diagnosis related group (DRG) of the admission. Hospitals that are exempt from the DRG reimbursement system may bill for Medicaid-covered swing bed days beginning the day of admission to the swing bed.

The total number of Medicaid-reimbursed hospital swing bed days is limited to 100 days per beneficiary per calendar year.

Providers of swing bed hospital services must transfer a beneficiary to a nursing facility, located within a 50-mile radius of the beneficiary's residence, within five business days after the hospital has been notified, either orally or in writing, that a bed has become available.

Medicaid does not require the MDS for clinical assessment purposes or reimbursement for beneficiaries in hospital swing beds. The PASARR process must be completed, as outlined earlier in this chapter, prior to placement in a nursing facility.

(Refer to the Billing & Reimbursement Chapter of this manual for additional swing bed billing instructions.)

11.2 NURSING FACILITIES FOR MENTAL ILLNESS (NF/MI) (PROVIDER TYPE 72)

Medicaid reimburses NF/MI for services provided to qualified beneficiaries age 65 and older.

In order to be admitted to a NF/MI, a beneficiary must require specialized nursing care, in addition to having a psychiatric diagnosis requiring care.

In order to receive Medicaid reimbursement, NF/MI providers must meet all applicable state and federal requirements and provide all defined services.

Medicaid reimburses NF/MI providers at a per diem rate, which includes all of the usual covered nursing facility services as outlined in this chapter. In addition, ancillary services are also included in the per diem rate for NF/MI providers, e.g., laboratory, x-rays, medical surgical supplies (including incontinent supplies), hospital emergency room, clinics, optometrists, dentists, physicians, pharmacy. Therapy/speech pathology provided to these beneficiaries is included in the facility's per diem rate.

11.3 VENTILATOR-DEPENDENT CARE UNITS

There may be occasions when a beneficiary no longer requires acute hospital care but requires specialized care in a Ventilator Dependent Care Unit (VDCU). Medicaid authorizes admission of ventilator dependent Medicaid beneficiaries to hospital and nursing facility ventilator units with which it has agreements to provide VDCU services.

11.3.A. Placement Criteria

A request for placement must show that the:

- Beneficiary is dependent on life-supporting mechanical ventilating equipment for at least six hours per day
- Beneficiary stay **normally** meets or exceeds the hospital high-day outlier threshold for DRG 475

Approval for admission to a VDCU will **not** be given for a beneficiary who is only on CPAP or BiPAP. If a beneficiary has weaning potential or requires other rehabilitative services (in addition to the respiratory care) and is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for the first 45 days reimbursement in the post acute setting. If there is no weaning potential and the beneficiary requires only custodial care, disenrollment from the MHP may occur at the time the beneficiary is discharged from the hospital.

In situations where a beneficiary cannot immediately be placed in a nursing facility or hospital VDCU, Medicaid will cover nursing days in the inpatient hospital. When the beneficiary is in a hospital setting because a nursing facility placement is not available, Medicaid will cover the ancillary services provided by the hospital.

The hospital cannot charge a beneficiary the difference between the hospital's charge and MDCH's payment for nursing days.

If a beneficiary refuses an appropriate placement to a VDCU, the beneficiary is responsible for all hospital charges incurred after the date of referral.

11.3.B. Authorization for VDCU Placement

To begin the prior authorization process, the hospital discharge planner, case manager, or social worker must complete and submit a MSA-1634 (Medicaid Ventilator Dependent Care Assessment) form and a MSA-1635 (Medicaid Ventilator Dependent Care Authorization) form. The forms are available on the MDCH website.

The beneficiary's physician must sign the MSA-1635 and, by doing so, attests to the medical necessity of the patient transfer from an acute care setting to a nursing facility setting. Physician assistant, medical assistant, or nurse practitioner signatures may not be substituted for the physician's signature.

MSA-1634 and MSA-1635 forms must only be submitted when the resident has exhausted other resources of reimbursement.

The Directory Appendix of the Medicaid Provider Manual contains contact information.

NURSING FACILITY
COST REPORTING AND REIMBURSEMENT

TABLE OF CONTENTS

SECTION 1 - INTRODUCTION

This chapter outlines Medicaid policy pertaining to nursing facility ownership, nursing facility reimbursement, nursing facility costs, and nursing facility financial reporting. Cost reporting, rate determination, financial settlement, audit, and appeal processes are addressed in this chapter. Costs classifications, such as plant, variable, allowable and non-allowable, add-ons, used to determine nursing facility reimbursement are defined.

Throughout the chapter references will be made to the State Medicaid Agency (SMA) and the State Survey Agency (SSA). The Michigan Department of Community Health (MDCH), Medical Services Administration, is the designated SMA, and is responsible for administration of the Medicaid program. The MDCH Bureau of Health Systems is the designated SSA.

1.1 REIMBURSEMENT RATE METHODOLOGY – GENERAL

The Medicaid nursing facility reimbursement rate is prospectively determined based on the nursing facility's historical or acquisition costs, which are subject to limitations put forth in policy. Participating Medicaid providers' nursing facility resident days and cost information are reported to the SMA on an annual cost report submitted by the nursing facility. The nursing facility industry aggregate cost data is used to analyze and determine facility class reimbursement limits and related cost levels necessary for calculating nursing facility per diem rates and other analysis. The facility's routine nursing care per diem rate includes plant and variable cost based on the facility's audited allowable costs, measured against class wide rate limitations. Additional reimbursement for specific services outside of the routine nursing care per diem rate are also analyzed and determined from the facility's annual cost report and included in the Medicaid annual reimbursement settlement.

The intent of the Medicaid nursing facility reimbursement system is to:

- Assure high quality services at reasonable costs.
- Encourage the efficient use of nursing care resources.
- Provide reimbursement for allowable costs incurred by prudent, cost-conscious facility managers.
- Provide a review and appeal mechanism to assure that nursing facility providers receive fair and equitable treatment.

Reductions may be implemented to the variable cost portion of the NF rate due to Executive Order, legislative mandate, or cost savings initiatives. Notice of a reduction, or continuation of a reduction, will be issued via a policy bulletin. A record of recent NF variable rate reductions will be maintained on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

1.2 MEDICARE PRINCIPLES OF REIMBURSEMENT

Unless stated otherwise in this chapter, Medicaid reimbursement rates are determined for nursing facilities in accordance with the federal Principles of Reimbursement established for the Medicare Program. Nursing facility providers are expected to comply with applicable provisions in these Principles, with policies published by the SMA, and with all relevant federal and state statutes, rules and regulations.

When reviewing the Principles of Reimbursement, any references to "intermediary" should be interpreted as referring to the SMA.

Medicare Principles of Reimbursement appear in the Code of Federal Regulations (CFR), at Title 42, Part 413, and in manuals published by the federal Centers for Medicare and Medicaid Services (CMS). The Provider Reimbursement Manual, also referred to as PRM-15 and Pub. 15, may be obtained from CMS electronically or by contacting CMS as indicated below:

- Download a copy from the CMS web site at http://cms.hhs.gov/manuals/cmstoc.asp; or
- Order a paper copy by contacting the Centers for Medicare and Medicaid Services at:
  - 7500 Security Boulevard, Baltimore, Maryland 21244; or
  - 1-800-MEDICARE (1-800-633-4227).

SECTION 2 - OWNERSHIP CHANGES AND MEDICAID TERMINATION

2.1 PREREQUISITE

When an ownership change is anticipated, the Certificate of Need (CON) requirement must be satisfied before Medicaid enrollment can occur. The Department of Community Health, Bureau of Health Systems office, administers the CON Program. Contact information and subject matters pertaining to the CON may be found on-line at www.michigan.gov/mdch, click on Health Systems & Licensing, Bureau of Health Systems, Certificate of Need.

2.2 OWNERSHIP CHANGES

When an ownership change is anticipated, the proposed Seller(s) and the proposed Purchaser(s) must provide written notice to both the State Medicaid Agency (SMA) and the State Survey Agency (SSA) at least 90 calendar days prior to the anticipated ownership change. The written notice to the SMA must be sent to the MDCH LTC Reimbursement and Rate Setting Section (RARSS) and to the Provider Enrollment Unit. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) The written notice to the SSA must be sent to the nursing facility's licensing officer. Failure to provide written notice to either agency could result in payment and settlement delays.

Prior to the ownership change date, the new ownership must complete a New Provider Information Packet to provide RARSS with the necessary information for the rate setting and reimbursement process. Failure to provide this information prior to or immediately upon completion of the purchase will delay the rate setting and reimbursement processing for the new ownership. For New Facility/Owner Requirements, refer to the Cost Reporting Section.

Depending on the circumstances of the change in ownership, the new owner may be required to complete a new Medical Assistance Provider Enrollment and Trading Partner Agreement, and obtain a new provider number. The new owner must not use the prior owner's Medicaid provider number for reporting and billing Medicaid services. Failure of the new ownership to secure a new provider number for billing, subjects the new owner to financial responsibility for the prior owner's claim liability. Refer to the Provider Enrollment Section, General Information for Providers Chapter of the Medicaid Provider Manual for provider agreement requirements.

The Seller(s) and the Purchaser(s) will be notified by RARSS and advised of any requirements related to cost reporting and rate setting, including final settlement for the former owner. For information regarding reimbursement settlement, refer to the Cost Report Reimbursement Settlement Section of this chapter.

2.3 NURSING FACILITY SALE BETWEEN FAMILY MEMBERS

The sale of a family owned nursing facility between family members is allowable and recognized as a transfer of ownership and a recognized sale transaction for Medicaid reimbursement within allowable cost and reimbursement limits if **all** of the following requirements are met. However, if it subsequently determined control is not relinquished, by the prior entity or interested parties, asset values will revert back to the values prior to the recognized sale and any additional reimbursement paid will be recovered.

- A purchase contract or agreement must be present. The transaction must terminate the seller's interest in the business. The seller must not have any recourse or ownership protection to retain

or have a security interest in obtaining future ownership of that nursing facility in the event of the termination of the new ownership (purchaser) at a later date.

- Borrowing or financing for the sale transaction must be between the purchaser and a non–related third party (i.e., a financial institution). Financial loans from the family-related seller individual or entity to the family-related purchaser are not allowable for reimbursement. The finance instrument must not be a land contract from the seller.
- Total dollar amount of allowable borrowings cannot exceed the purchase price (allowable asset value). The Capital Asset Value (CAV) limit applicable to the nursing facility immediately prior to the sale, appropriately adjusted for nursing facility asset items that are excluded from the sale transaction, is the maximum reimbursable borrowing balance applicable to the asset transaction.
- The nursing facility property appraisal must be obtained. The facility appraisal value must support the purchase price negotiated between the sales parties. Refer to the Appraisal Guidelines Section of this chapter for additional information.
- The new ownership operation must be a different legal entity, in which the family-related seller is not an officer or board member exercising control over the new operation. The nursing facility entity may remain as an ongoing business entity in a situation where the real estate sale does not involve the licensed nursing facility operator. This occurs where a related party lease exists between the nursing facility entity prior to the real estate transaction, and the real estate transaction of the leased nursing facility is between the family-related parties. The requirement that the family-related lessor/seller cannot exercise active interest or control in the management of the nursing facility after the sale must be met.

The following will be applied to a change in ownership as a result of a sale between family members:

- The allowable asset value to the purchaser is limited to the allowable historical capital asset cost of the seller party (or nursing facility entity owned by the family member) minus the dollar amount of depreciation expense allowed and reimbursed under the Medicaid Program. There is no increase in nursing facility asset values. MDCH considers Medicaid reimbursement to the nursing facility for depreciation expense was zero dollars during the time period that the seller provider was reimbursed by Medicaid for plant cost based upon capital asset value tenure reimbursement rate.
- The tenure factor for the nursing facility following the sale will revert to zero due to the capital asset transaction affecting a plant cost increase.
- The Medicaid program plant cost reimbursement limitations of the Deficit Reduction Act (DEFRA) of 1984 will not apply to the transaction as a result of the purchase limitation to the historical asset cost base of the seller.
- The seller may be subject to depreciation recapture dependent on the sale price of the assets and the depreciation reimbursement made to the seller during the time period in which the seller was reimbursed a plant cost component under the depreciation cost method. The reimbursement period of depreciation recapture is limited to Medicaid services reimbursed during the time period from October 1, 1984 through the date in which the nursing facility transferred to the tenure plant cost component reimbursement. The dollar amount of depreciation recapture may impact the asset acquisition allowable dollar amount for the purchaser.

2.4 Facility Asset Change of Ownership

In the event of a binding agreement and/or sale occurring on or after July 18, 1984, the Plant Cost Component for the nursing facility, attributable to the agreement and/or sale, is limited to the Medicaid Program policy provisions applying federal reimbursement limits of the DEFRA. Refer to the plant cost component rate determination provisions in the Rate Determination Section of this chapter for additional information.

At the time of the facility asset ownership change, the Provider must complete a Plant Cost Certification and submit a copy of the purchase and/or lease agreement, along with plant cost information, to the LTC Reimbursement and Rate Setting Section. The information is necessary to establish the reimbursement rate for the Plant Cost Component due to the asset ownership change. For Plant Cost Certification requirements and timeframes for filing the data, refer to the Plant Cost Certification Section of this chapter.

For an explanation of the effect of the sale of assets on the Tenure Factor, refer to the Rate Determination Section of this chapter.

In the event of a sale after March 31, 1985, Medicaid will recapture from the selling provider any reimbursement received in the form of depreciation expense, through the date of either the sale and transfer of assets or, for a Class I facility, that provider's conversion to a "Return on Current Asset Value Component" reimbursement, whichever is earlier. This reimbursement provision does not apply to Class I nursing facility providers whose ownership began after March 31, 1985. For information regarding depreciation reimbursement adjustment, refer to the Cost Report Reimbursement Settlements Section of this chapter.

2.5 Termination of Medicaid Participation

A nursing facility that loses its Medicaid certification as a result of regulatory action, irrespective of whether that action requires facility closure, or a nursing facility that chooses to terminate its participation in the Medicaid program without closing must comply with notice and cost reporting requirements. Refer to the Cost Reporting Section in this chapter and to the Nursing Facility Closure Section in the Survey, Certification and Enforcement Chapter for relevant information.

When Medicaid participation is terminated voluntarily or involuntarily, payment for at least one month of services rendered is retained for Final Settlement.

SECTION 3 - DEFINITIONS

General definitions are provided in this section. More detailed explanations are provided in relevant sections related to cost, audit or rate setting.

Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
Acceptable Cost Report	A complete and accurate accounting of the financial and statistical activities of a nursing facility provider prepared in accordance with Medicaid policy and cost reporting instructions on the electronic format required by the State Medicaid Agency. The cost report must include the certification statement signed by an authorized representative of the nursing facility certifying the cost report as a true, correct and complete statement of facility financial and statistical activities prepared from the nursing facility provider's books and records.
Administrator	A nursing facility administrator is a person(s) who is on site and responsible for the professional administration, supervision and management of the nursing facility and operations as they relate to resident care. The nursing facility administrator must be licensed in accordance with the law in Michigan.
Allowable Costs	Costs incurred in the provision of nursing facility services subject to guidelines and limitations set forth in Medicare Principles of Reimbursement, as they appear in federal regulations and in manuals published by the federal Centers for Medicare and Medicaid Services, unless stated to the contrary in policies and procedures issued by the State Medicaid Agency.
Ancillary Services	Services for which charges are customarily made in addition to routine services charges. Services as defined in the Coverages and Limitations chapter of Medicaid policy.
Asset Acquisition Cost	The cost or value for a nursing facility asset determined in accordance with Medicare Principles of Reimbursement. Medicaid further defines acquisition cost as the cost incurred by the present owner in acquiring the asset. For Class I, II, III and IV Nursing Facilities ▪ For depreciable assets acquired after July 31, 1970, the historical cost may not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of purchase, or the fair market value of the asset at the time of its purchase. For Class III and IV Nursing Facilities ▪ For depreciable assets acquired on or after December 1, 1997, the allowable historical cost of the asset may not exceed the historical cost less depreciation allowed to the owner of record as of August 5, 1997 or, if the asset did not exist as of August 5, 1997, the first owner of record after August 5, 1997.

Authorized Representative	An individual who has legal authority to obligate the nursing facility entity. The individual may be an officer, senior or majority partner, possess controlling ownership interest or an appropriate management employee of the licensed nursing home business entity. For purpose of signatures required for cost reporting and reimbursement request actions, individuals not included in these positions must have designated legal right to act in behalf of the subject business entity.
Available Bed	A bed considered available for occupancy. Beds are considered available except in the following situations: ▪ Unoccupied beds when the facility is under a regulatory Ban on Admissions (does not include beds unoccupied when the facility is under a Denial of Payment for New Admissions action). ▪ Beds covered under a State Medicaid Agency-approved Non-Available Bed Plan. ▪ Beds temporarily unoccupied due to renovation or construction where the State Survey Agency has deemed the beds unacceptable for occupancy.
Available Bed Days	The number of available bed days for a facility is the number of available beds in the facility multiplied by the number of days in the cost reporting period that they are available.
Average of Variable Costs	See Class Average of Variable Costs.
Ban on Admissions	A regulatory/enforcement sanction, imposed by the State Survey Agency (SSA), prohibiting the admission of any new resident(s) into the nursing facility, regardless of payment type, while the prohibition is in effect. Readmissions are allowed during this period on an individual case basis at the discretion of the SSA. A modified ban on admissions is a regulatory/enforcement sanction, imposed by the State Survey Agency, which may be imposed for a period of time after a ban on admissions has ended. The length of the modified ban on admissions is at the discretion of the SSA and may limit the number of new admissions for a designated period of time. **Note:** A Ban on Admissions is different from a Denial of Payment for New Admissions.
Base Costs	Costs that cover activities associated with direct patient care. Major items under these categories are payroll and payroll-related costs (salaries, wages, related payroll taxes, fringe benefits) for departments of nursing, nursing administration, dietary, laundry, diversional therapy, and social services; food; linen (does not include mattress and mattress support unit); workers compensation; utility costs; consultant costs from related party organizations for services relating to base cost activity, nursing pool agency contract service for direct patient care nursing staff, and medical and nursing supply costs included in the base cost departments. With the exception of nursing pool services, purchased services and contract labor from unrelated parties or from related organizations, incurred in lieu of base costs as previously defined, are separated into base and support costs using the industry-wide average base-to-variable cost ratio.
Base Costs Per Day	Facility base costs divided by the total number of resident days for the same period.

Base Cost Component, Indexed	See Indexed Base Cost Component.
Base Period	An interval of time for which cost data is obtained and used in the calculation of a prospective reimbursement rate.
Capital Expenditure	Expenditure not limited to cost of construction, engineering, and equipment, which, under Generally Accepted Accounting Principles, is not properly chargeable as an expense of operation.
Census	See Resident Days/Occupancy.
Census Day	A census day is counted when a resident is occupying a nursing facility bed at midnight. A census day is counted if the resident is away from the facility for therapeutic leave and the facility is paid to hold the bed (therapeutic leave days paid by the resident or Medicaid); the resident is on a one-day stay and the nursing facility is paid for the day; the resident is discharged due to death and the nursing facility is paid for the day. A resident is not counted for census purposes if the resident is admitted to the hospital, even if the facility is being reimbursed by any payer source to hold the bed. A resident is counted for census purposes on the day of admission, but not on the day of discharge except as noted above.
Chain Organization	A group of two or more nursing care facilities, or at least one nursing care facility and another business or entity, that is owned, leased, or through any other device controlled or operated by one organization. Chain nursing facility organizations include, but are not limited to proprietary organizations and various religious, charitable, and governmental organizations, any of which may be engaged in other activities not directly related to health care.
Change of Ownership	The exchange of real property, e.g., a sale of stock or real estate, including a sale of a building housing a nursing facility provider as a lessee; a change in corporate structure for a nursing facility, e.g., a change from a sole proprietorship to a corporation; or any other ownership change that affects the provider/licensed operator of a nursing facility.
Class I Facilities	Proprietary and nonprofit nursing facilities that do not fall under the Class II, Class III, Class IV or Class V definitions. The provider type assigned to this Class is 60.
Class II Facilities	Proprietary nursing facilities for the mentally ill or developmentally disabled (mentally retarded), with a different variable cost limit than Class I facilities. The provider type assigned to this Class is 72.
Class III Facilities	Proprietary nursing facilities, hospital long term care units, and nonprofit nursing facilities that are county-operated medical care facilities. The provider types assigned to this Class are 61 or 62, for the respective facility types.

Class IV Facilities	State-owned and operated institutions for the mentally retarded (developmentally disabled), Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and nonprofit nursing facilities for the mentally retarded. The provider type assigned to this Class is 65.
Class V Facilities	A distinct part of a special nursing facility for the care of ventilator-dependent residents. The provider type assigned to this Class is 63.
Class VI Facilities	Hospitals that provide a program of short-term nursing care (Swing Beds) not exceeding 100 days per stay. The provider type assigned to this Class is 63.
Class Average of Variable Costs (AVC)	The total *indexed* variable costs for all facilities in a class divided by the total resident days for all facilities in the class. An AVC is calculated for each nursing facility class. For example, the AVC for October 1, 2003, which is used for rate year October 1, 2003 to September 30, 2004, is based on variable costs reported in cost reports for facility fiscal years ending in 2002, indexed to October 1, 2002.
Class Variable Cost Limit (VCL)	A limit set at the 80th percentile of the Indexed Variable Costs (IVC) for facilities in a particular class during the current calendar year. The 80th percentile is determined by rank ordering facilities from the lowest to the highest IVC, then accumulating Medicaid resident days of the rank-ordered facilities, beginning with the lowest, until 80% of the total Medicaid resident days for the class are reached. The Variable Cost Limit for the class of facilities equals the IVC of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs. A VCL is calculated for Class I and Class III nursing facilities. For example, the VCL for October 1, 2003, which is used for rate year October 1, 2003 through September 30, 2004, is based on variable costs reported in cost reports for facility fiscal years ending in 2002, indexed to October 1, 2002.
Common Ownership	A situation in which more than one individual possesses significant (5% or greater) ownership or equity in a nursing facility or an organization serving the nursing facility provider.
Compensation	The total monetary, fringe, and/or benefits received by an employee or owner for services rendered to the nursing facility.
Control	A situation where an individual or organization has the power, directly or indirectly, to significantly influence and/or direct the actions or policies of a nursing facility or an organization serving the nursing facility provider.
Corporate Official or Employee	An individual representing an organization with the authority to exercise control over a nursing facility.
Cost Center	A division, department, or subdivision thereof; a group of services; or any other unit or type of activity into which functions of an organization or nursing facility are divided for purposes of cost assignment and allocation.

Cost Index	An indicator used to adjust nursing facility cost levels. The cost index used by Medicaid is Global Insight's Skilled Nursing Facility Market Basket Without Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Care Cost Review. The cost index is used to adjust reported costs from the facility's cost report period end date to October 1 of the year that is one year prior to the rate year being calculated. For example, cost report data used to set rates for the October 1, 2003 to September 30, 2004 nursing facility rate year are indexed to October 1, 2002.
Cost Report	A formal compilation of the nursing facility ownership, financial and statistical data in MDCH prescribed format, and required on an annual basis for the reporting period generally extending over a 12-month period based on the nursing facility's fiscal year. Each nursing facility provider's cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the facility.
Current Provider	The provider that operated the nursing facility during the time period of the last cost report on which normal rate setting would occur. Also see Provider.
DEFRA	Deficit Reduction Act of 1984
Denial of Payment for New Admissions (DPNA)	A regulatory/enforcement action, imposed by the CMS or the State Medicaid Agency, prohibiting payment for new Medicare and/or Medicaid admissions. Medicaid will not pay for services provided to a resident admitted during a DPNA. **Note:** A Denial of Payment for New Admissions is different from a Ban on Admissions.
Economic Inflation Rate	The annual economic inflation percentage for Class I and Class III nursing facilities established by the state legislature through the appropriations process.
Economic Inflation Update	The Economic Inflation Rate (EIR) for the facility class applied to the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit.
Facility	An entire nursing facility or a distinct part thereof being considered for rate setting. The entire building may be considered a distinct part unit for rate setting purposes. A unit smaller than the entire building may also be considered a distinct part unit for rate setting purposes if the identified facility space area meets required certification requirements.
Fair Market Value	The price that an asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition, generally comparable to the price at which other sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition.
Fiscal Year - Facility	For purposes of cost reporting, a nursing facility provider's financial reporting year for tax purposes, normally a 12-month period unless approved for exception due to change in provider ownership or fiscal period end date change.
Fiscal Year – State	October 1 through September 30.

Fixed Equipment (Major)	Equipment that is affixed to or constitutes a structural component of the nursing facility as defined by the current version of the American Hospital Association Chart of Accounts.
Hold A Bed Day	See Leave Day.
Home Office	The central office of a chain organization (See Chain Organization.)
Hospital-Attached Long Term Care Unit (HLTCU)	A distinct part of a general hospital licensed as a nursing facility.
Hospital Leave Day	See Leave Day - Hospital.
Indexed Base Cost Component	A facility's total per resident day allowable base costs indexed to October 1 of the year that is one year prior to the rate year being calculated.
Indexed Support Cost Component	A facility's indexed base cost component multiplied by the lesser of the facility's support-to-base ratio or the support-to-base ratio limit for that facility's bed-size group.
Indexed Variable Costs	The sum of a facility's allowable base and support costs per resident day indexed to October 1 of the year that is one year prior to the rate year being calculated.
Leave Day – Hospital	A day where a facility may be reimbursed by any payor source to hold a resident's bed for his/her return. (Medicaid policy pertaining to reimbursement is contained in the Coverages and Limitations chapter. The day is not counted as a census day of care for resident occupancy on the nursing facility's cost report.
Leave Day – Therapeutic	A day where a facility may be reimbursed by any payor source to hold a resident's bed for his/her return. Medicaid policy pertaining to reimbursement is contained in the Coverages and Limitations chapter. The day is counted as a census day of care for resident occupancy on the nursing facility's cost report.
Management Company	An entity contracted by a licensed and Medicaid-enrolled nursing facility provider to manage one or more of the daily operations of the facility.
Medical Care Facility (MCF)	A county-operated nursing facility.
Net Quality Assurance Supplement (Net QAS)	The Quality Assurance Supplement minus the bed fee assessment (fee per licensed bed per day.

New Facility (for rate-setting purposes)	A nursing facility provider that does not have a current Medicaid historical cost, including a newly constructed facility or an existing facility that has never before participated in the Medicaid program, or a facility that has participated in Medicaid in a different provider class, or an existing facility that qualified as a "No Medicaid" or "Low Medicaid" activity cost reporting provider for two consecutive fiscal years. A nursing facility that has made physical plant additions and/or renovations, including a total replacement or a facility that has been sold or resold is not considered a new facility.
New Provider in a Medicaid-Enrolled Facility	A person or business entity that has purchased or is purchasing a nursing facility that previously had Medicaid participation and whose new ownership individual(s) or business entity are not related through family or business ties to the owner's business entity of the previous owner. Under certain circumstances, a sale between family members may be approved by the State Medicaid Agency and the new owner may be considered a new provider.
Nursing Facility or Nursing Home	A facility (or distinct part of a facility) that is licensed by the State of Michigan to provide nursing care and related medical services for residents who require such care above the level of room and board.
OBRA	The federal Omnibus Budget Reconciliation Act, initially passed in 1987 as Public Law 100-203, with amendments in 1988, 1989, 1990 and 1994. This law incorporated specific provisions for nursing facility reform, including revised requirements for the survey and certification process and for the enforcement process.
Occupancy	See Resident Days/Occupancy.
Occupancy Rate	The total number of resident days in a given time period divided by the number of available bed days in the facility for the same time period.
Owner/Administrator	A person who is employed and functions as the administrator, assistant administrator, business manager, or in any other administrative capacity in the nursing facility, and who is also part or full owner of the nursing facility operating entity, i.e., the provider and/or the nursing facility's real property. If a Director of Nursing is an owner and acts occasionally in an administrator capacity, the time acting in an administrative capacity is allocated to the owner/administrator salary.

Ownership/Corporate Interest	A person, partnership, or corporation that: ▪ Has ownership interest totaling 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Has an indirect ownership interest equal to 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Has a combination of direct and indirect ownership interests equal to 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility, if that interest equals at least 5% of the value of the property or assets of the facility/disclosing entity; or ▪ Is an officer or director of a nursing facility, i.e., in the disclosing entity, that is organized as a corporation; or Is a partner in a nursing facility, i.e., in the disclosing entity, which is organized as a partnership. **Examples:** ▪ If Ms. C owns 10% of a note secured by 60% of the nursing facility provider's assets, Ms. C's interest in the provider's assets equates to 6% and must be reported. Conversely, if Mr. S owns 40% of a note secured by 10% of the provider's assets, Mr. S's interest in the provider's assets equates to 4% and need not be reported. ▪ If Mr. F owns 10% of the stock in a corporation that owns 80% of the nursing facility, Mr. F's interest equates to an 8% indirect ownership interest and must be reported. Conversely, if Ms. N owns 80% of the stock of a corporation that owns 5% of the stock of the nursing facility, Ms. N's interest equates to 4% indirect ownership interest and need not be reported.
Patient	See Resident.
Per Resident Day Cost	The total cost for a cost component divided by the total number of resident days. The number of resident days used is the greater of the number of resident days listed in the facility's cost report or 85% of the total number of available bed days for the cost reporting period.
Plant Costs	Plant costs include depreciation, interest expense (incurred for either working capital or capital indebtedness, mortgage discount points), property taxes, amortization costs associated with loan financing costs (e.g. letters of credit), letter of credit application or commitment fees, amortization of legal fees, recording fees or other fees relating to the capital asset acquisition, and specific lease expenses.
Property Owner	A person, partnership, corporation, organization, or entity, other than the nursing facility provider, having the property rights to the building in which a nursing facility operates or to the land on which a nursing facility sits.

Proprietary Provider	A provider or organization that is organized and operated with the expectation of earning profit for its owner[s], as distinguished from providers organized and operated on a nonprofit basis. Proprietary providers may be sole proprietorships, partnerships, or corporations.
Provider	A legal entity (person, partnership, corporation, or organization) that has been approved to participate in the Michigan Medicaid Program and has signed a Medical Assistance Provider Enrollment and Trading Partner Agreement. Some conditions of provider participation continue after enrollment in Medicaid has ended, e.g., record retention.
Purchase Allowance	A deduction granted for damage, delay, shortage, imperfection, or other causes, excluding discount and return.
Purchase Discount	A reduction (off the original price for property, goods or services) granted for the settlement of debts (e.g., 5/10 days which means a 5% discount if paid within 10 days).
Purchase Price	The total price agreed upon between a buyer and a seller for property, goods or services.
Quality Assurance Assessment Factor (QAAF)	The percentage increase determined and implemented by Medicaid for a class of nursing facilities.
Quality Assurance Supplement (QAS)	The product of the QAAF for the class times the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit.
Related Entity or Organization	An entity having a business relationship with a nursing facility provider that has 5% or greater beneficial interest or common ownership in or has control of the facility or the facility owner, whether such control has legal standing or is utilized. Also see Chain Organization and Ownership/Corporate Interest.
Related Party	An individual, group of individuals, or business entity that meets criteria similar to that defining a related entity or organization.
Resident Days/Occupancy	Resident days or occupancy for nursing facility Medicaid cost reporting is the sum of the census days in a specified period of time. To calculate the resident days for a particular day, total the census days for that day. (Residents who are hospitalized are not counted in the census). **Example:** Residents occupying beds in facility = 100 Residents on therapeutic leave = 5 Residents hospitalized = 3 Total resident days = 105

Routine Nursing Services	Organized nursing care and activities for the resident, under the observation and assessment of licensed nurses, that enable the resident to attain or to maintain the highest practicable physical, mental, and psychosocial well being in accordance with a written plan of care.
Routine Nursing Costs	Costs including, but not limited to, necessary medical, nursing, and mental health services, and all items of expense that nursing facility providers incur in the provision of routine nursing services. Costs must be included in the nursing facility provider's Medicaid cost reporting in accordance with established cost classifications.
State Medicaid Agency	The Michigan Department of Community Health. The work unit within the department with administrative responsibility for the Medical Assistance (Medicaid) Program is the Medical Services Administration.
State Survey Agency	The Michigan Department of Community Health. The work unit within the department with administrative responsibility for nursing facility survey and certification is the Bureau of Health Systems.
Support Costs	Costs that are payroll and benefit-related (salaries, wages, related payroll taxes, fringe benefits) for the departments of housekeeping, maintenance of plant operations, medical records, medical director, and administration; administrative costs; all consultant costs not specifically identified as base; all equipment maintenance and repair costs; purchased services; and contract labor not specified as base costs.
Support Costs Per Day	A facility's support costs divided by the total number of resident days for the same period.
Support Cost Component, Indexed	See Indexed Support Cost Component.
Support-to-Base Ratio	A facility's allowable support costs divided by allowable base costs. A facility's support-to-base ratio is limited to the 80th percentile support-to-base ratio for the facility's bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. Group bed size is based on the number of licensed beds in a facility regardless of bed type or whether the bed is available. This includes all types of licensed nursing beds, Home for the Aged beds, or any other type of licensed bed where nursing care is provided. A facility's support-to-base ratio is rebased annually from the most recent audited base period, regardless of ownership.
Support-to-Base Ratio Limit for Bed Size Group	The support-to-base ratio limit for a bed-size group is set at the 80th percentile of the support-to-base ratios for facilities in the same bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. The 80th percentile is determined by rank-ordering facilities within the same bed-size group from the lowest to the highest support-to-base ratio, then accumulating Medicaid resident days of the rank-ordered facilities, beginning with the lowest, until 80% of the total Medicaid resident days for the group are reached. The support-to-base ratio limit for the bed-size group equals the support-to-base ratio of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs.

Swing Beds	A program of short-term nursing care not exceeding 100 days, provided to patients in a hospital as defined in federal law and Michigan statute.
Therapeutic Leave Day	See Leave Day – Therapeutic.
Variable Costs	A facility's total allowable base and support costs for providing routine nursing services to residents, as determined in the Allowable Costs Section of this Chapter. Also see definitions for Base Costs and Support Costs.
Variable Cost Component	The lesser of a facility's Variable Rate Base or the Class Variable Cost Limit, plus the Economic Inflation Update.
Variable Cost Limit	See Class Variable Cost Limit.
Variable Costs Per Day	A facility's variable costs (total base and support costs) divided by the total number of resident days for the same period.
Variable Costs, Indexed	See Indexed Variable Costs.
Variable Rate Base	The sum of a facility's indexed base cost component and indexed support cost component. For rate setting purposes, the figure used as the facility's Variable Rate Base is the lesser of the facility's calculated Variable Rate Base or the Class Variable Cost Limit.

SECTION 4 - COST REPORTING

A nursing facility participating in the Medicaid program, must submit a Medicaid cost report to the MDCH annually as a condition of participation. An electronic copy of the cost report, the cost report completion instructions, completion and submission checklists, and related information are available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

4.1 EXCEPTIONS

4.1.A. EXCEPTION FOR HOSPICE PROVIDER OWNED NURSING FACILITY

A hospice provider that owns and operates a nursing facility is not required to file an annual cost report to Medicaid. The nursing facility industry aggregate cost data is used in place of individual facility cost data to establish a Medicaid reimbursement rate for this type of nursing facility. Rate determination procedures are addressed in the Rate Determination Section of this chapter.

4.1.B. EXCEPTION FOR SWING BEDS

Hospitals providing short term nursing services (swing beds) are not required to submit a Medicaid nursing facility cost report. Costs associated with swing beds are combined with those of the hospital and submitted on the hospital cost report. Refer to the Hospital Chapter of the Medicaid Provider Manual for information regarding cost reporting requirements related to swing beds.

4.2 NURSING FACILITY COST REPORT

An annual cost report is required for the cost reporting period which is based on the nursing facility's fiscal reporting year end. Each cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the facility. These records must be maintained in a manner consistent with cost finding regulations in the Medicare Principles of Reimbursement except where modified by Medicaid reimbursement and cost reporting policy. Records must also be kept in a manner consistent with previous cost reporting periods. The accrual method of accounting is mandated for all providers. For any cost situation that is not covered by the Medicare Principles of Reimbursement guidelines or Medicaid policy, Generally Accepted Accounting Principles (GAAP) should be applied. Related organizations and costs to related organizations, as defined in federal regulations, must be disclosed on the nursing facility cost report. Related organization costs claimed for Medicaid reimbursement through the nursing facility's rate determination process must be documented to RARSS on a completed home office cost report or an alternative cost reporting schedules as defined in the Home Office Cost Report subsection of this chapter.

RARSS retains the filed nursing facility cost reports for a minimum of three years from the date of receipt. Nursing facilities are required to retain documentation supporting filed cost reports for a minimum of seven years from the end of the applicable cost reporting period, or beyond the seven year period if audit determinations have not been resolved.

4.3 Cost Report Requirements

The RARSS will mail a notice to the facility or business office as designated by the provider soon after the end date of the nursing facility's cost reporting period on record. The notice specifies the nursing facility's county and license number coding, fiscal reporting period end date, cost report due date, and other pertinent data necessary for the completion of the cost report. The provider will also receive a compact disk (CD) with the specific information required to file an acceptable Medicaid Cost Report package in an electronic format. The CD has the applicable electronic cost report template, completion instructions, Marshall Valuation Services Cost Multiplier index for asset acquisitions, and other pertinent information.

The completed cost report package submitted to RARSS must include:

- The standardized electronic cost report (ECR) data in accordance with specified formatting and software.
- A paper copy of the Certification Statement (Worksheet A), which has been prepared and printed from the completed ECR file, and signed by an authorized representative of the nursing facility certifying to the accuracy of the prepared cost report.
- A copy of the nursing facility's trial balance of revenues and expenses.
- A completed cost report submission checklist.

The completed cost report package must either be mailed or delivered to RARSS as indicated in the notice.

4.4 Cost Report Acceptance

Each cost report submitted to RARSS is verified prior to its acceptance. The cost report package will only be accepted if all the following conditions are met:

- The package is complete.
- The cost report calculations are mathematically accurate, reasonable and consistent.
- The completed electronic cost report (ECR) data uses the required software and specified format.
- MDCH audit staff can generate a full cost report applicable to the cost year from the ECR file.
- The paper copy of the Certification Statement is completed and signed, and agrees with the submitted ECR file.
- The data meets a set of validation checks contained within the ECR plus the appropriate bed size and certification reporting requirements.
- The submitted ECR file includes proper reporting of costs and related cost report allocations in accordance with prior year(s) audit adjustment determinations for like costs or cost reporting issues.
- The cost report preparation complies with Medicaid policy and cost reporting instructions.

A cost report is considered not filed until it is accepted by RARSS. If the submitted cost report is determined to be unacceptable, RARSS will return the cost report to the nursing facility for correction and provide notice of the date the corrected cost report is due. The returned cost report will include information that indicates the reason(s) for the unacceptable report.

A corrected cost report – a revision of the most recently submitted cost report – may be submitted to RARSS for acceptance upon approval by RARSS. The provider should contact RARSS to obtain the acceptance status of that reporting period most recent cost report ECR file prior to submission of a corrected cost report. A corrected cost report that is accepted by RARSS defaults as the original cost report.

4.5 Less Than Complete Cost Report

With written approval from the RARSS, a nursing facility may submit a less than complete cost report.

4.5.A. No Medicaid Utilization

A nursing facility that has not furnished any services to Medicaid beneficiaries during the entire cost reporting period does not need to submit a cost report to comply with Medicaid's cost reporting requirements. The nursing facility may replace the cost report with a letter signed by an authorized representative that identifies the cost reporting period to which the statement applies (includes the facility name and Medicaid provider ID number), and states that:

- No covered services were furnished during the reporting period.
- No claims for Medicaid reimbursement will be filed for this reporting period.

The signed statement must be submitted to the RARSS within 30 calendar days following the date of the nursing facility cost report filing notice.

4.5.B. Low Medicaid Utilization

RARSS may authorize a less than complete cost report for a nursing facility with low utilization of Medicaid services in a reporting period. "Low utilization" is defined as an average of five or fewer Medicaid residents per day in the facility for the cost year, i.e., fewer than 1,825 Medicaid nursing days. The nursing facility must submit a written request to RARSS for approval to file a less than complete cost report for the specific cost reporting period. The request must be signed by an authorized representative of the nursing facility, identify the reporting period the request applies to, include the facility's name and Medicaid provider ID number, and:

- Indicate the reason(s) for the request.
- Indicate Medicaid utilization and the approximate Medicaid dollar amount of payments received for the year.

The written request must be submitted to the RARSS within 30 calendar days following the date of the nursing facility cost report filing notice.

After RARSS reviews the filed utilization and payment information, RARSS will send a written response to approve or deny the facility's request to submit a less than complete cost report. If approved, the facility will be required to furnish the following information using the required formats (ECR file worksheets):

- Information and Certification page.
- Statistical and Fiscal Data page.
- Ownership Information and Questionnaire.

In addition, the facility must prepare and submit the following information for the cost reporting period:

- Balance Sheet, and
- Prepared Financial Statements.

The nursing facility must submit the data within the same time period required for complete cost reports. Medicaid reserves the right to require the facility to file a complete cost report.

4.6 Cost Report Due Date

The RARSS will notify the nursing facility of the cost report due date by letter mailed to the nursing facility or designated business office. An acceptable cost report must be received by RARSS within five months following the nursing facility's cost reporting period end date. Subsequent notice of the cost report due date is addressed in the Cost Report Delinquency subsection of this chapter.

A cost report is considered filed timely if the acceptable cost report is submitted to the RARSS on or before the last day of the fifth month following the cost report period end date. Late submission of an acceptable cost report may cause a delay in determination of the provider's annual reimbursement rate and the rate notice to the provider. Refer to the Rate Determination subsection of this Chapter for additional information.

4.6.A. Corrected Cost Report Due Date

If the cost report is returned to the provider unaccepted, the provider is given 15 calendar days from the date that RARSS returned the cost report to resubmit a corrected cost report. A written request for an extension may be made to RARSS for additional days (not to exceed 30 calendar days from the return date). The RARSS will notify the provider in writing of the extension decision. If a corrected cost report is not received by the correction due date, the nursing facility is subject to cost report delinquency and payment termination notification. Refer to the Cost Report Delinquency subsection of this chapter for additional information.

4.6.B. Cost Report for Facility Closure or Change of Ownership

A nursing facility that has terminated its Medicaid program participation, either voluntarily or as the result of regulatory action, is required to submit a final cost report within five months following termination date.

The former owner of a nursing facility that has undergone a change of ownership is required to submit a final cost report within five months following the effective date of the ownership change.

4.7 New Facility/Owner Requirements

A new Medicaid provider (either a new owner or a new Medicaid participating provider) must notify RARSS of its fiscal year and cost reporting period, and other pertinent information regarding the nursing facility. In order for RARSS to establish the facility's Medicaid reimbursement rate, this notice must be submitted to MDCH at least 30 calendar days prior to the begin date of Medicaid participation. Untimely submission of the data will result in delaying Medicaid payment to the nursing facility.

The new provider information packet is available by request to the RARSS. An electronic copy of the packet may also be accessed on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact and website information.)

The new provider information data must include the following items:

- Operations begin date.
- Fiscal year reporting period.
- Federal employer identification number.
- Facility business name.
- Corporate name (if different from business name).
- Facility address.
- Business mail address (if different from facility address).
- Affiliation to a home office chain or related nursing facility group, including corporate organization, address, fiscal reporting time period, federal employer identification number and contact person information.
- Nursing facility Medicare Program status.

The new provider information data packet must be signed and submitted by an authorized representative of the nursing facility.

4.8 Changing a Cost Reporting Period

An annual cost report is required for the reporting period based on the nursing facility's fiscal reporting year. A nursing facility provider must file an annual cost report in accordance with the cost reporting period established with RARSS. However, under certain circumstances, RARSS may authorize a change in the nursing facility cost reporting period. The new cost reporting period must concur with the time period of the nursing facility financial reporting year.

4.8.A. New Facility/New Ownership Initial Cost Report

A new Medicaid provider (either a new owner or a new Medicaid participating provider) must notify RARSS of its fiscal year and cost reporting period, and other pertinent information regarding the nursing facility. The initial cost report must cover a period of at least two months but may not exceed 13 months.

4.8.B. Written Request for Cost Reporting Period Change

A nursing facility owner interested in changing a cost reporting period must submit a written request to RARSS. The request for such a change must be filed at least two months prior to the first day of the new fiscal reporting period being requested. The request must include documentation supporting the change, such as a copy of an approval of Medicare Program reporting change or Internal Revenue Service reporting year change notice. If the reporting year change is not yet approved by these agencies, a copy of notice to Internal Revenue Service reporting or application for Medicare Program reporting change may be submitted. The request must also include a copy of the nursing facility director or governing board approval resolution or minutes adopting the fiscal reporting revision.

RARSS will notify the provider in writing of the approval or denial of the request and cost report time period requirements resulting from the request.

4.8.C. Approval for Transition Period Cost Reporting

If the change is approved, the nursing facility will be required to file a cost report for the period between the end date of the original cost reporting period and the beginning date of the new cost reporting period. This cost report must cover a time period not less than two months and not more than 13 months. Cost report periods that cover a period less than seven months may be used for Medicaid reimbursement for retrospective cost settlement determination for specific cost items, but are not used for prospective rate setting determinations affecting a subsequent rate setting year.

4.8.D. Extended Period Cost Report

A provider may submit a request for a cost report period of more than 13 months if the:

- Provider is terminating Medicaid Program participation.
- Facility is closing.

Written request must be made to the RARSS and must outline the exceptional circumstances. The provider will be notified in writing of approval or denial.

The RARSS may approve such requests if the Medicaid program or the nursing facility are not significantly adversely affected. Examples of not adversely affected include where:

- the request is not made for purpose to gain access to higher ceiling rates or economic inflation adjustors;
- the cost report data will have limited use for reimbursement determinations, i.e., not used for annual rate setting;
- the report is not used for subsequent time period rate determination; and
- it is used solely for retrospective settlement items.

4.9 Cost Report Delinquency

The nursing facility cost report is considered delinquent if:

- An accepted cost report has not been received by RARSS by the cost report due date and the cost report remains not filed with RARSS.
- A corrected cost report has not been received by RARSS by the cost report due date or correction period due date and the cost report remains not filed with RARSS.

If the nursing facility cost report is delinquent, RARSS will send a delinquency and Medicaid payment termination notice by certified mail to the nursing facility or the provider's designated business office. The notice will indicate the date (not less than ten business days from the notice date), on which Medicaid payment will be terminated unless a cost report is received by the RARSS.

If an acceptable cost report is received after payment termination, payments will be reinstated through the normal pay cycle(s) process. Medicaid will remove the payment termination entry pertaining to the cost report delinquency action allowing the release of all payments withheld for the cost report delinquency action.

4.10 Amended Cost Report

An amended cost report to adjust a previously accepted cost report may be permitted or required by Medicaid.

An amended cost report is accepted by Medicaid to:

- Correct material errors detected subsequent to the filing of the original cost report.
- Comply with health insurance policies or regulations.
- Reflect the settlement of a contested liability.

Before completing and submitting an amended cost report, the nursing facility should contact the RARSS by verbal or written communication to determine the appropriate mode for making the necessary amendment(s). Amended cost report data will be effective for reimbursement rate determination and payment for nursing facility services rendered beginning in the month following the receipt of the provider's notice to RARSS of the need to amend the cost report.

The provider must include a disclosure letter with the amended cost report identifying the reason for the amended report and citing the cost report Worksheet(s) and the data input cell(s) within the Worksheet(s) that have been revised.

The provider cannot amend an audited cost report. Amended cost reports will not be accepted by RARSS after the completion of an audit except in cases where the filed and audited cost report continues to be the basis for the nursing facility's current reimbursement rate. An amended cost report must properly reflect any audit adjustments made to the original cost report. Amended data will be used, as appropriate, to compute future rates but will not be used to retroactively change a previously paid prospective rate. Use of amended cost report data for retroactive application to prior services will only be made in cases related to fraud or failure to disclose required information in the cost reporting. Situations where retroactive changes are permissible are described in the Cost Report Reimbursement Settlements Section of this chapter.

4.11 Home Office Cost Report

Nursing facilities that have costs applicable to services, facilities, and supplies furnished to the provider by organizations or entities related to the nursing facility by common ownership or control may include the costs in the nursing facility cost report. These costs may arise from arrangements involving a home office of a chain organization or services provided to the nursing facility or purchased by the nursing facility from related party businesses.

For facilities that are operated as part of a chain organization, home office costs claimed on the individual nursing facility's cost report must be reported using the Medicare Home Office Cost Statement, Schedules A through J, of the HCFA 287-92.

For nursing facilities reporting costs of services provided by a related party organization, the Medicare Home Office Cost Statement, Schedules A through J, HCFA 287-92 is the recommended format. Alternative cost reporting worksheets or accounting schedules may be substituted for the Home Office Cost Statement if RARSS agrees that the alternative format provides supporting documentation to adequately identify expenses and the allocation of costs to the nursing facility. RARSS will approve the format as submitted, require additional data or revisions to the reporting format, or disapprove the alternative reporting.

The Provider must submit two copies of the annual Home Office Cost Statement or related party cost report.

When the fiscal year for the home office or related organization coincides with the nursing facility's fiscal year, the due date for the home office or related party cost report must coincide with the nursing facility's annual cost report due date. In cases where the fiscal years do not coincide, the nursing facility must submit the cost report of the home office or related party for the most recently completed fiscal year of that entity. The report may have been submitted to RARSS previously, it must be submitted by the same due date as the nursing facility's cost report. (Refer to the Related or Chain Organization Cost Allocation subsection for additional information.)

If the facility does not provide the above referenced supporting documentation to support home office or related party costs, the facility must remove the costs from the nursing facility's cost report. The nursing facility's cost report will not be accepted if the provider does not remove the unsupported costs.

4.11.A. Home Office Costs - Chain Organization

For Medicaid purposes, a chain organization consists of a group of two or more nursing facilities, or at least one nursing facility and any other business or entity owned or operated and controlled by one organization.

For Medicaid policy regarding allowable costs, refer to the Cost Classification and Cost Finding Section of this chapter.

4.11.B. Related Party Business Transactions

The operating costs of a related ownership organization are allocated to the individual nursing facility as a purchased service. This cost must be identified within the appropriate cost center in the Medicaid cost report. Identification of the type of service determines if the costs qualify to be apportioned between base and support cost using the industry-wide base and support cost percentages. If the service does not qualify to be apportioned by this method, the allocated costs are classified as support costs in the individual nursing facility.

The related party cost reporting is required for the specific related party business entity in the following cases:

- If the dollar amount of routine nursing care costs to the individual nursing facility exceeds $10,000 in aggregate, regardless of the number or type of services provided.
- If the sum, total dollar amount, of routine nursing care costs to multiple nursing facilities exceeds $50,000 in aggregate, regardless of the number or type of services provided and number of nursing facilities served.

These dollar limits apply to related party business transactions whether they are routine or ancillary nursing services.

Facility lease arrangements between related parties must be separately reported in the cost report as described in the Allowable and Non-Allowable Cost Section of this chapter.

4.12 Cost Report Filed Under Protest

As part of the cost settlement and cost report audit process, a nursing facility provider may dispute a Medicaid regulatory or policy interpretation. (Refer to the Appeal Process Section of this chapter for additional information.) If the provider has a dispute regarding the annual cost report, the nursing facility must submit a separate cost report, referred to as a 'protest cost report' to establish their reporting of the dispute issue. In order to preserve the nursing facility cost report claim, this separate cost report must be identified as under protest for the disputed issues that remain under appeal or are subject to an appeal. The protest cost report filing must include an accompanying letter, signed by the nursing facility authorized representative, listing the disputed issue(s) and respective dollar amount(s) for the basis of the protest cost report filing. Protest cost reporting issues will be addressed in the cost report audit process dependent upon resolution of the disputed issues. The cost report filed under protest will not be used for rate determination, but will provide information for audit consideration relative to disputed issues. The auditor will address necessary audit adjustments to the accepted cost report to reflect the appeal resolution.

Protest cost report filing is not for general disagreement with promulgated Medicaid policy. The RARSS will not accept protest cost reports filings that include items considered as disagreement or dissatisfaction with promulgated policy.

SECTION 5 - PLANT COST CERTIFICATION

Medicaid reimburses nursing facilities for costs associated with capital asset ownership. The costs are referred to as plant costs and are reimbursed as the Plant Cost Component of the per diem reimbursement rate. The Plant Cost Component is based on the cost report data submitted by the nursing facility for the previous calendar year. The Plant Cost Component includes costs associated with capital asset acquisition, depreciation, interest expense (either working capital or capital indebtedness), property taxes, amortization costs associated with loan financing costs (letters of credit, asset acquisition legal fees) and specific lease expenses. The Plant Cost Component of the reimbursement rate determined for a nursing facility remains consistent throughout the State's fiscal year period (October through September), unless the facility qualifies for an interim reimbursement rate.

Example: Plant cost data from cost report year-end December 31, 2002 is the basis for the Plant Cost Component for the October 2003 through September 2004 rate period. Refer to the Cost Classification and Cost Finding, and the Rate Determination sections of this chapter for additional information.

The process used to determine if a facility qualifies for an interim reimbursement rate is called Plant Cost Certification. Special rate setting provisions qualify facilities to use current year costs associated with capital ownership instead of the prior year's cost report data to determine the Plant Cost Component of the reimbursement rate. Rate setting provisions are available for facilities incurring exceptional changes in the facility's plant costs during the current year. Qualifying situations such as new construction or renovation, new asset acquisition, new ownership, or changes in the nursing facility's bed size or the type of resident services are considered to determine eligibility for Plant Cost Certification.

5.1 PLANT COST CERTIFICATION ELIGIBILITY CRITERIA

A facility may plant cost certify when there is no plant cost data available or when the plant cost data inadequately reflects the current rate period plant costs. Plant Cost Certification is available in the following situations:

- The nursing facility provider is constructing a new building or incurring physical plant improvements with Certificate of Need (CON) approval, or the asset costs are, on average, $1500 per licensed bed in capital expenditures in a single cost reporting period.
- There is an approved CON ownership change for an existing facility, or the nursing facility assets have changed ownership in a manner that requires CON review.
- The State Survey Agency has changed the class level of the facility, change in Medicaid certified beds, or the type of nursing or resident care services provided in the nursing facility.
- The nursing facility has an approved non-available bed plan in the cost report period.
- The nursing facility is in the first full cost report year following the termination of an approved non-available bed plan.

5.2 PLANT COST CERTIFICATION SUBMISSION

The provider must complete the Plant Cost Certification process and qualify in order to receive an interim reimbursement rate. The RARSS must receive a compilation of the nursing facility's expected allowable plant costs and a statement signed by the nursing facility's authorized representative attesting to the data's accuracy and adherence to the Plant Cost Certification policy. The provider must use the MDCH

required format for document preparation. A provider having a nursing facility license and leasing the facility must report facility costs of the lessor in accordance with Medicaid's reimbursement policy. Refer to the Allowable Cost and Non-Allowable Cost, and Cost Classification and Cost Finding sections in this chapter for additional information.

A provider requesting an interim reimbursement rate must provide the information in the Medicaid Long Term Care Plant Cost Certification format and submit copies of supporting documentation. A copy of the format is available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.) The Plant Cost Certification packet, of accepted sample formats is available by request to RARSS. An Electronic copy of the packet can also be accessed on the MDCH website.

Supporting documentation must include the following items:

- For Facility Purchase
  - CON approval
  - Purchase Agreement
  - Mortgage and Loan Agreements
  - Interest Amortization Schedules for Financing
  - Property Tax Statements
  - Capital Asset Cost Appraisal
  - Purchase Closing Statement or Recording

Supporting documentation must include the following items, where applicable:

- For Renovation, Addition or New Construction
  - CON approval
  - Licensed Bed Notice issued by the State Survey Agency
  - Mortgage and Loan Agreements, if applicable
  - Interest Amortization Schedules for Financing, if applicable
  - Property Tax Statements
  - Construction Contract Statement or Summary

The completed information and support documentation may be mailed or delivered to the RARSS. Inquiries relating to the submission of the data should be directed to the RARSS office. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

If RARSS determines that the plant certification eligibility criteria are met, the submitted cost data will be desk reviewed, adjusted if necessary, and used to calculate the nursing facility's Plant Cost Component. If the fiscal year cost report filing and subsequent cost report audit determine the data used to calculate the reimbursement for the Plant Cost Component resulted in an overpayment or underpayment to the provider, the Medicaid recovery or additional reimbursement due the provider is included in the cost report reimbursement settlement. (Refer to the Cost Report Reimbursement Settlement section of this chapter for additional information.)

5.2.A. Plant Cost Certification Requirement for Reimbursement – Building and Equipment Changes

A new or existing provider or business entity operating a nursing facility that is incurring a change involving the nursing facility's building and equipment must complete a Plant Cost Certification. A provider that obtains ownership of the nursing facility building and equipment or enters a lease agreement for the facility must submit a completed Plant Cost Certification. In the instance that a lease change is the result of a facility ownership change where the provider has a different landlord, a plant cost certification is required if any terms of the lease agreement changes, such as, lease amount, duration etc.

The Plant Cost Component of the reimbursement rate will be zero until the Plant Cost Certification is received by the RARSS. In order to be eligible for retroactive reimbursement, the provider must submit a completed Plant Cost Certification on or before the date of the initial filing of cost report for the year in which the ownership change or asset transaction occurred. The effective date of the Plant Cost Certification will be the month that new ownership becomes the licensed entity or the asset transaction. Plant Cost Certification requests received by RARSS subsequent to the cost report filing will not be eligible for retroactive reimbursement, and future plant cost reimbursement rates will be effective as outlined under the effective time period policy.

5.2.B. Plant Cost Certification Submission Waiver

If the provider qualifies for Plant Cost Certification under the approved non-available bed plan or because it is the first cost report year after the non-available bed plan termination, the data submission requirement is waived. The provider has the option to file during the rate year or to defer the plant cost rate revision until the cost report reimbursement settlement. Settlement adjustments for plant costs for the cost report period will automatically apply to non-available bed time periods. If a Plant Cost Certification is not filed, the nursing facility's interim Plant Cost Component will continue to be based on the previous year's cost report, and the cost report reimbursement settlement will be adjusted to the allowable plant cost level for the cost report time period. Refer to the Cost Report Reimbursement Settlement section of this chapter for additional information.

5.3 Plant Cost Certification Effective Time Period

The effective time period of the plant cost certification will be determined by the RARSS. A completed Medicaid Long Term Care Plant Cost Certification request in required format, with documentation, received by the RARSS prior to the 16th of the month is effective and included in the reimbursement rate as of the first day of the following month (e.g., a request received between September 16 and October 16 will be reflected for days of care beginning November 1).

The effective date of the plant cost certification cannot be prior to the month in which the facility experienced the change of ownership or the qualifying asset change. The rate is not revised for partial months. For interim rate setting, the revised reimbursement rate due to the Plant Cost Certification will not be applied to prior service dates except in instances where a provider meets certification eligibility under the nursing facility ownership change or lease provisions. If a plant cost certification is filed prior to the provider's cost report year end, an interim reimbursement rate is effective on a prospective basis

for service dates after filing date. Retroactive reimbursement due to the plant cost change for that cost report year services will be addressed in the initial and final settlement determination of the cost report. Refer to the Cost Report Reimbursement Section of this Chapter for additional information.

If a Plant Cost Certification is filed after the provider's cost report year end, the plant cost reimbursement rate change is only effective on a prospective basis in accordance with the time period established by the Plant Cost Certification request receipt date.

The Plant Cost Certification interim reimbursement ends when the nursing facility's prospective Plant Cost Component is based on the first complete cost report year that reflects the plant costs which qualified the nursing facility for Plant Cost Certification.

Example: A nursing facility with a cost report period of January 1, 2004 through December 31, 2004 completes an eligible renovation project in June 2004, and submits a Plant Cost Certification before June 16, 2004 to be effective July 1, 2004. (**Note**: Rate Year refers to a time period coinciding with the state fiscal year rate period. The time periods listed below the Rate Year identify the period during which the rate will be paid and the cost report year on which the rate is based.)		
Nursing Facility Initial Period Interim Rates for Plant Cost Reimbursement		
Rate Year: October 2003 – September 2004	October 2003 – June 2004: Plant cost for the cost year end December 2002	July 2004 – September 2004: Plant cost based on plant cost certification reflecting expected cost for the cost report year end December 2004
Nursing Facility Final Rates for Plant Cost Reimbursement		
Rate Year: October 2003 – September 2004	October 2003 – December 2003: Plant cost for the cost report year end December 2002	January 2004 – September 2004: Plant cost for the cost report year end December 2002
Rate Year: October 2004 – September 2005	October 2004 – December 2004: Plant cost for the cost report year end December 2004	January 2005 – September 2005: Plant cost for the cost report year end December 2005
Rate Year: October 2005 – September 2006	October 2005 – December 2005: Plant cost for cost report year end December 2005.	January 2006 – Septemer 2006: Plant cost for the cost report year end December 2006.

Rate Year: October 2006 – September 2007	October 2006 – September 2007: Plant cost for cost report year end December 2005.

5.4 Plant Cost Certification Updates and Revisions

The nursing facility's initial Plant Cost Certification will continue to be used for the interim Plant Cost Component unless the nursing facility submits a revision to the Plant Cost Certification.

Following the initial submission of the Plant Cost Certification, the nursing facility is responsible to submit an updated or revised Plant Cost Certification to assure the interim Plant Cost Component reimbursement is representative of the current rate period plant costs.

The nursing facility provider may revise its submitted Plant Cost Certification at the beginning of subsequent fiscal year rate periods or the beginning of a calendar quarter, but not more than two times per year. The effective timeframes for payment based on the updated information are the same as noted above.

The overpayment penalty provisions, if applicable, remain in effect regardless of payment based on initial submission or revised data.

5.5 Plant Cost Certification Overpayment Penalty

At the time of the MDCH audit of the provider's fiscal year cost report, if the interim reimbursement payments resulting from Plant Cost Certification exceed cost report settlement plant cost reimbursement, all excess funds paid as a result of the Plant Cost Certification request will be recovered by Medicaid. The provider will be assessed a penalty for overpayments resulting from Plant Cost Certification. The penalty will be based on 10 percent of the aggregate dollar amount difference between the interim reimbursement payments resulting from the Plant Cost Certification and the cost report settlement plant cost reimbursement. The penalty will be waived if the aggregate dollar amount difference is equal to or less than 10 percent of the provider's aggregate Plant Cost Component reimbursement amount for the cost settlement period. Overpayment recovery and penalty determination are included in the Cost Report Reimbursement Settlements Section.

SECTION 6 - AUDIT

The goal of the cost report audit is to provide the MDCH assurances that the cost report information is accurate for the determination of Medicaid reimbursement rates, and includes the following objectives:

- To review, analyze, and test the nursing facility's Statement of Reimbursable Cost and underlying financial records to confirm that only reasonable and allowable costs have been included.
- To confirm that the methods used to calculate the required statistical information are adequate and that the statistical data is recorded accurately.
- To confirm that the cost finding and cost apportionment have been accurately and fairly computed.
- To confirm the accuracy of the costs allocated to Medicaid by independently applying the method approved for the provider's use in computing reimbursable cost.
- To confirm that, in all material aspects, the nursing facility provider is in compliance with the reimbursement regulations.
- To review, analyze and test the nursing facility's revenue and billings to determine the propriety of billing practices and identify potential errors and financial risk to Medicaid.
- To identify the underlying causes of significant errors or problems noted during the audit and to suggest improvements.
- To follow up on significant problem areas identified in previous audits.
- To confirm consistent and uniform application of federal and state laws, rules, and regulations for reimbursable costs.

6.1 AUDIT PROCESS

The annual audit process may include a desk audit/review, a computer check, and/or an onsite audit. This process may be performed by MDCH audit staff or by a qualified designee.

Onsite audits will be conducted no less than once every four years. An audit of either limited or full scope will be performed on the records of each participating nursing facility provider to ensure that the expenses attributable to allowable cost items are accurately reported in accordance with established principles and guidelines.

A Preliminary Summary of Audit Adjustments Notice is issued to the facility upon completion of the audit.

6.1.A. REQUIRED INFORMATION

Each provider must allow access or arrange for access by MDCH staff, or their designees, to required financial records and statistical data including:

- Records required by the Medicare Principles of Reimbursement.
- Complete financial records of related organizations.
- Complete records of lessors necessary to determine underlying costs of leasing facilities and items of equipment.

These records include, but are not limited to, the following:

- Census records and numbers and types of leave days for each Medicaid beneficiary/resident (i.e., hospital, therapeutic).
- Resident medical records, with details of medical services received by each resident.
- Resident service charge schedules.
- Resident trust fund account records, with evidence of quarterly reporting to each resident.
- Medicaid Cost Report with supporting documentation for cost finding statistics utilized on the report.
- Supporting documentation for Nurse Aide Training and Competency Evaluation Program activity and cost data.
- Documentation to support the cost and activity level for special Medicaid reimbursement provisions beyond the scope of services included in routine nursing care.
- Total and Medicaid ancillary charge summaries and logs.
- Medicare Cost Report, if applicable.
- Medicare and other health insurance billing and payment records for each resident.
- Books of original entry, including standard/special journals, payroll journals, disbursement journals, etc.
- Employee records, including detailed payroll records, personnel files, employee wage scales, shift schedules, union contracts, agreements, fringe benefits (e.g., deferred compensation, pension plans, insurance, personal use of assets, special allowances), individual accounts of leave days, job descriptions, and payroll tax returns.
- Facility policy and procedure manuals and related materials.
- Plans for internal control.
- Minutes of meetings of the governing body.
- General and subsidiary ledgers, including stock ledgers, cash receipts, etc.
- Purchase requisitions and orders.
- Vouchers and invoices in detail to support services and goods purchased.
- Records related to management fees, executive services or personal services contracts, and contracts for services under arrangement.
- Charts of accounts.
- Checking account registers, canceled checks, and bank statements.
- Vehicle mileage and use logs.
- Fixed asset records.
- Capital expenditure records and depreciation lapse schedules.

- Copies of long-term debt obligations, mortgages, notes payable/receivable, amortization schedules, year-end statements, and loan histories.
- Tax returns, or federal informational returns for tax-exempt facilities.
- Provider organization ownership disclosure records, e.g., Articles of Incorporation, Partnership Agreement, and other similar documentation.
- Records regarding chain organizations, including corporate home office costs.
- Work papers and records regarding the preparation of cost reports.
- Audit reports of financial statements.
- Work papers of internal and external accountants used in the preparation of the cost report(s).
- Records regarding working capital. Analysis of source and use of funds, which includes working capital loan principle payments.
- Leases and all related records.
- Accounts receivable Aging Schedule.
- Accounts payable Aging Schedule.

6.1.B. AVAILABILITY OF INFORMATION

The nursing facility must have an accounting and records maintenance system to provide accurate cost, revenue and statistical data, and other information that can be verified by Medicaid auditors. MDCH audit staff or their designees will not complete an audit if the nursing facility does not make required information available. If the required information is not released within 15 business days of a written request by an auditor during an audit, the MDCH may assess a financial penalty to the provider until the requested records are made available to the auditor. The MDCH will issue prior notice to the provider that they will assess the penalty equal to 20 percent of the facility's monthly Medicaid payments, effective in the first month following the expiration of the 15-day notice period. Waiver of the penalty assessment is only allowed by approval of the Medicaid Director following the provider's request for waiver consideration, including justification for the request and additional time to provide the records.

NOTE: A nursing facility provider that has been assessed a penalty is prohibited from collecting additional funds from Medicaid beneficiaries to compensate for the penalty.

If, after the 15-day period, the records become available for auditor review, an authorized representative of the nursing facility must give written notice of record availability to the MDCH Office of Audit. This acknowledgement to release the requested records must designate the contact person and record location. The payment penalty will be discontinued effective for the month following the date the auditor determines that the required records have been released and the dollar amount of penalty assessments will be refunded to the nursing facility provider. The auditor's determination that the requested records have been provided will be made within 60 calendar days of such written agreement to release the requested records.

The auditor may determine that records necessary to verify specific cost report expenses are required to complete the audit. Failure to release the requested records within 15 business days of a written request will result in a disallowance of costs associated with the item in question. If the nursing facility disagrees with the disallowance, this disallowance can be appealed at the completion of the audit. (Refer to the Appeal Process Section of this chapter for additional information.)

6.1.C. Retroactive Rate Changes

A retroactive change in a nursing facility's rate and reimbursement may be made after completion of an audit in the following situations:

- For those providers that are retrospectively settled.
- For those providers that had an interim rate set prior to completion of the cost report audit.
- For those providers that were retrospectively settled because they were granted Rate Relief.
- For audit adjustments required as a result of a hearing decision.

Refer to the Reimbursement Rate Determination section of this chapter for detail information regarding retroactive effective time periods for rate determination and reimbursement actions.

6.1.D. Reopening Audit Determinations

The MDCH may elect to reopen an audit determination following completion and closing of the audit of a nursing facility cost report. The MDCH will provide notice to the nursing facility of the audit reopening and the issues for which the audit is under review. Results of the audit reopening will be submitted to the provider, who will be given the opportunity to review the findings and appeal in accordance with Medicaid policy. If it is determined that the audit cost report contains incorrect data, the MDCH will use corrected data to compute future rates. The audit revisions will be effective for reimbursement rate determination and payment for nursing facility services rendered beginning the month following notice to the provider that the subject audit is being reopened.

The results of audit reopening actions will only be effective for retroactive reimbursement revision in cases of fraud or when the provider's failure to disclose required information was pertinent to the determination of allowable cost.

The Department will not reopen an audit determination for any reason other than fraud beyond three years following the date of final settlement.

6.1.E. Record Retention

Each nursing facility's accounting and related records must be kept for a period of not less than seven years. This obligation does not end if a provider closes or sells a facility. All records, source documents, contractual agreements, and corporate minutes must be available onsite, or at a readily accessible location, for verification and inspection by MDCH staff or their designees. When accounting personnel, books and records are located out of state, the provider is required to pay auditor travel expenses if MDCH staff or their designees deem it necessary to access documentation during the course of an audit.

6.2 Financial Fraud and Abuse

Federal Medicaid law and regulations require the Medicaid program to establish and maintain methods and criteria for the identification, investigation, and referral of potential fraud and abuse. In accordance with federal and state requirements, the MDCH will authorize the suspension of Medicaid payments (in whole or in part) to a nursing facility provider on receipt of reliable evidence that the provider committed fraud or willful misrepresentation while enrolled as a Medicaid provider. The provider will receive written notice of such suspension and may request an administrative review. (Refer to the Appeal Process Section of this chapter for additional information.)

A MDCH auditor or designee that observes potential fraud or financial abuse will prepare a separate report of observations. Observations of potential fraud or abuse include, but are not limited to, the following:

- Recording of personal expenses
- Overutilization of services to inflate charges
- Unauthorized use of resident trust funds
- Payroll entries of personnel who provide no services
- Concealment of business activities
- Falsifying records
- Charging Medicaid for costs not incurred
- Duplicate billing
- Billing beneficiaries inappropriately for Medicaid services
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Knowingly failing to disclose required information in the Medicaid cost report

Reports of observations will be reviewed by MDCH staff and appropriate actions taken. This may include forwarding a copy of the report and supporting documentation to the state Attorney General's Health Care Fraud Division.

SECTION 7 - COST REPORT REIMBURSEMENT SETTLEMENTS

The nursing facility reimbursement rate is determined in accordance with the policy provisions outlined in the Rate Determination Section of this Chapter. The reimbursement rate may include routine nursing care services and various rate add-on amounts depending on the Medicaid reimbursement policy effective at the time. The reimbursement rate is a per diem amount determined by the Provider Type. Rate determination may be based on filed cost report data, audited cost report data, cost data submissions and projections for specific reimbursement activity, or interim reimbursement provisions in accordance with Medicaid policies. The reimbursement rate is determined at the beginning of the rate year and the nursing facility is provided notice of the rate determination prior to implementation of the rate. The reimbursement rate may be revised any time during the rate year in accordance with rate determination policies. Rate revisions can result from the following actions as detailed in the Rate Determination Section:

- More recent Fiscal Year filed cost report
- Audited cost report
- Plant Cost Certification
- Nurse Aide Training and Competency Evaluation Program
- Special Dietary Cost Allowance
- Special Reimbursement policy actions

Reimbursement for ancillary services provided to Medicaid-eligible residents will be made in accordance with policies identified in the Nursing Facilities Coverage and Limitations Chapter of this manual, and the Institutional Billing and Payment Chapter of the Medicaid Provider Manual.

7.1 INTERIM REIMBURSEMENT AND RATE REVISIONS

The Rate Determination Section in this chapter outlines the process for determining the nursing facility's annual reimbursement rate. If RARSS determines that a reimbursement rate must be revised, the rate change may affect payment for future and/or previous dates of service. RARSS will notify the provider of the rate change and the rate's applicable time period.

If a rate revision applies to future dates of service, RARSS will send written notice to the provider's designated address specifying the revised rate and the applicable time period for the rate.

If a rate revision must be applied to previous dates of service in the current cost report year, RARSS will notify the provider of the applicable time period and the reimbursement rate. If the rate revision applies to previous dates of service in the current cost report year, RARSS will make the determination of an underpayment or overpayment amount, and RARSS will notify the provider of the process for implementing the payment adjustment(s).

If the rate revision applies to a prior cost report year's dates of service, the payment adjustment process is addressed in the Initial Settlement Section of this chapter.

7.2 Initial Settlement

The SMA may determine that a retroactive adjustment to the nursing facility reimbursement rate and payments is needed after the end of the provider's rate year. The retroactive adjustment may be due to a previous interim rate revision or to implement a rate based on actual cost report data. After the filing and acceptance of the cost report, the RARSS will determine if an Initial Settlement adjustment is necessary to make a retroactive payment adjustment for the rate period covered by the cost report. The Initial Settlement uses the most recent accepted cost report data to calculate the retroactive reimbursement and paid Medicaid claims and other payment data. (Refer to the Rate Determination Section of this Chapter for additional information.)

The RARSS will consider provider requests for Initial Settlements on an exception basis in the following situations:

- The provider anticipates a significant amount due them by Medicaid and requests an Initial Settlement in writing. The provider may make the request with the filing of the cost report.
- A payment adjustment is necessary for several months of the cost report period, and the current date is beyond the cost report period end date.
- The review of a filed cost report identifies that the interim rate add-on amount, plant cost certification amount, or other special reimbursement interim amount included in the interim rate exceed the amounts filed in the cost report.
- The provider has terminated Medicaid participation and has failed to file an acceptable cost report. An overpayment determination will be made for the payments to the provider during the time period that cost report data is required for determining final reimbursement.

If the RARSS determines that the Initial Settlement is an underpayment amount to the nursing facility, additional payment will be made to the provider for not less than 70 percent and not more than 80 percent of the determined settlement amount due the provider based on a review of the provider's financial situation and the effect of the filed cost report data on the reimbursement settlement determination. Although the provider may request a review of the Initial Settlement amount, the Initial Settlement payment level percentage is not subject to appeal.

If RARSS determines there is an overpayment to the nursing facility, the SMA will recover the overpayment amount as outlined in the Medicaid Recovery of Overpayments subsection.

Before making any payment adjustment, the RARSS will notify the provider in advance using a Notice of Program Reimbursement letter. The provider is given 15 calendar days for review of the settlement determination. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is mailed to the provider. A provider may request up to an additional 30 days to review an Initial Settlement. The provider must submit a written request stating the reason and the amount of the additional time needed (up to 30 days) for review. RARSS will review the request and notify the provider in writing of the approval or denial for additional time

If the settlement action requires correction following the review, a new notification and review time period will apply to the corrected settlement. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the recovery payment date(s) is mailed to the provider.

The RARSS may process a Revised Initial Settlement for the cost report period if it determines that additional payment adjustment is necessary after processing an original Initial Settlement and before completing a final settlement. A Revised Initial Settlement will be completed when there are significantly more approved claims, rate revisions or errors in the prior determination and a final settlement action cannot yet be completed. The notification and payment processing actions identified with the original Initial Settlement procedures also apply to the Revised Initial Settlement process. The payment criteria will be applicable to the aggregate dollar amount of the Initial and Revised Settlements for the reimbursement time period.

7.3 Final Settlement

The RARSS may determine that withholding of payment is necessary or that a retroactive adjustment to the nursing facility reimbursement rate and payments is needed after the end of the provider's rate year. A retroactive adjustment may be due to a previous interim rate revision or to implement a rate based on actual cost report data. After a cost report is audited, RARSS will determine if a Final Settlement adjustment is necessary to make a retroactive payment adjustment for the rate period covered by the cost report. The Final Settlement uses the audited cost report data to calculate the retroactive reimbursement and paid Medicaid claims and other payment data. Final Settlements determine if additional payment is due to the nursing facility or Medicaid.

When Medicaid participation is terminated voluntarily or involuntarily, payment for at least one month of services rendered is retained for Final Settlement.

RARSS mails a Notice of Program Reimbursement to the provider's designated address. The notice explains the:

- Settlement adjustment(s) and the process prior to RARSS taking the payment action.
- Provider's appeal rights.

The provider is allowed 15 calendar days for review of the settlement determination. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is mailed to the provider.

To obtain an extension, RARSS will review written requests from the provider stating the exceptional reason and the amount of additional time needed for the review (up to 30 calendar days). RARSS will review the exceptional circumstances stated in the request and notify the provider in writing of the approval or denial for additional time. If approved, an extended time period of up to an additional 30 calendar days may be granted to the provider for review. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the recovery payment date(s) is mailed to the provider.

If the settlement action is corrected following a review, a new notification and review time period will apply to the revised determination. After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is mailed to the provider.

RARSS may process a Revised Final Settlement for the cost report period if RARSS determines that additional adjustments are necessary subsequent to processing the Final Settlement. The adjustment(s) will be processed if significant adjustments or errors exist in the prior settlement calculation. Notification and payment processes outlined in the Final Settlement process also apply to the Revised Final Settlement process.

7.4 Depreciation Recapture Reimbursement Adjustment

If a provider has been reimbursed for asset depreciation expense in the Plant Cost Component and has sold the nursing facility assets, the sold assets may be subject to a depreciation recapture reimbursement adjustment in the reimbursement settlement for the cost report period in which the nursing facility assets are sold. The depreciation reimbursement adjustment uses reimbursement rates paid for services between October 1, 1984 and the date the facility was sold, or the date the Plant Cost Component of the per diem rate was converted to the tenure plant cost reimbursement method. (Refer to the Rate Determination Section of this Chapter for additional information.)

The depreciation recapture adjustment is only applicable to the reimbursement rate time periods the provider was paid a rate that specifically included depreciation expense in the Plant Cost Component of the Medicaid per diem rate. If the provider has never received Plant Cost Component reimbursement that specifically includes depreciation expense as a cost element of the rate calculations, the provider is not subject to the depreciation recapture reimbursement adjustment and is not required to complete the Medicaid Program Depreciation Recapture reporting.

A nursing facility provider that was reimbursed for depreciation in the Plant Cost Component and sells the nursing facility's assets must complete the Medicaid Program Depreciation Recapture reporting schedules for each applicable cost reporting year where depreciation was reimbursed. The Medicaid Program Depreciation Recapture schedule must be submitted with the cost report for the year that the asset sale occurs. Reporting schedules and instructions will be provided to the Provider with the final period cost reporting request or may be requested from RARSS. The reporting schedules (Excel file) and completion instructions (Word file) are available in electronic format or hard copy format.

If the Medicaid Program Depreciation Recapture is not applicable, the schedules must indicate N/A (not applicable) and be submitted with the cost report filing. If RARSS does not receive completed reporting schedules, RARSS will apply a 100 percent depreciation expense reduction rate to calculations for each cost report period used to calculate the settlement.

The net depreciation reimbursement adjustment for each cost report year the provider was reimbursed by Medicaid will be included in the settlement calculation. The depreciation adjustment will be limited to the amount Medicaid reimbursed for depreciation expense in each cost report year. Plant cost reimbursement allowances will be included in the calculation of the depreciation adjustment, and may result in reducing the net depreciation adjustment if the provider had not previously qualified for the incentive allowances prior to the depreciation reduction. The cost report reimbursement settlement notice will include the determination of depreciation recapture reimbursement adjustment.

7.5 Medicaid Recovery of Overpayments

Overpayment(s) due from a participating provider will first be offset against other settlements, payment adjustments, claims processing or any amounts due to the provider through lump sum or sequential installments until the overpayment amount is satisfied. If the provider is not participating in Medicaid, the overpayment amount must be paid to the State of Michigan for the Medicaid program immediately upon notification.

7.5.A. Request for Settlement Extended Payment of Schedule

If a participating provider alleges inability to repay the total overpayment amount in a lump sum or in sequential offset(s), the provider may request consideration for an extended repayment schedule. Extension requests for Settlement repayments must be received by RARSS within 15 calendar days of the Notice of Program Reimbursement date sent to the provider from RARSS. RARSS will notify the provider in writing of the decision. Requests received after 15 calendar days will be considered at the discretion of RARSS.

7.5.B. Criteria for Determining Extended Payment Arrangements

Extended settlement repayment schedules will only be considered if the net dollar amount of the current settlement notice reflects an overpayment amount of more than 10 percent of the provider's normal monthly Medicaid reimbursement payment(s). The provider's request must demonstrate that lump-sum recovery will create extraordinary financial hardship on the provider, and that the cash flow need of the nursing facility prevents the immediate repayment of the overpayment amount. Other factors that must not be present in creating financial hardship to the provider are significant expenditures for unallowable costs, ownership and management compensation exceeding Medicaid allowable cost limits, or significant dollar amounts for unallowable related party business transactions.

RARSS will mail the notification of the provider's repayment schedule and the repayment recovery dates and dollar amounts to the designated address. Requests for longer than three months will only be considered under exceptional circumstances e.g., the monthly recovery schedule amount would be greater than 50 percent of the provider's normal monthly Medicaid reimbursement payment.

SECTION 8 - ALLOWABLE AND NON-ALLOWABLE COSTS

Unless stated to the contrary in this section, Medicaid allowable costs for nursing facilities are determined in accordance with provisions in the federal Principles of Reimbursement established for the Medicare program. This section does not propose to set reimbursement standards or reimbursement methodology. The focus here is the determination of allowable costs. Reasonable costs associated with nursing facility services included in the provider's per diem rate, as identified in the Coverages and Limitations Chapter of this manual, are allowable costs within the parameters of the Principles.

NOTE: Definitions for the principal terms used in this section may be found in the Definitions Section of this chapter. A copy of the cost report referenced in this section, completion instructions for the report and related information are available on the Michigan Department of Community Health (MDCH) web site. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

8.1 ADVERTISING

Allowable advertising costs are considered those costs incurred by the nursing facility for an informational objective to inform the public about its services. Costs incurred for a promotional objective in an attempt to increase patient utilization are not properly related to patient care and are not allowable. Advertising in the Yellow Pages is an allowable cost, except that Medicaid limits the cost to that associated with a black ink Yellow Pages ad listing not to exceed 2" x 2" in size.

8.2 APPRAISALS

Appraisal expenses incurred by providers may be allowable costs (administrative and general) if the appraisal is of assets related to resident care and if it meets the Medicaid's Appraisal Guidelines. Expense for an appraisal of assets not related to resident care is not an allowable expense. Refer to the Appraisal Guidelines Section of this chapter for additional information.

8.3 ATTORNEY AND LEGAL FEES

The provider must maintain documentation and evidence of expenses incurred for legal fees and related costs as being related to the nursing facility's furnishing of patient care in order for such expenses to be allowable costs. Attorney fees are considered allowable costs incurred in the course of providing patient care, except as noted below.

Where the Michigan Department of Community Health (MDCH) or the Centers for Medicare and Medicaid Services (CMS) takes an action against the provider by initiating an enforcement action or issuing an audit finding, then the legal costs of responding to the action are allowable only in the following circumstances.

8.3.A. AUDIT FINDINGS AND RATE ACTIONS

- The provider prevails and the action is reversed.
  Example: The audit finding is not upheld and the audit adjustment or rate action is reversed.

- The provider prevails as defined by reduction of the contested audit finding by 50 percent or more.
  Example: An audit finding for an adjustment of $50,000 is reduced to $25,000.

8.3.B. Enforcement Actions

- The provider prevails and the action is reversed.
  Example: A Denial of Payment for New Admissions is rescinded and does not go into effect or when a provider is not in compliance before the effective date of the DPNA, but succeeds in disputing the imposition and the DPNA is rescinded with no interruption in payment for the covered service.
- The time period of imposition of a DPNA is reduced by 50 percent due to a change in the date that a nursing facility is determined to have been in compliance.
  Example: The length of a DPNA is reduced from 20 days to 10 days.
- The provider prevails as defined by reduction of a fine by 50 percent or more.
  Example: A Civil Money Penalty fine is reduced from $5,000 to $2,500.
- A federal enforcement action (F tag) is reduced in scope or severity.
  Example: An H-level citation reduced to a G-level citation, an F (SQOC)-level citation reduced to an E-level citation, or an Informal Dispute Resolution decision results in a reduction from an E-level citation to a D-level citation. Abatement of an Immediate Jeopardy or correction of a deficiency does not constitute a reduction.
- A state enforcement action (M tag) is eliminated.
- A settlement agreement is reached between the provider and the state and federal government prior to a Hearing.

8.3.C. General Administration of the Facility

- Attorney fees incurred in connection with facility acquisition, mortgage or finance transactions are allowable if Medicaid determines the fees reasonable. The fees must be reported under plant cost and capital asset cost reporting. Legal expenses incurred relative to a nursing facility or capital asset acquisition are considered allowable if they are capitalized and amortized over the loan for up to a five-year period.
- Legal fees incurred in the process of securing financing or refinancing of facility loans must be amortized over the life of the mortgage.
- Attorney fees relating to employer activities, labor negotiation, or in response to employment related issues or allegations, to the extent that the engaged services or actions are not prohibited under federal principles of allowable cost.

8.4 Bad Debts, Charity and Courtesy Allowances

Bad debts, charity, and courtesy allowances, as defined in the Medicare Principles, are deductions from revenue and are not allowable costs.

Bad debts are amounts considered to be un-collectable from accounts and notes receivable that were created or acquired in providing services. Charity allowances are reductions in charges made by the nursing facility provider due to the indigence of a resident. Courtesy allowances indicate a reduction in

charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the nursing facility, for services received by the provider.

Uncollected revenue for Medicare co-insurance and deductible billing amounts and patient payments for Medicaid eligible residents, and for non-covered services for Medicaid are not allowable costs.

8.5 Civil Money Penalties

Costs incurred for fines or money penalties for violation of federal, state, or local laws are not allowable.

8.6 Educational Activities and In-service training

Medicaid has established credentials/requirements for educational activities to be recognized as allowable costs. Educational activities outside the continental United States are not allowable.

Approved educational activities are formally organized or planned programs of study engaged in by nursing facility providers in order to enhance the quality of resident care in a facility. These activities must be licensed where required by state law. Where licensing is not required, those presenting the educational activity must be recognized as a professional for the particular activity. Examples of allowable educational activities costs are:

- Part-time education for a facility's employee at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work to enhance the quality of medical care or the operating efficiency of the nursing facility.

- Costs, including associated travel expense within the continental United States, for employees to participate in educational seminars and workshops to enhance the quality of medical care or the operating efficiency of the nursing facility that does not lead to the ability to practice and begin employment in a nursing or allied health specialty.

The costs of the following in-service training activities but are recognized as routine nursing care costs and are allowable costs:

- Orientation and on-the-job-training.
- Mandatory in-service education for Medicaid and Medicare certification.
- Maintenance of a medical library.
- Training of a resident or resident's family in the use of medical appliances.

Costs incurred for activities related to an approved Nurse Aide Training and Competency Evaluation Program (NATCEP) are not allowed under routine nursing care, except as provided in the Medicaid allowable cost and reimbursement policy outlined in the Cost Classifications and Cost Finding Section of this chapter.

8.7 Facility Vehicles and Travel

The cost of operating a facility-owned or leased vehicle must be adequately documented and differentiated between types resident care serviced, business use or personal use. Only the costs for resident care and costs related to the conducting of facility business are allowable vehicle and travel

costs. Use of a facility vehicle by facility personnel to commute from home to the facility and to return home at the end of the daily work period or other personal travel activity is considered personal use. Cost related to personal use travel activity is not allowable. Vehicle personal use is only allowable if the costs are reported employee compensation and satisfies Internal Revenue Service individual compensation tax reporting requirements.

The minimum documentation that must be retained and be available to auditors for all vehicles is:

- A Mileage log for each vehicle.
  - The log must contain at least the date, total miles for business use, name of driver, origination and destination, and the reason(s) for the vehicle use.
  - The log must report the monthly beginning and ending odometer reading.
- Business mileage and total mileage use of the vehicle to support the dollar allocation for determining allowable cost.
- Charge slips or invoices for fuel, maintenance, and other similar items.

If the reason for a trip is to transport a resident for medical care or treatment, the medical condition necessitating the trip must be documented. If the reason is to attend a seminar, convention, or meeting is related to nursing facility operation, invoices must document proof of attendance and mileage logs must be documented to identify the reason for the trip. Vehicle use for general business travel or other activity must include the reason in the mileage log.

Medicaid considers mileage that is not logged as not related to resident care or facility operation. The cost relating to unrecorded or non-supported as business use mileage is not allowable.

Travel by nursing facility personnel via personal vehicle use is an allowable expense if the travel is consistent with the aforementioned purpose criteria. Medicaid will allow such documented mileage at the State of Michigan, Department of Management and Budget (DMB), approved private vehicle rate. The mileage rate includes all vehicle costs and is treated as a variable support cost. The approved private vehicle mileage rate information can be accessed on the DMB website at www.michigan.gov/dmb, click on Agency Services, Travel, and Travel Rates.

8.8 INTEREST

Interest is the cost incurred for the use of borrowed funds. Necessary and proper interest on both current and capital indebtedness is an allowable cost in accordance with Medicare Principles of Reimbursement. The allowance for interest expense is determined using one of the following principles.

- Allowable interest expense is determined in accordance with current Medicare Principles. Medicaid applies the following guidelines, although not fully inclusive, in determining allowable interest expense. Interest expense must be reduced by all investment income, except where such income is from:
  - Gifts, grants, and endowments held separately or pooled with other funds.
  - Qualifying deferred compensation and/or self-insurance trust funds.
  - Income from a provider's qualified pension fund.

- The rate of interest on a loan must not be in excess of what a prudent borrower would have had to pay in the market place at the time the loan was made.
- Interest expense, to be allowable, must be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization. Interest paid by the provider to partners, stockholders, or related organizations of the provider is, therefore, not allowable.

  Exception: A nursing facility operated by a religious order is allowed to borrow funds from the order and claim necessary interest expense for those funds.
- Interest on loans in excess of asset value acquisitions (after July 1970) is not an allowable cost. In a situation where the purchase price exceeds the historical cost or the cost basis, the interest expense on that portion of the loan used to finance the excess is not allowable.
- Interest expense applicable to borrowings principle balance for a nursing facility acquisition must be separately identified and reported from interest expense applicable to working capital or miscellaneous capital asset acquisitions (assets that are not part of or related to a facility acquisition). See Cost Finding and Cost Classifications for borrowing principle balance descriptions.
- Working capital borrowings are considered funds borrowed for a relatively short time period to meet current normal operating expenses. Interest on current indebtedness - loan amounts meeting program working capital criteria are allowable, whereas interest expense for long-term working capital indebtedness is not considered allowable. The nursing facility must document the reason(s) and need for the working capital loan. The use must be to meet normal operating expenses and must be supported by an application of funds analysis demonstrating the use of loan proceeds for nursing facility expenses. The loan must include/require repayment of the principle balance within a prescribed time period including regular scheduled repayment amounts applying to the principle borrowings amount. The loan must meet allowable cost principles.
- Interest income is applied first as a reduction to mortgage related borrowing allowable interest expense, and then to other borrowings allowable interest expense.
- Interest expense is distinguished from penalty or finance late fees by the existence of a lender and borrower relationship pertaining to the financed amount. Penalty and finance fee assessments relating to late payment of liabilities are not considered borrowing costs and are not allowable.

8.8.A. Interest Class I and Class II Nursing Facilities

For the Class I and Class II facility, interest on borrowed funds related to the facility acquisition allowable interest expense is determined in accordance with the Principles in effect on July 17, 1984, prior to the changes associated with the mandates of the DEFRA of 1984 and its limitations on the revaluation of assets.

- The dollar amount of facility acquisition financing is limited to the lesser of:
  - the purchase price of the nursing facility,
  - the current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of purchase, or
  - fair market value at the time of purchase; minus the purchase down payment.

- Interest expense on the dollar amount of a facility acquisition loan principle in excess of the financing limit is not allowable.
- Depreciated replacement cost is defined as the current reproduction cost adjusted for straight-line depreciation over the life of the asset.
- Depreciated replacement cost must be determined by an independent appraiser, chosen and paid for by the nursing facility provider, in accordance with the "Appraisal Guidelines" in the Principles.

Note: For Class I and Class II facilities that choose to forego increased reimbursement for interest expense, they must adopt the prior owners financing and acquisition costs, interest expense schedule of borrowings, principal amortization, and interest expense recognized for reimbursement by the Medicaid program prior to the sale. Annual cost reporting must continue to be based on the prior owners.

8.9 Lease Costs

The Medicaid allowable cost provisions for asset lease transactions depend on the type of asset. Generally asset lease transactions require that the lease expense be removed from cost and replaced by the underlying ownership cost of the property owner. Lease or long-term rental agreement (more than twelve months duration) transactions must be reported in the Medicaid cost report Statement of Leased Capital Assets. Cost reporting disclosure of lease costs is required to properly classify ownership costs for determining Medicaid reimbursement. There are also specific asset lease transactions that must be reported in the cost report statement, but are exception to the underlying ownership disclosure requirement. Specific types of lease expenses are discussed in the following sections.

Maintenance costs for leased capital assets, other than lease situations qualifying under "pass-through lease" criteria, are classified as variable costs. The nursing facility must determine and report these costs in the appropriate cost center or department. This requirement may necessitate the breakout of the maintenance costs for the lease contract.

Lease costs are differentiated from incidental or non-recurring rental expenses incurred to address a limited need of the facility. Rental expense incurred for incidental or limited time rental items, or non-recurring rental transactions are allowable operating costs in the applicable cost center or department requiring the rental action. Limited time rental is considered as not longer than twelve months, non-recurring, and prohibits several/numerous sequential transactions for the same or similar rental items.

Exception: An extension period of 24 months may be approved by RARSS in instances related to construction or renovation. The provider must submit an extension request to RARSS in writing at least 45 calendar days prior to the effective date of the extension. The request requires disclosure of item, duration, and action that precipitated the need to extend and the project. RARSS will respond in writing.

8.9.A. Facility Lease

Cost reporting and reimbursement for capital assets relating to the nursing facility premises are under the same methods whether the items are owned or leased. For items to be considered allowable costs, the acquisition dates and asset costs, interest expense and other applicable ownership costs must be reported. Allowable lease costs are determined using one of the following principles:

- A nursing facility provider that entered into an acceptable, arm's-length lease prior to September 1, 1973, where the lessor has refused to open its books, is allowed an actual lease cost up to a maximum of $2.50 per resident day. This limit was developed from the average lease/rental costs for facilities leased prior to September 1, 1973, at which time the current method of calculation was effected. The pre- September 1, 1973, lessee has the right of appeal of an acceptable, arm's-length lease agreements for costs that exceed the $2.50 limit.
- A nursing facility provider that entered into, or amended, an acceptable, arm's-length lease agreement on or after September 1, 1973, is allowed a plant cost component determined in accordance with the Rate Determination section of this chapter, as applicable to an owner-provider, if the lessee discloses the allowable cost information required for rate setting. Leased assets are treated as though the lessor and the lessee are one and the same. Without full disclosure, lease expenses are not an allowable cost.

Interest expense allowed in the case of the lessor is also limited by Medicare Principles of Reimbursement. Further, interest income of the provider (lessee) is offset against all interest expense including interest expense allowed on rental properties.

8.9.B. Plant Cost Lease Other Than Facility Space

Lease expense for nursing facility equipment or other activity that does not qualify for pass through lease expense is not allowable and must be reported utilizing the ownership underlying cost reporting requirement. If a lease is a virtual purchase and the lessee becomes the property owner at the termination of the lease, or for a nominal buyout amount, ownership cost reporting must be applied. The definition criteria of a virtual purchase are addressed in the federal Principles of Reimbursement.

Office space costs incurred in a home office or related party administrative service transaction is allowable under application of allowable depreciation, interest and property tax underlying ownership cost principles. Reasonable and necessary lease expenses incurred by a home office or related party for administrative services office space are allowable. Ownership underlying cost reporting is not required for leased business office space or similar leased space except in rental transactions involving a related party landlord. Related party transactions for office space is limited to ownership underlying costs applicable to allowable depreciation cost principles. The cost of office space is included in the cost of the home office or related party administrative services space cost and must be reported in accordance with Medicaid policy identified in the Cost Classification and Cost Finding Section of this chapter.

8.9.C. Plant Cost Pass Through Leases

A select group of rental and lease situations are exceptions to the requirement for disclosure of the underlying ownership costs. The lease or rental cost of qualifying items is allowed as plant cost in the lease rental cost classification to the extent that the asset use and cost is related to patient care. The pass through lease allowance applies to the following:

- Vehicle lease to a maximum of $425/month or $5,100/year, per vehicle

- Photocopiers
- Postage meters
- Telecommunications systems (including FAX machines)
- Desktop or notebook computers and printers
- Parking lots and off-site record storage for rental from an unrelated party ownership and arm's length transaction

8.10 Life Insurance Premiums

Life insurance premiums are allowable when the premium is a fringe benefit for the insured employee, when the beneficiary of the employee's insurance is not the provider. The cost of life insurance premiums for insurance on the lives of officers and employees, including provider-based physicians, is an allowable cost only within the provisions of Medicare Principles of Reimbursement.

8.11 Liquidation of Short-Term Liabilities

A short-term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. The liquidation of liabilities requirement for Medicaid applies the federal Principles of Reimbursement for the determination of allowable costs. In instances where a nursing facility provider does not liquidate a short-term liability within the period specified in the federal requirements, the costs for the related goods and services is not allowed in the cost reporting period in which the liability was incurred, but is allowable in the cost report period when the liability is paid.

Exception to the one-year time limit to liquidate a short-term liability will be considered in accordance with the federal Principles of Reimbursement. A provider may request an extension for good cause to liquidate short-term liability. The provider must submit a written request at the time of submission of the Medicaid cost report to RARSS identifying the liability amount(s) and an explanation for the nonpayment of the liabilities and expected payments to liquidate the liability. RARSS will review the request and notify the Provider of the approval of an extension, not to exceed three years after the end of the cost report period that the request is filed, or of the denial of the request.

8.12 Lobbying and Political Activity Costs

A provider's costs incurred to support or oppose decisions of the federal Congress or state Legislature, costs related to campaigns for particular candidates or issues, and contributions to political action committees involving partisan elections are not allowable. Costs incurred, whether directly or indirectly through organization membership dues, fees or assessments, for these activities or to influence legislation are not allowable. Contacts with federal or state agencies in the course of business operations of the nursing facility and general comment on proposed policies are not considered lobbying activity.

8.13 Maintenance Of Effort Contributions by County Government

In accordance with Public Act 408 of 1984, as amended, county governments that own and operate a nursing facility are responsible for maintenance of effort funding levels for the operation of the county owned and operated nursing facility. The county government contributions to the nursing facility operations specifically due to the provisions of the Act, as amended, are not allowable costs of the county medical care facility Medicaid cost reporting.

8.14 Membership Fees

Reasonable costs of memberships in professional, technical, or business-related organizations are allowable if the organization's mission or objectives are primarily related to resident care and/or long term care services activities. Costs of memberships in civic organizations for the purpose of implementing civic objectives are also allowable for Medicaid purposes (e.g., Chamber of Commerce). Any portion of membership fees used for lobbying, supporting political candidates and campaigning, or in social, fraternal, and other such organizations are not allowable. Awareness of an organization's ongoing lobbying and political activities requires identification of the portion of the organization's fees, dues, assessments or other allocations of costs to members or associated nursing facility providers. If an amount of non-allowable cost is not identified relating to this purpose, all costs associated with the fees or dues are non-allowable, unless the provider can document the appropriate unallowable portion.

8.15 Medical Director/Physician Services

The nursing facility must have a designated medical director that maintains responsibility for the implementation of resident care policies, for coordinating medical care, and is directly accountable to nursing facility management. The cost(s) applicable to the provision of the duties and responsibilities of the medical director are allowable routine nursing care. The nursing facility must maintain adequate records to document the level and type of services rendered by the medical director as a facility employee, or under a service contract, or some other designated capacity. The cost(s) relating to the medical director duties and responsibilities must be distinguished from physician services activities that are not allowable routine nursing care. Refer to Practitioner Chapter of the Medicaid Provider Manual for discussion regarding physician services.

8.16 Non-Paid Workers/Volunteers

The value of services of non-paid workers is an allowable cost. The services must be performed on a regular, scheduled basis. The services must be of the type customarily performed by full-time employees and necessary to enable the nursing facility provider to carry out the functions of normal resident care and the operation of the facility. The value of services of a type for which providers generally do not remunerate individuals performing such services is not an allowable cost.

Example: Donated services of individuals in distributing books and magazines to residents, administering a provider canteen or cafeteria or a provider gift shop are not allowable/reimbursable.

8.17 Owner and Administrator Compensation

The cost for compensation to nursing facility owners is determined in accordance with Medicare Principles of Reimbursement, except the compensation to administrators, owner/administrators, or owners who function as administrators or assistant administrators, and corporate office executive management compensation is subject to specific dollar amount cost limits. Allowable cost limits are applied to nursing facilities based upon the bed size of the facility. Allowable cost limits are applied to individuals based upon the aggregate number of beds in nursing facilities being served or within the corporate organization. Compensation is remuneration to the individual for job performance and includes the costs of salary and wages, fringe benefits, director fees, and costs of services or items provided to the individual.

The compensation limit schedule is available on the MDCH web site. MDCH annually adjusts the Owner/Administrator Compensation Limits to include cost-of-living changes as reflected by the United States Department of Labor Consumer Price Index for the metropolitan Detroit area. (Refer to the Directory Appendix of the Medicaid Provider Manual for the web site address.)

8.17.A. Compensation Limit for Individual Nursing Facility

The allowable cost limit for compensation to nursing facility administrators, owner/administrators, or owners who function as administrators or assistant administrators is determined according to the following criteria.

- Facility bed size includes licensed beds for nursing home, home for the aged and hospital services beds. Other categories of resident beds or housing arrangement beds are not included in determining the facility bed size for determining the appropriate compensation limit.
- The owner/administrator compensation limit used must coincide with the number of beds available for occupancy. The measurement criteria for determining the facility bed size is the number of beds available for resident or patient care at the beginning of the cost reporting period.
- Each nursing facility having 50 licensed beds or more must have a full-time licensed facility administrator. As required under State law, this individual is expected to be in the facility directing, conducting, or participating in activities directly related to the nursing facility during the normal 40-hour business week. A current position description that adequately defines the duties and responsibilities for the administrator position must be retained at the facility.
- The total compensation amount claimed for allowable costs for the facility administrator and related positions must not exceed amounts established by the State Medicaid Agency. These amounts are established by facility bed size: 1-49 beds, 50-99 beds, 100-149 beds and 150 beds or more. Owner/Administrator Compensation Limits are expressed as facility annual compensation amounts and must be pro-rated on a monthly basis in situations where the cost reporting time period is not twelve months.

The owner/administrator compensation limits apply to the costs for the positions of administrator, assistant administrator, and/or other administrative employees performing functions or having work responsibilities normally considered nursing facility administrator work activity. If an individual is functioning in a position that requires a nursing facility administrator's license, that person's compensation must be subjected to the limit. However, if a person does not have a license, but is performing the job functions and work activity of an administrator, that individual's compensation must also be included in the amount subjected to the limit. Inclusion of an individual's compensation in the total amount subjected to the limit is not only based on the individual having a license; it is also based on the job functions and work activity. Compensation paid by a related party or central office and charged directly to the nursing facility for individuals performing these activities must be included in the individual nursing facility compensation amount subjected to the limit.

The compensation limit schedule does not apply to the salary of owners employed in capacities other than administration of the nursing facility provider's operation. The allowable salary level of an owner employed in a non-administration position cannot exceed the market value salary for that position, e.g., director of nursing, social services director. The allowable salary level must be commensurate with the amount of time the owner spends working in the non-administration position. If the owner also participates in facility administration, the portion of the payroll costs attributed to the administrative work must be included in the owner/administrator salary compensation and subject to the appropriate salary limits. The individual's administrative work must be appropriately documented with a position description and job responsibilities, and the allowable salary level for the administrative work must not exceed salary levels for similar administrative positions.

8.17.B. Compensation Limit for Owner and/or Administrator Serving Multiple Nursing Facilities

Where an individual is involved in the administration of more than one nursing facility, the maximum compensation allowed for allocation per facility and the allowable facility compensation is computed as follows:

- Total the number of beds, as defined in the individual nursing facility section, in all facilities served by the owner and/or administrator.
- Determine the appropriate compensation limit from the published schedule for the total number of beds.
- Compare the appropriate compensation limit with the actual allowable total salary and fringe benefits paid to the individual. The compensation limit is expressed as an annual amount (12 months time period) and applicable to a full time position defined as a minimum of 40 hours per week committed to nursing home related management and administrative activity. Adequate work activity records must be available for verification of time expended for nursing facility related activity. Time commitment for less than full time requires the compensation limit be prorated to reflect the portion of time committed to this activity. Example, if 30 hours per week during an annual period is attributed to this activity, the adjusted limit for the individual is 75 percent of the appropriate compensation limit.
- The lesser of total allowable compensation or the compensation limit per the schedule is then allocated to all the facilities served by the owner and/or administrator based on a ratio of the number of beds in the individual facility to the total number of beds in all facilities served. The hours directly devoted to individual homes may be used as the allocation basis if verified by auditable records.
- Combine the allocated owner and/ or administrator compensation with the allowable compensation of the facility's administrator/assistant administrator/co-administrator.
- Compare the combined compensation amount to the compensation limit schedule maximum allowable for the number of beds for that particular sized facility. The lesser of the facility's combined compensation or the facility's compensation limit is the allowable compensation to be used in the determination of allowable cost related to resident care.

The following illustrates an example of the allowable owner/administration compensation limit application for a group of four facilities of varying sizes with a total of 330 beds, and the allowable facility compensation. The owner and/or administrator total compensation is $225,000 for full time nursing facility related activity for a cost reporting period ending December 31, 2003. The compensation is $48,914 greater than the limit ($225,000 minus $176,086 equals $48,914).

Total number of beds in all facilities served	330
Compensation Cost Limit for 150+ bed facility as of 12/31/2003	$176,086
Owner and/or Administrator Total Compensation	$225,000
Amount allowed for allocation to individual facilities (lesser of bed size limit or actual compensation	$176,086
Amount of compensation not allowed	$48,914

Nursing Facility Bed Sizes	1-49 Beds	50-99 Beds	100-149 Beds	150+ Beds
Facility Compensation Limit 12/31/2003	$58,696	$97,826	$117,393	$176,086
Example Facilities	Facility 1	Facility 2	Facility 3	Facility 4
Total Facility Beds	40	70	100	120
Allocation of Owner and/or Administrator Compensation[1]	$17,609	$30,815	$44,021	$83,641
Compensation of Facility Administrator	$35,000	$75,000	$85,000	$100,000
Facility Total Compensation to be compared to Limit[2]	$52,609	$105,815	$129,021	$183,641
Disallowed Compensation per Facility	$0	$7,989	$11,628	$7,555

[1] The percentage of the facility's beds of the total across all four facilities is multiplied by the compensation limit, e.g., 40/330 x $176,086.
[2] Total compensation equals the sum of the allocation amount and the individual nursing facility administrator compensation.

8.17.C. Compensation Limitation For Home Office Executive/Management

Salary and wages, fringe benefits and other related compensation costs for home office executive and management staff are included in the provider's home office cost report and costs are allocated to the individual nursing homes and other business activities conducted by the organization. The allocation of the compensation costs is made to the operating entities of the corporation through the home office cost statement and these

costs are not included in the limit imposed on the individual nursing facility owner/administrator compensation.

The compensation limit for high-level management employees at the corporate home office level is enhanced to acknowledge increased scope of the business activity and corporate responsibility. The enhanced compensation limit is applicable in chain organization or related party management services situations where home office cost statement reporting exists, and full management oversight and administrative services are being provided to the nursing facilities and other business activities of the organization. Compensation costs for corporate office individuals under the enhanced compensation limit must be documented by a current position description, employment contract or other verifiable documentation that adequately defines the position, duties and responsibilities for the individual and demonstrates the presence of services provided to the organization. Compensation to an individual employee of the corporate or central office regardless of employment position or job activity function is subjected to the enhanced compensation limit to determine allowable cost. The enhanced compensation limit is expressed as an annual amount (12 month time period) and is applicable to a full time position.

Employees paid by the corporate or central office but charged directly to the individual nursing facility for administrator or assistant administrator work functions at that facility are not eligible for the enhanced compensation limit. Allowable cost limits for such employees are addressed under individual nursing facility compensation limit.

The enhanced Medicaid allowable compensation for individual corporate office official and executive management employee personnel is applicable only to organizations greater than 150 beds. The enhanced compensation limit is based on the total number of beds owned and operated by and under full management control of the corporate organization and determined in accordance with the following schedule:

Number of beds in the chain organization	Enhanced compensation limit
151 to 500 beds	100% of the 150+ bed facility limit
501 to 1000 beds	120% of the 150+ bed facility limit
1001 to 2000 beds	130% of the 150+ bed facility limit
Over 2000 beds	150% of the 150+ bed facility limit

The total number of beds includes all types of nursing home, home for the aged, hospital services, resident and other housing arrangement beds. If the business activity for the beds is not included in the allocation of the home office costs, the beds must not be counted for determining the number of beds in the chain organization. The 150+ bed facility limit used to determine the enhanced compensation limit amount is the MDCH published limit for the year end corresponding to the reporting time period end date of the home office cost statement.

8.18 Oxygen

Medicaid coverage of oxygen services for residents in nursing facilities is addressed in the Medicaid Services Descriptions Section of the Nursing Facilities Coverages and Limitations Chapter. The costs of oxygen gas, equipment, and supplies for intermittent and infrequent use are allowable in the routine nursing care cost and are included in the per diem reimbursement rate. Oxygen equipment rental costs for a limited time period for purposes of providing this service is allowable in accordance with the incidental rental cost provisions addressed in the Lease Cost subsection of this chapter.

The costs of oxygen related services for frequent or prolonged use by individual nursing facility residents, regardless of payer source, is an ancillary services cost and is not an allowable routine nursing care cost. These costs must be separately identified in the facility's accounting records or adequately compiled and verifiable for audit, and excluded from Medicaid cost report routine nursing care unit cost.

8.19 Patient Transportation

The Transportation Section of the Nursing Facility Coverages and Limitations Chapter addresses the nursing facility's responsibility to arrange or provide for non-emergency patient transportation. The cost for this transportation is a routine nursing care cost included in the nursing facility annual cost report and any reimbursement for the services is included in the routine nursing care per diem rate. Patient transportation costs are classified as support costs for Medicaid cost reporting.

The nursing facility is encouraged to utilize an efficient and cost effective mode of transportation for resident care, which may include utilizing a facility owned vehicle or contracted outside service. Costs relating to the nursing facility vehicle operation are addressed under the Facility Vehicles and Capital Asset Cost subsections of this chapter.

Cost incurred for contracted outside service for patient transportation must be included in the Medicaid cost reporting under the following reporting procedures:

- Administration and General Transportation – when the expense is not directly identified for specific residents or the care unit in which the resident resides in the facility, or
- Routine Nursing Care, Miscellaneous Support Cost
  - when there is only one routine nursing care unit in the facility and all resident transportation is for residents in that unit, or
  - when there are multiple nursing or residential care units in the facility, and the expense is directly identified by individual resident and location unit where the individual resides in the facility. Costs classified in item b) must be to the corresponding nursing unit cost center identified in the Medicaid cost report.

8.20 Personal Comfort Items

The costs of services and items that do not contribute primarily to the resident's treatment of an illness or the resident's ability to function are not allowable. Direct costs, and the appropriate share of indirect costs, relating to such items as telephones, televisions, radios that are located in the patient's accommodations and furnished solely for the personal comfort of the resident are not allowable. The cost of television and radio services furnished to residents generally are allowable if furnished in common use areas of the facility such as day rooms, recreation rooms or similar purpose area of the facility for the common benefit of facility residents. The cost of nurse-patient communications system that has no capability other than nurse and patient communication is allowable.

The costs of systems, including nurse-patient communications, television and telephone services, and similar items, may have the capability of providing residents with outside entertainment and providing nurse-patient communications. Only the cost of the component for nurse-patient communication is allowable routine nursing care. Direct distinction of cost related to the nurse-patient communication must be made for proper cost reporting, or an appropriate allocation must be established for Medicaid approval for the purpose of identifying the patient related and personal comfort related cost portions of combined systems.

8.21 Private Duty Nurses

Costs for nursing staff services provided by or under the supervision of a registered professional nurse is allowable, however, the cost of services of a private-duty nurse or other private-duty attendant are not allowable routine nursing care. Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient under arrangement between the patient and the private-duty nurse or attendant.

A patient, or someone acting on their behalf, may arrange and pay for a private-duty nurse, or the nursing facility that initially incurs the requested costs may look to the patient for payment of the non-covered nursing facility service. Where the nursing facility acts on behalf of the resident, the services of the private-duty nurse or other attendant(s) under this arrangement are not allowable routine nursing care services regardless of the payment process to the private duty or other personnel or the control which the nursing facility may exercise with respect to the services rendered by the private-duty nurse or attendant.

8.22 Provider Donations for Outstationed State Staff

Provider donations for administrative costs and incidental costs (workspace and telephone), incurred by the provider for outstationed staff are allowable costs. Costs are allowable to the amount contractually determined with the State.

8.23 Purchase Discounts

All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

Purchase discounts have been classified as cash, trade, or quantity. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required.

As with discounts, allowances and rebates received from purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. In addition, late charges on purchases are not an allowable expense. These would be in addition to regular costs authorized.

8.24 Rebates Larger than One Year's Expense and Extraordinary Expense

Normal refund or rebate amounts are reported as a reduction offset to current operating costs in accordance with federal Principles of Reimbursement. A refund or rebate amount of previous years' allowable expenses must not be reported in total in the current fiscal year-end cost report where the refund or rebate amount pertains to more than one prior year reported expense. Likewise, extraordinary expense pertaining to more than one prior year must not be reported in total in the current fiscal year-end cost report. Refund or rebate and the extraordinary expense amounts pertaining to more than one prior year must be equally spread over as many subsequent years as the number of years represented by the refund or rebate or the extraordinary expense amount not to exceed three years. In the instance of a sale, the selling provider must include 100 percent of the remaining rebate balance in the final cost report. The apportionment will start in the cost-reporting year in which the refund amount is received or the extraordinary expense is discovered. These provisions are limited to Medicaid cost reporting requirements and do not change the applicable accounting principles for financial reporting.

8.25 Research Activities

The cost of research activities is allowable in accordance with Medicare Principles. If research is conducted in conjunction with and as a part of the care of residents, the costs of usual resident care are allowable to the extent that such costs are not met by funds provided for the research.

8.26 Routine Nursing Services

A provider's costs associated with the provision of necessary medical, nursing and mental health services, within the provisions of Medicare Principles of Reimbursement and requirements specified in the Coverages and Limitations chapter of this manual, are allowable expenses. This includes costs incurred for meeting state federal requirements associated with specialized mental health rehabilitation services, e.g., monitoring the necessity for Annual Resident Reviews and coordinating or providing required services. The medical supply costs associated with routine nursing services and reimbursed by Medicare Part B are not allowable routine costs for Medicaid if the provider is reimbursed by Medicare.

8.27 Sick Leave

The reasonable cost of sick leave taken (or payment in lieu of sick leave taken) by an employee is recognized as a fringe benefit and is included in allowable costs in the cost reporting period when paid. If the sick leave is vested and refunded, contributions to the fund are allowed under applicable provisions of the Medicare Principles. However, where the nursing facility provider's sick pay plan grants employees

the right to demand cash payment for unused sick leave at the end of each year, the pertinent accruals are includable, without funding, in the cost reporting period when earned.

8.28 Taxes and Fees

Taxes, including employee payroll taxes, sales taxes, and state imposed sales and use taxes, are allowable variable costs. The Michigan Single Business Tax is an allowable variable support cost.

8.28.A. General Taxes

Real and personal property taxes are allowable plant costs.

8.28.B. Quality Assurance Assessment Tax

A nursing facility's Quality Assurance Assessment Tax is an allowable cost and must be reported in the nursing facility Medicaid annual cost report. The tax must be reported on the provider's cost report as assessed and accounted for on the accrual basis. The Quality Assurance Assessment Tax cost is adjusted through the cost reporting process to be segregated from use in rate setting.

8.28.C. Fees and Assessments

Costs incurred for late payments, or for violation of federal, state, or local laws are not allowable.

8.29 Therapy and Pathology Services

A nursing facility provider must establish accounting procedures to reflect individual cost centers for reimbursable ancillary services, including physical therapy, occupational therapy, speech pathology and other services not classified as routine nursing care. Whether the therapist/pathologist is salaried, under contract, or an independent provider, a nursing facility provider must record Medicaid program payments as income and all expenditures for therapist/pathologist supportive personnel, equipment and its maintenance, supplies, and other costs directly attributable to rendering services in these cost centers.

The service is considered ancillary if the complexity of the service prescribed for the resident is such that it can be performed safely and/or effectively only under the general supervision of skilled rehabilitation personnel. Ancillary therapy services are evidenced by the presence of the following conditions:

- A written physician order.
- The skills of a qualified technical or professional health personnel such as physical therapists, occupational therapists, speech pathologists or audiologists are required.
- Services are provided directly by, or under the general supervision of, the skilled personnel to assure the safety of the patient and to achieve medically desired results. General supervision requires that initial direction and periodic inspection of the actual activity is necessary.
- Services are rendered as part of an active treatment for a specific condition that has resulted in a loss or restriction of mobility or function.

Therapy services considered routine nursing care are services rendered under circumstances where the general supervision of exercises, which have been taught to the patient, can be performed repetitiously without skilled rehabilitation personnel. This includes maintenance programs where the performances of repetitive exercises, which may be required to maintain functions, do not require the involvement and services of skilled rehabilitation personnel, but may require the assistance of a trained nurse aide. Routine nursing care may include repetitive exercises to improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.

The cost of the development of the maintenance plan when prepared by a licensed therapist is allowable. A Provider must maintain documentation, which includes the amount of time required by the therapist to develop the maintenance plan. Medicaid considers maintenance plan development as routine nursing care included in the per diem rate.

Depreciation for equipment and facility space assigned to these services must be included as an expense in the ancillary cost centers and computed in accordance with Medicaid guidelines for allowable depreciation. A uniform charge structure must be applied to the entire facility population receiving the services.

SECTION 9 - COST CLASSIFICATIONS AND COST FINDING

Medicaid-enrolled providers must develop and adopt a uniform Chart of Accounts that meet the minimum requirements established by Medicaid for classifying and reporting costs incurred in providing care to nursing facility residents. A nursing facility's accounting system will normally include more detailed accounts for recording facility costs. However, for cost reporting purposes, the detailed accounts are compiled into aggregate cost classification centers in accordance with program policies.

The following cost descriptions are guidelines to provide consistency in nursing facility provider cost reporting. Reimbursement classifications are identified for individual cost elements in Attachment B of this chapter. More detailed discussions of cost categories are in the Allowable and Non-Allowable Costs section of this chapter.

9.1 NURSING FACILITY BED DAYS AND RESIDENT OCCUPANCY

A provider must report nursing facility bed days and resident occupancy statistics in the annual cost report. Policy related to facility census is presented in the Definitions section of this chapter. Specific attention should be directed to the following definitions: available bed, available bed days, ban on admissions, census, census day, denial of payment for new admissions, hold a bed day, leave day – hospital, leave day – therapeutic, occupancy, occupancy rate, per resident day cost, resident, resident days/occupancy, therapeutic leave day.

The nursing facility's resident occupancy statistics and cost reporting requirements will be significantly affected in cases where the provider requests, and is granted, approval for designating non-available beds as outlined in the Non-Available Beds subsection of this chapter.

9.2 VARIABLE COSTS – BASE AND SUPPORT

Variable costs include the total allowable base and support costs in a facility's routine nursing service units. A provider must allocate variable costs (support or base) depending on the activity for which the cost was incurred. The provider must also report direct costs for ancillary service costs and other non-reimbursable service costs. The direct costs incurred or attributed to these activities will not specifically be identified as base or support costs, however the cost report cost finding process will allocate general services cost activities as base or support cost depending on the activity for which the cost was incurred.

9.2.A. BASE COSTS

Base costs cover activities associated with direct patient care. Major activities under these categories are payroll and payroll-related costs for departments of nursing, nursing administration, dietary, laundry, diversional therapy and social services, food, linen (excluding mattress and mattress support unit), workers compensation, utility costs, consultant costs from related party organizations for services relating to base cost activity, nursing pool agency contract service for direct patient care nursing staff, and medical and nursing supply costs included in the base cost departments.

9.2.B. Support Costs

Support costs cover allowable activities not associated with direct patient care. Major items under these categories are payroll and payroll-related costs for the departments of housekeeping, maintenance of plant operations, medical records, medical director, and administration, administrative costs, all consultant costs not specifically identified as base, all equipment maintenance and repair costs, purchased services, and contract labor not specified as base costs. Contract services costs for these departments are also support costs.

9.2.C. Base/Support Costs – Payroll Related

Nursing facility expenses related to payroll taxes and employee health and welfare are classified as base/support costs. These costs include fringe benefits such as employer contributions to FICA, FUTA, MESC, employee life and health insurance, retirement, physicals and all other insurance provided to employees as fringe benefits. If a nursing facility's accounting records do not separately reflect the payroll taxes and employee health and welfare expenses for "base" and "support" personnel by cost center identification, the total amount of these costs must be reported in the appropriate 'base/support' cost category. Workers compensation is a base cost and not divided between base and support.

If the nursing facility's accounting system allows the allocation of costs to specific personnel or activities, the specified costs must be used on the cost report. If the nursing facility accounting system does not allow for this specificity, then a reclassification of costs must be made to the appropriate service areas. In these cases it will be necessary to reclassify such costs on the basis of salary and wage costs distribution.

9.2.D. Base/Support Costs – Contract Services for Direct Patient Care

A provider that purchases direct care services as an alternative to employing personnel may apportion the contract services costs between base and support cost by applying the industry-wide average base-to-variable cost ratio. The nursing facility must appropriately report these costs in the annual cost report. Medicaid reviews the industry-wide average base-to variable cost ratio annually and revises it if a difference of 2 percent or greater exists between the current calendar year cost report aggregate average industry data and the previously promulgated industry-wide base-to-variable cost ratio. If a revision is applicable, the revised cost ratio will be effective for subsequent year cost reporting.

9.3 Plant Costs

Plant costs include depreciation, interest expense (either working capital or capital indebtedness), real estate and personal property taxes, amortization costs associated with loan financing costs (amortization of legal fees, recording fees or other fees relating to the capital asset acquisition points, letters of credit), and specific lease expenses.

9.4 Capital Asset Expenditure

Medicaid limitations on capital expenditure costs are determined in accordance with Medicare Principles except as modified by Medicaid policy.

A nursing facility provider anticipating capital expenditures should contact the CON Health Facilities Evaluation Section to make application for a CON. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

If a CON is approved, the provider may be eligible for increased reimbursement, subject to Plant Cost Component limits. If a new capital expenditure required CON review and was denied, the provider's reimbursement rate must exclude the costs of the denied capital expenditure. The provider's cost report must identify capital expenditures approved and denied by CON.

The nursing facility must have written policies and procedures that establish dollar level thresholds beyond which an asset acquisition is considered a capital asset. Medicaid sets the thresholds at having an estimated useful life of at least two years and a historical cost of at least $5,000. The nursing facility capital asset policy may have lower dollar level threshold than the Medicaid limit, but may not have a higher limit. The provider must follow its established policy for cost reporting when its capitalization policy sets lower thresholds than Medicaid.

Assets that are acquired as part of an integrated system must be considered as a single asset for capitalization purposes. Assets that have a stand-alone functional capability may be considered on a single item basis. Individual asset items that do not meet the dollar and useful life threshold are classified as minor equipment and will be reported as minor equipment expense in the cost report of the year of acquisition.

Example: An office workspace with connecting portions dependent upon other portions for support and stability; a communication system installed in the facility and in resident rooms to allow the full functioning of two-way communication system.

Repair and improvement costs related to assets that results in extending useful life or increased productivity must be capitalized for Medicaid if they are capitalized under Generally Accepted Accounting Principles. Providers must demonstrate consistency in financial reporting.

Providers must follow Generally Accepted Accounting Principles (GAAP) in reporting repairs to capital assets. Repairs that should be capitalized under GAAP must not be an expense item on the cost report.

9.4.A. Capital Asset Cost Data for Class I Facilities

9.4.A.1. Capitalized Asset Acquisition Costs

Capitalized asset acquisition costs are used to determine the Current Asset Value for the Plant Cost Component in the Class I nursing facility reimbursement rate. The Medicare Principles of Reimbursement are used to determine the acquisition costs allowable to the original provider/owner of the asset. The SMA uses only the acquisition cost incurred by the original owner to determine the capital asset value cost data. Asset acquisition costs are allowed for related party transactions in accordance with Medicare's interpretation for costs to related organizations.

The cost basis for capital assets is the CAV value determination of the original owner's audited historical acquisition cost. It is the responsibility of the current owner to provide the audited historical cost and purchase year of the original owner; otherwise, the assets are assumed obsolete for payment determination purposes, i.e., of no current asset value. The current provider must annually report the cost and the applicable year's depreciation for newly purchased assets and value changes to previously acquired assets. Cost reporting for asset acquisition costs related to a capital asset that is traded-in for a new replacement item must also report the value of the capital assets.

Capital costs related to assets that are no longer used in the facility operation and assets that are not necessary for resident care, e.g., excessive land not allowed under the Principles, are not allowable in the nursing facility capital asset value cost data.

To ensure that Medicaid does not pay for assets that are no longer being used to provide resident care, the original acquisition costs, or an estimate thereof, is removed from the current capital asset cost data. The costs of retirement or replacement of buildings, building improvements, building additions, fixed building equipment, land improvements, or movable equipment is removed from the capital asset cost data for the corresponding year of the original acquisition of that retired or replaced asset.

When the original value can be ascertained through such methods as component part depreciation records, the provider must remove the original costs of the retired or replaced assets from the year of the original acquisition, and report the new asset item cost for the year purchased.

Building components, building services equipment or other fixed equipment assets or land improvements may have historically been included within the asset price of the building to which they are attached, and as a result, are not separable for purposes of calculating depreciation or the capital asset cost data. However, in the determination of the Current Asset Value, an asset must exist in the nursing facility for it to have a value. Therefore, if a fixed asset has been retired or replaced and the asset cost cannot be determined from the provider's Medicaid/Medicare asset cost schedule, construction records, or tax records, the provider must determine and report the original asset cost based on the cost of a similar asset.

If a nursing facility provider is unable to report the original asset cost by either individual asset cost or component basis, the new asset will be assumed as a replacement of a similar asset for determining the necessary revisions to the capital asset cost data using the asset trade-in provisions.

When a capital asset is traded-in for a new replacement item, either the original owner's cost or a derived value of the item traded in is removed from the capital asset cost data. The purchase price of the new asset, prior to consideration of the value of any trade-in, is added into the capital asset cost data for the current year of purchase. If the original cost of the item is unknown, the provider must derive a value by backdating the purchase price amount for the new replacement asset. If the asset being replaced is of a different quality or type than the new asset, the amount to be backdated may be based on the expected current cost of a similar asset of like quality and type. The derived value calculation is made by applying the annual Marshall Valuation Services Book of Comparative Cost Multipliers (exclusive of the annual obsolescence adjustment) to the

value of the new asset item cost, then subtracting the derived value from the previous capital asset cost data historical cost for that original acquisition year. An electronic copy of the annual economic index compilation and reference to Marshall Valuation data, and the derived application process used for nursing facility cost reporting can be accessed on the MDCH website at www.michigan.gov/mdch.

Capital assets that are leased or rented are treated as obsolete assets for rate determination purposes when the underlying historical acquisition cost to the original owner has not been disclosed, or when the underlying information cannot be verified through audit.

Capital assets recorded in the central office, home office, or related organization financial records, that are identifiable to a specific nursing facility, are included in that facility's capital asset cost data determination process. The asset values, interest, and property taxes identified with these assets must be charged directly to the nursing facility and will be reimbursed in accordance with the applicable policy.

Costs of capital assets associated with the operation of related organizations are not included in the capital asset cost data determination for a specific nursing facility. The plant and variable costs of such organizations are treated as purchased services. (Refer to the Variable Costs – Base and Support subsections for discussion regarding purchase and contract services.)

9.4.A.2. EXCEPTIONS TO ASSET ACQUISITION COST CAPITALIZATION

Exceptions to the acquisition cost basis for assets may be allowed in the following situations:

- For the occasional purchase of used, movable equipment for ongoing nursing facility operations when the purchase is not related to a change in facility ownership. For the purchase of used replacement equipment, e.g., re-manufactured beds, a used lawn tractor, or used vehicles, the asset acquisition is treated as if new items were purchased. The allowable cost of acquisition is included in the year the asset is put into service by the current purchaser.
- For the nursing facility land value. The land value to be included in the Current Asset Value is based on the current owner's allowable acquisition cost determined in accordance with Medicare Principles, and not to exceed the amount reported to the Internal Revenue Service for federal tax purposes. The cost of the prior owner's land improvement asset, which are an integral part of the nursing facility land component, and are included in the new or current owner's land acquisition cost, must be excluded from the historical capital asset cost data. The current facility ownership capital asset cost data cannot include both the land purchase price and the original owner's land improvement cost data.
- When equipment is purchased as "used" equipment as part of a facility change of ownership, or only a change of ownership of the facility equipment has occurred, the prior owner's (seller) computation of value at the time of sale is continued to the new owner.

9.4.B. Capital Asset Categories (Fixed Assets)

Capital asset classifications and asset useful life for depreciation purposes are determined in accordance with the American Hospital Association (AHA) guidelines in effect at the time of the asset acquisition.

General descriptions of the asset cost categories for cost reporting are:

Land – includes the land owned and used in the provider operations and includes off-site sewer and water lines, public utility costs necessary to service the land, government assessments for street paving and sewers, cost of permanent roadways and grading of a non-depreciable nature, cost of curbs and sidewalks where the replacement is not the responsibility of the nursing facility, and other land expenditure of a non-depreciable nature.

Land Improvement – improvements of a depreciable nature including paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. where replacement is the responsibility of the nursing facility.

Building – includes the basic building structure, shell or frame, and additions thereto, building components, exterior walls, interior framing, walls, floors and ceiling, architectural, consulting, and interest expense associated with new construction or acquisition.

Building Improvement – includes building equipment attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating and air conditioning systems, etc. The general characteristics of fixed equipment are: (a) attachment or installed to the building structure, and (b) fairly long life but may be less than the building.

Leasehold Improvement – includes betterments and additions made by the lessee to the leased property, whereby the improvements become the property of the lessor after expiration of the lease. These items generally meet the requirements of building improvement assets.

Department Equipment – includes assets generally assigned to a specific department within the nursing facility with relatively fixed location but capable of being moved; as distinguished from building equipment. (Refer to Building Improvement)

Furniture and Fixtures – includes assets similar in characteristic to department equipment, however normally with no fixed location, or used by various departments within the facility.

Transportation Equipment – includes vehicles used in conducting of nursing facility operations relative to resident transportation, plant operations and maintenance, or general means of transport.

Capital asset costs incurred by a landlord that is leasing facility assets to a provider must be disclosed and reported in the provider's annual cost report. Capital asset cost reporting and allowable cost policies are applicable to the reporting of the leased assets in the same manner as if the assets were owned by the provider**.**

9.4.C. Depreciation

Class I and Class II nursing facilities are under the tenure plant cost reimbursement methodology and potential reimbursement is not based on depreciation expense for the nursing facility capital assets. The costs of services provided from home office or related party transactions, other than for capital assets related to the nursing facility physical plant, may include depreciation expense for asset costs applicable to the operations of the home office or related party business. Allowable depreciation costs for the home office or related party will be determined in accordance with Medicare Principles. These costs will be included in the home office or related party administrative services space costs and must be reported in accordance with Medicaid policy identified in the Related or Chain Organization Cost Allocations subsection of this chapter. Class III and Class IV nursing facilities reimbursed under the depreciation plant cost reimbursement methodology will have depreciation cost determined in accordance with allowable cost principles defined in this policy. The allowance for depreciation is determined in accordance with Medicare Principles except that only the straight-line method of depreciation may be used. The historical asset cost basis and the depreciation basis for nursing facility sales is subject to the limitation on the valuation of assets mandated by the Medicare Principles.

In addition to the depreciation standards in the Medicare Principles, Medicaid also requires adherence to the following standards:

- Consistent use of either component or composite asset depreciation schedules. Component depreciation is permitted in the case of a newly constructed facility and for recognized building improvements where the costs can be separated and acceptable useful lives determined. Composite depreciation must be used in the case of a newly purchased, existing facility.
- All abandonment losses are considered as a depreciation expense item.

9.4.D. Disposal of Depreciable Assets

9.4.D.1. Class I Nursing Facilities

Class I nursing facilities will account for asset acquisition and disposal in accordance with the Capital Asset Cost Data for Class I Facilities subsection of this chapter.

A Class I nursing facility purchased on or after March 31, 1985 is not subject to depreciation adjustment. In the event of a sale, the assets of Class I Providers whose ownership began prior to March 31, 1985, amounts included in the Medicaid per diem rate as an explicit depreciation expense item are subject to recapture in the event of a gain on the disposal of assets. The selling Provider must complete Medicaid Program Depreciation Recapture reporting schedules along with the applicable fiscal year cost report. Refer to the Cost Report Reimbursement Settlement, Depreciation Recapture Reimbursement Adjustment subsection of this chapter for additional information.

9.4.D.2. CLASS III NURSING FACILITIES

Class III providers whose Medicaid rate includes depreciation expense must adhere to the Medicare Principles of Reimbursement to account for the disposal of depreciable assets. If the disposal of depreciable assets in the reporting year results in a gain or aggregate loss below $5,000, the adjustment will be made in the nursing facility provider's current year cost reporting allowable cost. The allowable gain is limited to the amount of depreciation previously included in the provider's allowable costs for the disposed assets.

In the event of a sale of the entire nursing facility and the termination of Provider participation in the Medicaid program, the terminating Provider must complete Medicaid Program Depreciation Recapture reporting schedules along with the applicable fiscal period cost report. Refer to the Cost Report Reimbursement Settlement, Depreciation Recapture Reimbursement Adjustment section of this chapter for additional information.

9.5 LOANS/BORROWINGS BALANCE REPORTING

Necessary and proper interest on current and capital debt is a Medicaid allowable cost. All interest expense, whether on current or long term debt, is classified as a plant cost. Determination of allowable interest expense will be in accordance with Medicare allowable cost principles. However, there are reimbursement limits for determining the Plant Cost Component specific to Medicaid, which are addressed in Rate Determination section of this Chapter.

Medicaid requires nursing facilities to report the loans and borrowings balance in the annual cost report. The cost report instructions identify the schedules that must be used to report borrowing principle balances. The nursing facility must report the beginning balance and monthly end balance of outstanding allowable loans and borrowings for the time period corresponding to the cost report year. The loans and borrowings in the borrowing balance report must only include the outstanding loans or other liability obligations for which the nursing facility is claiming interest expense related to that borrowing principle. If the nursing facility is filing a cost report claim for interest expense as an allowable cost, the nursing facility must document the corresponding borrowing obligation related to the interest expense. The outstanding borrowing balance is defined as the allowable borrowing principle amount on which the interest rate, normally expressed as an "interest rate percentage", is applied for the purpose of calculating the interest expense applicable to the specific cost report time period.

Loans from related parties or unallowable borrowings must be excluded from the cost report borrowing balance schedule. The interest incurred on excluded borrowings must be removed from incurred interest costs in a like manner. Interest income or investment income which is required to be offset to interest expense in the cost report period must not to be considered a reduction in the outstanding borrowing balance principle.

Mortgage principle balances or similar finance arrangements for the purpose of nursing facility or business acquisition must be separately identified from other loan balances in the cost report borrowing balance schedule. Examples of other loan balances include working capital and miscellaneous asset acquisition purpose loans. In the event of refinancing and co-mingling of separate loan balances into a single finance arrangement, the nursing facility must identify the appropriate portions of the combined financed amount used for different purposes, and maintain the separation for cost reporting. Likewise, multiple loans for the same purpose must be combined for the appropriate category for cost reporting.

Borrowing principle obligations incurred by a home office must be reported on the individual nursing facility cost report borrowing balance worksheet only for loans directly associated with financing the individual nursing facility asset purchases or facility acquisition costs. The interest expense applicable to such loans must also be identified, directly charged to the individual nursing facility, and reported as interest expense for the nursing facility. Working capital and other loans incurred directly under the home office operation and not related to nursing facility acquisition are considered general administrative costs and are included, to the extent determined necessary and reasonable, in the home office cost allocation to the individual nursing facilities and other business operations of the corporate chain.

Allowable outstanding loan balances of landlord entities that are leasing nursing home facility assets to a provider must be disclosed and reported in the provider's annual cost report. Borrowings balance cost reporting and allowable cost policies are applicable to the reporting of the underlying cost of the landlord entity in the same manner had the borrowings been recorded on the financial records of the provider.

9.6 Cost Finding

Cost finding is the process of recasting the data from the accounts kept by a provider to determine the cost of services rendered, allocating direct costs, and prorating indirect costs in accordance with Medicare Principles of Reimbursement, except where modified by Medicaid policy. Medicaid determines reimbursement rates for nursing facility providers based on specific categories of cost, as addressed in other sections of this chapter.

9.6.A. Cost Allocation Basis

The Medicaid cost reporting process establishes the cost finding process. Indirect and non-revenue producing cost centers are allocated using a statistical basis that reflects an equitable measurement of the services provided to, or benefits derived by, a revenue producing or non-reimbursable activity. The nursing facility must develop and maintain adequate statistical data to corroborate the basis of the cost allocation. Adequacy requires that the data be accurate and include sufficient detail to accomplish the purpose for which it is intended. When completing the allocation of the general service cost centers, the nursing facility provider should first allocate those cost centers that render the most services to, and receive the least services from, other cost centers.

9.6.A.1. Facility Square Footage and Space Reporting

A facility space cost allocation is based on square footage identified with specific service areas or activities occupying and using that space. Square footage is an allocation base that may be applicable for multiple indirect cost center activities. However, for cost centers where the basis is the same (e.g., square feet), the total statistical basis over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been allocated.

A consistent and uniform process must be used by the nursing facility for compiling and charging the square footage to each service activity that is primarily benefiting from or using that space. Facility space that is used for multiple activities must be documented and connected to each applicable activity based upon current data that reflects actual use and is available for audit verification. Hallway space located within a specific department or service area is considered usable space for that department. Areas of the

facility for general use, such as connecting hallways, reception areas, lobby, and elevator, used or benefiting all service activities are considered common space. Identifying and counting common space must be consistent for all service areas of the facility.

For example, common space in one service department cannot be excluded from space allocated to that service activity, while similar common space located in other services departments is included in the space allocation of other services activities. The allocation basis must apply either the gross method, where all common area is included and charged to the specific services activity, or the net method, where common space located within the identified service area is not charged to the service activity. The nursing facility's handling of common space area in the cost report allocation must result in equitable distribution of costs associated with the common space to appropriate activities. A change in the process or methodology that the nursing facility uses for allocating space is a change in allocation basis, so appropriate notice and a request must be made to the SMA.

9.6.A.2. ANCILLARY/THERAPY SERVICES SPACE REPORTING

Facility space used for ancillary services delivery must be identified and charged to the appropriate ancillary services cost center. For example, space used for skilled rehabilitation services provided based on a physician's order must be allocated to the appropriate ancillary cost center.

Accounting procedures must be established and implemented to reflect individual cost centers for reimbursable therapy and pathology services. Irrespective of the therapist or pathologist's status as an employee, contractor or independent provider, the nursing facility must record all charges as income and all expenditures for supportive personnel, equipment and its maintenance, supplies and other costs directly attributable to reimbursable expenses in these cost centers.

9.6.A.3. ANCILLARY/THERAPY SERVICES ADMINISTRATIVE OVERHEAD

Medicaid requires that administrative overhead associated with ancillary services be allocated to the ancillary services cost center. The required basis for distribution of administrative costs to the benefiting activities of the nursing facility is accumulated costs. The accumulated costs base generally includes all services activities of the nursing facility.

In specific situations, the nursing facility may request exclusion of certain ancillary service groups from the administrative cost overhead allocation in the Medicaid cost report. The determination applies only to those service items where the billing to the third party only allows for the recovery of the direct cost of the service. The provider must demonstrate considerable inequity of the overhead cost allocation to these service activities that have been identified as excluded groups under the Medicare regulations and that it is not incurring additional costs beyond the activity for arranging for the services. The incidental costs for inclusion of the ancillary service bill preparation must be as follows:

- The facility representatives arrange for the services to be performed by an agency or entity that is not part of the nursing facility operation.
- The nursing facility is not directly involved in providing the ancillary service.
- The nursing facility does not incur any costs for supplies and equipment necessary to perform the service.
- The ancillary service is being recorded through the accounting records and billing system of the nursing facility for the consolidated billing of the services provided to the nursing facility resident.
- The nursing facility does not have physical space dedicated for the purpose of delivery or rendering of the ancillary service. Dedicated space is considered space that is used predominantly for the purpose of the ancillary service delivery.
- The nursing facility is not charging a mark-up related to the billing of the service.

If the nursing facility is allowed to bill for or recover revenue in excess of the direct cost of the services, the statistical and fiscal worksheet of the cost report may be adjusted to reflect the revenue received. The amount of revenue exceeding the direct cost will be considered the overhead amount that must be reflected as an adjustment to the "miscellaneous expense" in the Administrative and General cost center, in addition to the direct cost adjustment to exclude the ancillary service cost from the cost allocation step-down. The nursing facility must demonstrate that the excess revenue is a fair representation of the overhead cost or activity associated with providing the service. If this requirement is not met, the ancillary services activity must be included in the administrative cost allocation basis for the apportionment of overhead to the activity.

9.6.A.4. ANCILLARY GROUP EXCLUSION

A Provider may request an ancillary groups exclusion. The exclusion request must be approved by RARSS. The request must include the parameters under which the exception is requested. If the request is approved by RARSS and it is later determined non-applicable, the exclusion is void for that entire cost report period.

9.6.A.5. CHANGE OF OWNERSHIP – EXCLUSION REQUEST

If a CHOW occurs, the prior owner's ancillary group exclusion is no longer applicable. The new owner may submit an ancillary group exclusion request to RARSS for approval. The exclusion process is outlined in the Ancillary Group Exclusion subsection of this chapter.

9.6.B. CHANGE IN COST ALLOCATION BASIS

A provider who wishes to change the allocation basis for a particular cost center, or the order in which the cost centers are allocated, must submit a written request to the RARSS. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) The request must include reasonable justification and supporting documentation that the new basis is more accurate and appropriate for allocation of the cost activity for Medicaid reimbursement determination. The request must be made prior to the beginning of the cost-reporting period in which the change is to apply. The

effective date of the change will be the beginning of the cost-reporting period for which the request has been made. Failure to submit a timely written request will result in an audit adjustment. The nursing facility provider must maintain both prior and proposed statistics base data until the change is approved.

Medicaid may reject a submitted cost report if a request to change the allocation basis has not been submitted and approved by RARSS. If the previous allocation basis methodology has not been maintained for the current year, Medicaid may accept previous year's statistics for the current year cost reporting.

9.6.C. Related or Chain Organization Cost Allocations

The Medicare Principles of Reimbursement define a related organization as an organization linked to a nursing facility provider by common ownership or control, including a chain organization. An immediate family relationship establishes an irrefutable presumption of relatedness.

For Medicaid purposes, a chain organization consists of a group of two or more nursing facilities, or at least one nursing facility and any other business or entity owned or operated and controlled by one organization. To the extent that the home office furnishes services related to patient care to the nursing facility, the reasonable costs of the services are included in the nursing facility's cost report. Medicaid policy for related organization costs is determined in accordance with provisions in the federal Provider Reimbursement Manual for related organization costs. Exceptions to the application of federal provisions are addressed in the Cost Classification and Cost Finding and Allowable and Non-Allowable Costs sections of this chapter.

Home office costs apportioned to individual nursing facilities through the Home Office Cost Statement are classified as support costs. Cost report requirements for home office are addressed in the Cost Reporting section of this chapter.

Costs incurred by a nursing facility for services furnished by the related organization are allowable costs to the nursing facility at the level of cost to the related organization for the service provision. The cost allocated to the nursing facility cannot exceed the price of comparable services, facilities, or supplies that could be purchased in competitive market conditions. The principles of reimbursement applied for the determination of allowable cost to the nursing facility are also applicable in the determination of the allowable cost of the related organization. If a cost would be unallowable to the nursing facility, it would be unallowable to the related organization.

The operating costs of a related ownership organization are allocated to an individual nursing facility as a "purchased service" and must be identified within the appropriate cost center for Medicaid cost reporting. The type of service determines if the costs qualify to be apportioned between base and support cost using the industry-wide base and support cost percentages. If the service does not qualify to be apportioned by this method, the allocated costs are classified as support costs in the individual nursing facility. Refer to the Cost Classification and Cost Finding section of this chapter for additional information.

If the home office accounting period differs from the cost reporting period of the nursing facility, the allowable home office costs in the facility cost report must only include the costs allocated to the facility for the time period in which the completed home office cost statement coincides with the facility's cost report period. There may be a portion of the year where home office costs have not yet been determined or finalized. The facility must submit to RARSS a disclosure letter with it's cost report data stating that the cost report includes partial year home office costs. After the home office reporting period is completed, the nursing facility must amend it's cost report submitted to RARSS to include complete home office cost data. The cost report filed originally will be used for Program reimbursement actions until an amended cost report is filed. An accepted, amended cost report will be used for reimbursement determination actions for the same time period as the initial cost report. The nursing facility amended cost report must be submitted to RARSS within 3 months after the end of the home office or related party cost report year. Amended cost reports submitted after the 3 months filing requirement will be effective only on a prospective basis for the routine nursing care per diem rate determination. The Medicaid audit of the home office cost statement and related allocation to the nursing facility will be made in accordance with the final cost report filing data.

Example: The home office has an accounting year ending August 31; Nursing Facility A has a cost report year ending December 31; Nursing Facility B has a cost report year ending March 31.

Year 1

Home Office Cost Period and Amount	Facility A	Facility B
9/1/2003 – 8/31/2004 $204,000		
Allocation to chain provider facilities	$120,000	$84,000
Applicable to facility cost report year	12/31/2003 - 3/31/2004	
4 months 9/1/2003 – 12/31/2003	$40,000 (4/12)	
7 months 9/1/2003 – 3/31/2004		$49,000 (7/12)
Applicable to facility cost report year	12/31/2004 - 3/31/2005	
8 months 1/1/2004 – 8/31/2004	$80,000 - (8/12)	
5 months 4/1/2004 – 8/31/2004		$35,000 (5/12)

Year 2

Home Office Cost Period and Amount	Facility A	Facility B
9/1/2004 – 8/31/2005 $228,000		
Allocation to chain provider facilities	$132,000	$96,000
Applicable to facility cost report year	12/31/2004 - 3/31/2005	
4 months 9/1/2004 – 12/31/2004	$44,000 (4/12)	
7 months 9/1/2004 – 3/31/2005		$56,000 (7/12)
Applicable to facility cost report year	12/31/2005 - 3/31/2006	
8 months 1/1/2005 – 8/31/2005	$88,000 (8/12)	
5 months 4/1/2005 – 8/31/2005		$40,000 (5/12)

Year 3

Home Office Cost Period and Amount	Facility A	Facility B
9/1/2005 – 8/31/2006 $216,000		
Allocation to chain provider facilities	$126,000	$90,000
Applicable to facility cost report year	12/31/2005 - 3/31/2006	
4 months 9/1/2005 – 12/31/2005	$42,000 (4/12)	
7 months 9/1/2005 – 3/31/2006		$52,500 (7/12)
Applicable to facility cost report year	12/31/2006 - 3/31/2007	
8 months 1/1/2006 – 8/31/2006	$84,000 (8/12)	
5 months 4/1/2006 – 8/31/2006		$37,500 (5/12)

Individual Nursing Facility Cost Reporting	**Facility A**	**Facility B**
Amount reported in facility cost report initially filed for:	FYE 12/31/2004	FYE 3/31/2005
Home office cost year 8/31/2004	$80,000 (8 months)	$35,000 (5 months)
Amount reported in facility cost report amended for:	FYE 12/31/2004	FYE 3/31/2005
Home office cost year 8/31/2004	$80,000 (8 months)	$35,000 (5 months)
Home office cost year 8/31/2005	$44,000 (4 months)	$56,000 (7 months)
Total home office costs in cost report	$124,000	$91,000
Amount reported in facility cost report initially filed for:	FYE 12/31/2005	FYE 3/31/2006
Home office cost year 8/31/2005	$88,000 (8 months)	$40,000 (5 months)
Amount reported in facility cost report amended for:	FYE 12/31/2005	FYE 3/31/2006
Home office cost year 8/31/2005	$88,000 (8 months)	$40,000 (5 months)
Home office cost year 8/31/2006	$42,000 (4 months)	$52,500 (7 months)
Total home office costs in cost report	$130,000	$92,500
Amount reported in facility cost report initially filed for:	FYE 12/31/2006	FYE 3/31/2007
Home office cost year 8/31/2006	$84,000 (8 months)	$37,500 (5 months)

Individual nursing facility cost reports for 12/31/2006 and 3/31/2007 must be amended following completion of the home office cost reporting year 8/31/2007 to include the portion of that year costs in the nursing facility cost report.

9.7 Distinct Part Unit Reporting

For reimbursement purposes, the Nursing Facility is defined as the unit that is certified for participation in the Medicaid program, whether that unit comprises all of, or a distinct part of, a larger institution.

Certification regulations require that a distinct part be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. The provider must demonstrate to Medicaid that the system used for recording the hours of nursing services can be audited and equitably allocates the nursing services costs between the distinct part and other parts of the facility. The nursing services costs are only the gross salaries and wages of nursing and related personnel, such as RNs, LPNs, and CNAs. Costs applicable to general services areas of the institution must be allocated in accordance with the Cost Finding section of this chapter.

Nursing services costs allocated to that distinct part of the facility must relate only to services provided to those residents. While a provider may choose the record keeping method used to allocate these costs, the preferred system is time records identifying the time spent providing nursing care in the Medicaid distinct part and in other parts of the institution. Providers using the preferred method must obtain approval from the RARSS prior to changing its cost allocation method. The request must identify the reason for the change and must demonstrate that the proposed method is representative of actual nursing staffing within the facility and results in an equitable and accurate allocation of nursing services costs.

A nursing services cost allocation using an average cost per patient day may be used in the following situations:

- In the case of inadequate payroll record keeping.
- Facility failure to maintain assignment schedules or staffing reports.
- With prior permission from RARSS.

An institution may have more than one Medicaid distinct unit in specific cases where Medicaid has certified beds as special use for specialized nursing care. The specialized nursing care beds must be physically distinguishable, within a designated area, and identified as a separate nursing bed class for Medicaid reimbursement. Requirements for reporting nursing services costs also apply to nursing services for residents in specialized nursing care beds. The nursing facility must have prior approval from Medicaid for participation in a program for specialized nursing care.

9.8 Day Care Services provided in the Nursing Facility

According to federal regulations, day care services provided to an employee's dependent is not a fringe benefit when furnished for the convenience of the provider. Medicaid considers day care services provided to an employee's dependent a convenience to the provider due to potential support of staff recruitment and retention.

9.8.A. Employee Dependents

According to federal regulations, a nursing facility operating a day care center for the children of its employees and for employees of a related facility is classified as such an activity and must not be included in facility costs as an employee fringe benefit. The

costs are allowable to the extent that the amount is reasonable. "Reasonableness" means that the services are provided in accordance with regulations established for the provisions of such services and must take into account both direct and indirect costs of the services. The provision of services must also be considered reasonable in that the costs of operating a facility demonstrates sufficient benefits. For example, the number of children participating justifies the provision of services.

Total cost must not exceed what a prudent and cost conscious buyer pays for like services. If costs are determined to exceed such level and the nursing facility cannot provide clear evidence that the higher costs were unavoidable, the excess costs are not allowable. The day care center operations must be provided in accordance with, and satisfy applicable regulatory requirements, governing the operations of such activities. The nursing facility must maintain accounting records and documentation to demonstrate the total cost and utilization of day care services.

The following costs are non-allowable:

- diapers
- towelettes
- lotions
- oils
- similarly used hygiene products

9.8.B. Services Provided To Non-Employee Dependents

If a Provider renders services to non-employee dependents, the day care center must be established as a separate entity even if services are also provided to employee dependents. Medicaid will allow costs relative to intergenerational activities as an offset when the day care center suffers a financial loss. Intergenerational activities must be documented, organized activities between the children attending the day care and the nursing facility residents.

The nursing facility must maintain accounting records and documentation to demonstrate the total cost and utilization of day care services.

9.9 Nurse Aide Training and Competency Evaluation Program (NATCEP) and Competency Evaluation Program (CEP)

The Omnibus Budget Reconciliation Act (OBRA) of 1987 and 1990 requires that any nurse aide employed in a nursing facility complete a competency evaluation program. Medicaid will reimburse a Medicaid certified nursing facility for the Medicaid share of allowable costs directly related to meeting the nurse aide training and competency evaluation requirements. Reimbursement includes only costs incurred with a NATCEP or CEP approved by the State Survey Agency (SSA). Medicaid reimbursement applies only to Certified Nurse Assistants (CNA) working in a Medicaid certified nursing facility and are not available to CNAs in other residential or patient care settings.

A nurse aide who is employed by a nursing facility or who has received an offer of employment from a nursing facility on the date on which the nurse aide begins a NATCEP may not be charged for any portion of the cost of the program. The nursing facility must reimburse newly employed CNAs who have personally paid for NATCEP or CEP costs prior to employment in the facility, in accordance with criteria identified in the Nurse Aide Reimbursement section of this Chapter. Medicaid in turn reimburses the nursing facility.

Providers may obtain reimbursement from Medicaid for CNA costs. The reimbursement process and necessary forms are available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

9.9.A. Nurse Aide Competency Evaluation Program and Nurse Aide Registry

Nurse aide candidates must pass both a clinical skills test and a knowledge test in order to become certified. Fees for the individual nurse aide to take the tests, and retake each test up to three times - are allowable costs for nursing facility reimbursement. Refer to the Nursing Facility Reimbursement and Nurse Aide Reimbursement subsections of this chapter.

When a nurse aide has successfully passed the CEP, their name is placed on the Michigan Nurse Aide Registry. Fees relating to initial registration and biennial registry renewal are allowable costs for nursing facility reimbursement. Refer to the Nursing Facility Reimbursement and Nurse Aide Reimbursement subsections of this chapter.

Information about training requirements, competency evaluation program and registry data is available on the MDCH website at www.michigan.gov/mdch, click on Health Systems & Licensing, Licensing for Health Care Professionals, Nurse Aide.

9.9.B. Nursing Facility Reimbursement

Reimbursement to the nursing facility for NATCEP related costs is calculated as an add-on to the routine per diem rate. The Nurse Aide Training and Testing Program Interim Reimbursement Request (MSA-1324) and instructions are available on the MDCH website. The total NATCEP add-on amount will be adjusted through the annual cost report settlement process. The Medicaid share of the costs is computed based on the ratio of Medicaid resident days to total resident days for all nursing care provided in the facility during the cost report period. Refer to the Cost Report Reimbursement Settlement section and Rate Determination section of this chapter for additional information.

The NATCEP cost center on the Medicaid cost report must be used to report the following:

- Costs of conducting a nursing facility based NATCEP.
- Costs of having employees participate in an approved NATCEP outside the nursing facility.
- Costs of employee competency testing by a regional testing facility.

The costs and staffing levels relating to and charged to the NATCEP cost center must not be included in the nursing facility determination of routine nursing care costs.

The determination of allowable NATCEP costs is made in accordance with provisions in the federal Principles of Reimbursement established for the Medicare Program, and cost limitations in Medicaid policy. Training and evaluation program costs claimed for services and supplies furnished to or purchased by the facility from related organizations must adhere to related party allowable cost principles. The cost of such transactions must not exceed the cost of like items or services in an arms-length transaction with a non-related organization, or the actual cost to the related organization, whichever is lower.

The following are not NATCEP costs and must be classified as routine nursing care costs on the cost report:

- Administrative overhead in a facility-based training program.
- Space costs in a facility-based training program.
- Uniform allowance costs.
- Required in-service training.

NATCEP and CEP allowable cost must only include the costs of activities or items that are directly related to providing approved training and the competency evaluation process. The following table contains eligible training and evaluation activities.

Training staff	Salaries and wages, employee benefits and payroll taxes for conducting training and evaluation activities, including supervised practical training, and direct time devoted to development and preparation for conducting the NATCEP. Payroll costs allowed for NATCEP do not include the cost of time that the training staff devote to routine in-service training activities, general nursing administration or direct patient care, except for supervised practical training. These costs must be classified as routine nursing care cost for consideration in the routine per diem rate.
Training Consultants	Costs incurred for non-facility staff to assist in developing and conducting the facility's NATCEP.
Student Staff	Salaries and wages, employee benefits and payroll taxes incurred for the time the student is enrolled in the approved training program, i.e., classroom and required supervised practical training. A reasonable time allowance for student employees traveling to and from the off-site training location or competency evaluation, in accordance with a nursing facility's established and documented travel policy, is allowable as NATCEP cost. Payroll cost allowed for NATCEP do not include the cost of staff time for patient care activities that the nurse aide is performing during the time period the student is completing the training program. These costs must be classified as routine nursing care cost for consideration in the routine per diem rate.

Training Program Supplies	Costs of supplies and materials used in conducting an approved NATCEP.
Training Program Transportation	Travel or transportation cost incurred by facility staff in conducting the NATCEP activity, and for transportation or travel reimbursement to student staff for off-site NATCEP or CEP attendance. Refer to the Facility Vehicle and Transportation, Allowable and Non-Allowable Cost section of this chapter for mileage allowance provisions. Use of a facility owned vehicle for staff transportation for training is not charged to NATCEP. Facility vehicle operation cost must be classified as administrative overhead and is considered in the routine per diem rate.
Outside Contracted NATCEP Paid Directly by the Facility	Cost to obtain approved nurse aide training of facility employees by an outside entity approved NATCEP. The nursing facility is responsible to ensure that the contractor is an approved NATCEP.
Outside Contracted NATCEP Costs Reimbursed to Employee	Cost for reimbursement to an employed CNA who had personally paid for an approved NATCEP participation and completion prior to being employed in the facility. Refer to Nurse Aide Reimbursement.
Competency Evaluation Fees Paid Directly by the Facility	Fees paid by the nursing facility to a State-approved competency evaluator. This includes testing and retesting fees, rescheduling fees, and nurse aide registry.
Competency Evaluation Fees Reimbursed to Employee	Cost for reimbursement to an employed CNA who had personally paid for State-approved competency evaluation and registration fee prior to being employed in the facility. Refer to Nurse Aide Reimbursement.
Miscellaneous Costs	Allowable costs that are not specifically identified in another category include, but are not limited to the following items: ▪ Rental costs for space located out of the facility are allowable only if the space is used solely for the training and competency evaluation program. Space costs not meeting this requirement are reimbursable with the Plant Cost Component of the routine per diem. ▪ Reasonable rental expense for training equipment necessary for conducting an approved training program. Nurse aide biennial Registry Document renewal fees for current employees.

Equipment Purchased	Equipment purchased and used specifically for the nursing facility based NATCEP are reported as NATCEP cost center costs for Medicaid cost reporting and reimbursement purposes. NATCEP equipment costing less than $5,000 may be expensed in the year of acquisition and reported in the NATCEP cost center. Equipment acquired as part of integrated system costing greater than $5,000, must be amortized at an annual rate of 15% for each cost reporting year the equipment is used in the NATCEP, up to a maximum of seven years. Instructions for NATCEP equipment reporting are included in the annual cost reporting instructions.

9.9.C. Nurse Aide Reimbursement

A nursing facility must reimburse a newly hired CNA if the CNA paid for nurse aide training, competency evaluation and registry, and completed the approved training program within 12 months prior to employment in that facility. The nursing facility is not required to reimburse the CNA in cases where the expenses were paid by an employment or education training program, or were reimbursed by the CNA's previous employer. The nurse aide should not be reimbursed for more than 100 percent of the NATCEP or CEP costs they paid.

The nursing facility is responsible to ensure that a newly hired CNA who requests reimbursement of training and testing expenses has not already received payment for these costs. An aide who paid for any of these eligible costs and received payment of a portion of the expenses from prior facility employment is eligible for only the remaining balance from the new employer.

The CNA must request reimbursement by submitting to the nursing facility the Nurse Aide Training and Competency Evaluation Program, CNA Reimbursement Form, available in the Forms Appendix of the Medicaid Provider Manual and the MDCH website.

NATCEP costs that are eligible for reimbursement to the individual nurse aide include:

- Training program cost including fees for textbooks and required course material up to a maximum of $650. Medicaid will update the maximum allowable reimbursement limit effective October 1, 2006, and biennial thereafter, based on the Global Insight's Skilled Nursing Facility Market Basket without Capital Index corresponding to that update period.
- Competency Evaluation Program testing fees, including retesting fees; CEP testing required due to the nurse aide registry document expiration; and rescheduling fees.
- Registry or Registry Renewal Document fees that the CNA personally paid within 24 months prior to being employed in the nursing facility.

For cost reporting and audit purposes, the nursing facility must maintain, a copy of the Nurse Aide Training and Competency Evaluation Program CNA Reimbursement Form signed by the employee and documentation reflecting reimbursement to the employee. This documentation must include a copy of a receipt for cash payment, a copy of a cancelled check, or a credit card receipt showing the amount paid by the nurse aide and the date of payment, as well as copies of the nursing facility's cancelled checks disclosing reimbursement to the employee.

The nursing facility has the option to reimburse the individual via a one-time payment, or payment installments. The reimbursement to the individual, regardless of full-time or part-time employee status, must be fully paid within six-months of the individual's date of employment in the facility. If the nursing facility fails to reimburse a CNA employed in the facility within this timeframe, the unpaid balance will not be an allowable NATCEP or routine nursing care cost. This determination does not relieve the nursing facility of its obligation to reimburse the nurse aide. Wages may not be reduced to offset the facility obligation to pay the nurse aide for training, competency evaluation, and registry costs.

The nursing facility is not obligated to pay the remaining balance of nurse aide training costs at the time an employee who has worked less than six months leaves the facility employment. The CNA has the opportunity to recoup the non-reimbursed costs through subsequent employment at other nursing facilities. The facility should properly record payments so that the unpaid amount is not carried as a payment obligation.

9.9.D. Nursing Facility Lockout and Loss of NATCEP Approval

A provider with a facility-based training CNA program is not eligible for Medicaid reimbursement of training costs when it has been issued a final notice from CMS or the SSA of the withdrawal of NATCEP approval, or of a NAT prohibition (lockout). For Medicaid reimbursement purposes, the lockout effective time period coincides with the SSA time period notice to the nursing facility. The nursing facility must not claim Medicaid reimbursement for costs associated with any facility-based training class beginning after the withdrawal or lockout effective date identified in the final notice. Nurse aide students beginning training prior to the withdrawal effective date are allowed to complete training and the related costs to complete that training class are eligible for NATCEP reimbursement. Nurse aide training costs incurred for that facility based program subsequent to completion of that student class are not allowable NATCEP costs. This disallowed cost is also not allowable under routine nursing care cost.

Although the nursing facility experiencing approval withdrawal or lockout status cannot conduct its own training, the nursing facility must provide and reimburse for training and competency evaluation of its new nurse aide employees at approved sites. Such costs are eligible for Medicaid cost reporting and reimbursement in the annual cost report under the appropriate NATCEP cost categories. Nurse aide reimbursement for eligible training and competency evaluation personally paid expenses are allowable to be reported as NATCEP cost in the nursing facility annual cost report.

In the event that the nursing facility has been granted a waiver for a NAT program prohibition or lockout by the SSA, the nursing facility must comply with the provisions of the nursing facility waiver request, and the requirements set forth by the SSA in the waiver approval. The facility-based NATCEP operating under a waiver is subject to audit by Medicaid for compliance with these requirements. If the nursing facility fails to conduct the program in accordance with these requirements, the training program expenses are not allowable costs for NATCEP or routine nursing cost reimbursement by Medicaid.

9.10 Beauty and Barber Service Cost Center

Personal services for residents, such as simple barber and beautician services (e.g., shaves, haircuts, shampoos, and simple hair sets) that residents need are considered routine patient care. The costs of such services are reimbursed in the routine per diem rate when provided routinely without charge to the resident in the nursing facility.

If the nursing facility designates an area for providing non-routine personal hygiene services, such as professional manicures, or hair styling, costs must be separately reported and accounted for in the cost report. Direct and overhead costs related to these services must be separately accounted for in this special services cost center, and should not included in the cost of providing routine nursing care.

9.11 Special Dietary Cost Center

Medicaid provides for reimbursement outside the per diem rate to non-profit nursing facilities for the cost of meeting resident's special dietary needs for religious reasons. Nursing facilities requesting reimbursement must report these costs as a separate cost center in the Medicaid annual cost report. Direct costs may include food purchase, salary and wages for the extra staff time for preparation, supplies and kitchen utensils necessary for preparation and service. The costs applicable to plant operations costs related to the special dietary needs will be determined through the Medicaid cost finding process.

9.12 Hospital Leave Days

A separate accounting of costs incurred due to hospital leave days is not necessary.

9.13 Non-Available Beds

In special circumstances, nursing facility beds may be designated "non-available for occupancy" for Medicaid cost reporting when the patient care rooms in which the beds are located are not used for resident care. Beds with a "non-available" designation remain licensed or certified; the designation is for Medicaid cost reporting and reimbursement determinations only. An approved non-available bed plan reduces the total number of beds used for calculating available bed days for the annual cost report period coinciding with the time period of the non-available bed plan. Non-available beds must be located in a discrete area and readily identified for statistical cost reporting. During the time period the area is designated non-available for patient care, Medicaid does not reimburse for variable and plant costs attributed to the area designated as having non-available beds.

9.13.A. Qualifying Criteria

A non-available bed plan must include all of the licensed beds in a patient care room. The rooms must be a discrete area and primarily consist of a contiguous physical arrangement of rooms. Rooms may not be a random collection of individual rooms or beds located throughout the nursing facility.

Common physical space located adjacent to or within the designated rooms area will normally be included in the designated non-available bed area. Planned use of any common areas within the designated non-available bed area must be disclosed in the written notice to the RARSS.

Rooms with non-available beds may not be used for resident care service regardless of payer source nor can the space be used for any other normally reimbursable purpose.

Resident rooms that are not used for resident care do not qualify for non-available bed designation. Although the rooms may be used for alternative services, the beds located within the room area must continue to be counted as available for resident care. Physical plant area used for alternative use must appropriately be charged to the applicable alternative services cost center if the services activity results in ancillary care services or other revenue services.

The written request must be submitted within 30 calendar days of the date that the provider removes the beds from service.

9.13.B. Written Notice and Request for Plan Approval

The provider must submit a written request for a non-available bed plan to RARSS (Refer to the Directory Appendix for contact information). The RARSS must receive the request within 30 calendar days of the date that the beds are to be removed from resident care service. Non-available bed plan requests will not be approved on a retroactive basis. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

The written notice from the provider to RARSS must:

- Indicate the date that the beds will be removed from resident care service and the expected duration of the non-available plan.
- Indicate the reason for the request.
- Include a floor plan of the facility that marks the beds to be designated as non-available.

The RARSS will review the request and provide a written response of approval, denial or a request for additional information. If approved, the RARSS will notify the SSA of the non-available bed designated rooms and effective time period.

9.13.C. Life of an Approved Plan

Beds must remain non-available for not less than the balance of the provider's fiscal cost reporting year in which the beds are deemed non-available plus the entire following fiscal year. An exception is when the non-available bed plan is effective on the first day of the provider's fiscal year. The cost report year may qualify as the entire time period of the non-available bed plan if the cost report period is not less than twelve months.

Non-available bed designations will be effective on the first day of the month. If the notice is not received within the required 30 calendar day period, the plan will become effective on the first of the month in which RARSS received the notice if the beds have not been utilized during that month.

The initial period of the non-available bed plan expires upon completion of the minimum required time period.

The nursing facility may request up to two extensions of 12 months each following this minimum time period. The agreement may be extended on the basis of the provider's fiscal year. A request for extension must be submitted in writing to the RARSS 30 calendar days prior to expiration of the initial plan. The request for a second extension must be submitted to RARSS 30 calendar days prior to expiration of the first extension. The requests must include at least one of the following items:

- The same rooms and bed area.
- A revision to bring some, but not all, of the beds back into service (if applicable).
- A revision to increase the number of non-available beds that includes all of the beds already designated as non-available.
- A change in the room and bed designation area that is equal to the number of beds designated as non-available in the initial plan.

Requests for a revision to bring some, but not all, beds back into service must include:

- The same rooms and the same bed area.
- If applicable, the change in room and bed designation area that is equal to the number of beds designated as non-available in the initial plan.

The extensions must meet the elements of the qualifying criteria, notice requirements and related policy for initial non-available bed requests.

Non-available bed plans expiring on or after April 1, 2005 will be limited to two 12 month extensions. When a provider's initial or extended non-available bed plan ends, the nursing facility must return the beds to service or decertify the beds from Medicaid participation. Medicaid will not approve a non-available bed plan that substitutes beds elsewhere in the facility for the formerly non-available beds.

The nursing facility will not be eligible to submit a new non-available bed plan for 24 months following the expiration of the previously approved plan.

A provider may only request a grace period after the final extension period if the provider can demonstrate progress to place the non-available beds into resident care service. The request for a grace period must be made to LTC Services 30 calendar days prior to the expiration of the final extension period. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) The request for a grace period must be submitted before expiration of the final extension period, and must meet the elements of the qualifying criteria, notice requirements and related policy for initial non-available bed requests. The request must specify the date that the beds will be available for occupancy and may not exceed 12 months. An example for such action is gradual facility renovation involving periodic non-available beds in a nursing unit and replacement with non-available beds in another unit as renovation plans progress.

The provider must meet all appropriate certification requirements for distinct part units for the remaining Medicaid beds. Additional beds may have to be decertified in order to meet the distinct nursing unit requirements. The nursing facility may request re-certification of these beds for Medicaid participation after a 24 month time period. A request to re-certify must meet all current Medicaid certification requirements.

9.13.D. Change of Ownership (CHOW)

The non-available bed plan approval expires with a change of ownership of the nursing facility. If the new owner wishes to continue the non-available bed plan, they must submit a written request to the RARSS within 90 calendar days of the CHOW. A non-available bed plan submitted after the 90-day period will be considered a new request and must satisfy the qualifying criteria and related policy requirements. If the new owner does not request continuation of the existing plan, the beds will be deemed available for occupancy effective with the date of ownership change.

The new owner may apply to extend the plan to coincide with its cost reporting period by following the extension request policy outlined in the Life of an Approved Plan subsection. The nursing facility change of ownership does not relieve the nursing facility from the restrictions for non-available bed designation limitations for plan extensions other than allow for coinciding with the cost report year of the new ownership.

9.13.E Amending a Plan

The nursing facility may amend an approved non-available beds designation by submitting a written request to the RARSS. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) A non-available bed plan may be amended only one time during the life of the unavailable bed plan. A request for an amendment must include the same information as an initial request and will be reviewed using the same criteria. A plan amendment increasing the number of non-available beds is subject to the minimum time period requirement and the designation of all the beds must be effective for the time period of not less than the balance of the provider's current fiscal cost reporting year in which the beds are deemed non-available plus the following fiscal cost report year.

9.13.F. Penalty for Use of Non-Available Beds

Admitting residents to any beds in the area designated non-available for occupancy, regardless of payer source, before the end of the plan negates the plan retroactive to the beginning of the nursing facility's fiscal cost reporting period. All beds covered by the negated non-available bed agreement will be considered available for patient care for the entire cost report period.

9.13.G. Returning Beds to Service

All of the beds in the non-available bed plan will be considered returned to service and available for occupancy when the non-available bed plan expires.

In special circumstances, such as a sudden increase in demand due to closure of a nearby facility, non-available beds may be returned to service before the end of the approved plan with prior approval of the RARSS. A nursing facility with an approved non-available beds plan may submit a written request to return beds to nursing care if the individual nursing facility experiences the need for the beds due to the exception circumstances. The request must identify the reason for the need and the specific beds

and room designations being made available. RARSS will provide immediate review and response to the nursing facility request.

9.13.H. Plant Cost Certification

A provider with an approved non-available beds plan has the option to submit to a Plant Cost Certification for the cost report fiscal period in which the beds are approved as non-available for occupancy or the termination of the plan. Refer to the Plant Cost Certification Section in this chapter for additional information.

9.13.I. Cost Reporting

The variable and plant costs attributed to the area designated as non-available and the related capital asset cost are not Medicaid reimbursable costs. The non-available rooms and bed numbers must be reported as a Non-Available Beds cost center on the provider's Medicaid cost report.

Each general service cost center must be evaluated separately to determine if the non-available bed area benefits from the service. The nursing facility may charge specific costs to the Non-Available Beds cost center only when the dollar amount is identifiable. Costs that cannot be specifically identified must be apportioned to the non-available beds cost center using the Medicaid cost report allocation methodology. The statistic or measure used for the general services cost center must also be used to allocate costs to the non-available bed cost center.

Example: If square feet are used to allocate costs to the housekeeping activity the general services cost center, then square feet must also be used to allocate costs to the non-available bed area. The allocation to the non-available bed cost center is zero when the non-available bed area receives no benefit from the general service.

Example: If a wing is designated as non-available and does not receive any housekeeping services, then the allocation to the non-available cost center is zero.

The reduction in available beds is included in the provider's cost report effective for the fiscal period in which the non-available bed plan is approved by the RARSS. For Medicaid reimbursement determination of tenure and allowable average borrowings, the percentage of the total plant asset costs applicable to available beds must equal the percentage of the facility remaining available for resident nursing care.

9.14 Memorandums of Understanding (MOU) – Special Agreements for Complex Care

Memorandums of Understanding (MOU) – Special Agreements for Complex Care provide Medicaid reimbursement for residents receiving specialized services. Separate cost records are not required for identifying these costs. The Program has designated the special care revenue amount equal to cost. Providers with an MOU must adjust the annual Medicaid cost report by removing from the appropriate nursing care costs the dollar amount of the total difference between reimbursement at the special care rate and the established routine Medicaid rate. The rate provisions are identified in the provider's memorandum of understanding issued with the placement of the special care resident in the facility.

SECTION 10 - RATE DETERMINATION

There are six classes of nursing care facilities for which there are specific reimbursement methods. For a definition of the six classes, refer to the Definitions section in this chapter. Providers reimbursed for care using a special reimbursement calculation or method are addressed at the end of this section.

The determination of a nursing facility's class is made by the State Survey Agency. If a nursing facility changes ownership or the services it provides such that a change in class is appropriate, the facility will be reimbursed according to the respective facility class to which it has been changed. The effective date of the reimbursement change is the effective date of the State Survey Agency's determination. Nursing facility providers other than Class IV are reimbursed under a methodology that pays the lower of the customary charge to the general public or a prospective payment rate determined by Medicaid.

Payment rates described in this section refer to the provider's prospective per resident per diems, and are generally set 30 calendar days in advance of the State's fiscal year, which is October 1 through September 30. (Rate determination timing is dependent on legislative approval of the Department of Community Health's budget.)

NOTE: An illustration of the timeline and calculations for per diem rate setting is available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

Prospective payment rates are calculated using the facility's cost report ending in the previous calendar year. If this cost report covers a time period that is less than seven months, the cost report used for rate setting is the most recent cost report available prior to the previous calendar year that covers a period of at least seven months.

The reimbursement rate determination process uses a provider's most recent fiscal period audited cost data to calculate the routine nursing care per diem rate. If audited data is not available, an interim prospective rate is calculated using the filed cost report, if the cost report was acceptable and was filed with Medicaid within five months from the end date of the cost reporting period. If an acceptable cost report was not filed within this time frame, Medicaid is not required to set the prospective payment rate in advance of the State's fiscal year. If the nursing facility did not file within the five month time period, or has amended an original cost report subsequent to the five month period, Medicaid will calculate the prospective rate for an effective date for services no later than the beginning of the fourth month (January 1) of the State fiscal year. Nursing facilities that are required to file an amended cost report in order to include home office costs that were not included in the original cost report due to the difference in cost reporting period from the home office are exempt from this provision. The amended cost report, if filed timely following the completion of the home office cost statement, will be considered timely filed if the original cost report had met the five month filing requirement. Refer to the Cost Classification and Cost Finding section of this chapter for home office cost statement and nursing facility amended cost reports.

10.1 RATE DETERMINATION PROCESS

The per diem reimbursement rate for Class I and Class III nursing facility providers is made up of three components: a plant cost component, a variable cost component, and add-ons.

- For Class I facilities, the plant cost component is made up of the Property Tax/Interest Expense/Lease Component plus the Return on Current Asset Value Component.

- For Class III facilities, the Plant Cost Component is the lesser of the Facility Per Patient Day Plant Cost or the Facility Plant Cost Limit. The Facility Plant Cost Component is the depreciation, interest and lease expenses calculated on a per patient day basis.
- For Class I and Class III facilities, the Variable Cost Component is made up of the facility's Variable Rate Base plus the Economic Inflationary Update.

Class II facilities, being proprietary nursing facilities for the mentally ill or mentally retarded, are reimbursed an all-inclusive prospective payment rate negotiated with the MDCH State Mental Health Agency on an annual basis. Final reimbursement is a retrospective cost settlement, not to exceed a ceiling limit. The provider may be eligible for a reimbursement efficiency allowance in the final rate if total allowable costs do not exceed the prospectively established ceiling limit.

Class IV facilities, being state-owned and operated institutions, Intermediate Care Facilities for the Mentally Retarded (Developmentally Disabled), and non-profit nursing facilities for the mentally retarded, are reimbursed allowable costs determined in accordance with Medicare Principles of Reimbursement and are retrospectively cost settled.

Per diem rates for Class V facilities, Ventilator Dependent Care Units, are set prospectively. Services included in the per diem rate are outlined by contract with Medicaid.

Payment rates for Class VI Hospital Swing Beds are set prospectively as a flat per resident day rate determined by Medicaid.

10.2 Retroactive Rate Changes

A retroactive change may be made for facilities that have interim prospective rates based on filed cost reports. A retroactive change may be made for:

- audit adjustments to a filed cost report that was used for setting an interim rate.
- facilities that were approved for Plant Cost Certification due to capital cost changes, an approved non-available bed plan, or a plant rate affected by a DEFRA rate limitation for the cost report time period.
- audit adjustments that are required as a result of an appeal.
- audit adjustments that are required as a result of fraud or facility failure to disclose required financial information.
- Class I nursing facilities approved for Rate Relief for the rate year period.

The Plant Cost Component of a rate for the nursing facility that experiences a change of ownership will be retroactively adjusted under the Plant Cost Certification process. The DEFRA Reimbursement Limit application will continue to apply to each rate year until a fiscal year retrospective rate change results in zero DEFRA limit. The nursing facility Plant Cost Component will be calculated on a prospective basis for the year following the zero DEFRA limit rate year.

10.3 Plant Cost Component Class I Nursing Facilities

The prospectively established Plant Cost Component for each Class I nursing facility provider is the sum of the facility Net Property Tax/Interest Expense/Lease Component and Return on Current Asset Value Component. The Plant Cost Component is expressed as a per patient day amount.

10.3.A. Net Property Tax/Interest Expense/Lease Component Per Patient Day

The Net Property Tax/Interest Expense/Lease Component per patient day is calculated under the following formula:

Property Tax/Interest Expense/Lease Plant Cost	-	CAV Excess Borrowings Limit	+	DEFRA Reimbursement Limit (not to exceed zero)	=	**Net Property Tax/Interest Expense/Lease Plant Cost**

Net Property Tax/Interest Expense/Lease Plant Cost	÷	Nursing Facility Resident Days	=	**Net Property Tax/Interest Expense/Lease Plant Cost Per Patient Day**

10.3.A.1 Property Tax/Interest Expense/Lease Plant Costs

These plant costs consist of allowable costs for real estate and personal property taxes, interest expense, and lease expense, defined under the allowable and non-allowable cost section and cost classification section of this chapter. The aggregate dollar amount for these plant costs is obtained from the nursing facility cost report. The time period of the cost report will correspond with the cost basis period identified for the respective State rate year.

10.3.A.2 CAV Excess Borrowings Limit

The CAV excess borrowings limit is unreimbursable interest due to excess borrowings. An example of the calculation is available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

The dollar amount of allowable interest expense included in the reimbursable plant cost will be reduced if the nursing facility loan balance applicable to the nursing care unit exceeds the facility reimbursement limit. The nursing facility's average allowable borrowing balance cannot exceed the lesser of the "Nursing Facility Current Asset Value" or the "Nursing Facility Capital Asset Value Limit." If the nursing facility borrowing balance exceeds the limit, a reduction is made to the allowable plant cost for the portion of the excess borrowing. The amount of the reduction is based on the ratio of the limit amount to the average borrowings balance times the dollar amount of allowable interest expense. The following formula is applied to calculate the reduction:

Lessor of (NF CAV) or (NF CAV LIMIT)	÷	Facility Average Borrowing Balance	x	Total Allowable Interest Expense	=	**Reimbursable Interest**	
Total Interest Expense	-	Reimbursable Interest Expense	=	**CAV Excess Borrowings Limit (N/A if less than zero)**			

A nursing facility that has undergone a change of ownership and is incurring interest costs relating to the acquisition financing will be subject to a DEFRA Reimbursement Limit disallowance. The DEFRA Reimbursement Limit calculation will determine if the nursing facility acquisition and financing costs exceeds Medicaid allowable reimbursement increase limit. Reductions to the facility total borrowing balance is made to avoid including the borrowings balance is made to avoid including the total allowable interest expense in amount both in the DEFRA limit and the CAV excess borrowing limit.

If the nursing facility has a DEFRA Reimbursement Limit due to the nursing facility acquisition, the nursing facility's total average borrowing balance used in the calculation for CAV excess borrowings limit will be reduced by a calculated dollar amount of borrowings corresponding with the DEFRA Reimbursement Limit. The borrowing amount corresponding with the DEFRA Reimbursement Limit is calculated under the following formula:

Dollar Amount of DEFRA Reimbursement Limit	÷	Nursing Facility Total Allowable Interest Expense	x	Nursing Facility Total Borrowing Balance	=	**Reduction to NF Average Borrowing Balance**	

10.3.A.3. DEFRA REIMBURSEMENT LIMIT

Increases in reimbursement for tenure and interest expense subsequent to a sale or resale (after July 18, 1984) are limited under provisions of the Deficit Reduction Act (DEFRA) of 1984 as defined in federal Medicaid law. The Medicaid application of DEFRA provisions is a limit on the dollar amount of plant cost component reimbursement increase to the Provider due to the nursing facility change of ownership. An established formula calculation is used to determine the new ownership's eligible increase reimbursement for tenure and interest (DEFRA Application Limit). If the new ownership tenure and interest increase before application of the DEFRA Reimbursement Limit does not exceed the DEFRA Application Limit , the DEFRA Reimbursement Limit is not applicable. If the new ownership tenure and interest increase before application of the DEFRA Reimbursement Limit exceeds the DEFRA Application Limit allowable increase, the DEFRA Reimbursement Limit reduction will be made to the allowable plant costs.

The calculation is made as follows:

DEFRA Application Limit - Increase in tenure and interest for new ownership prior to DEFRA Limit = DEFRA Reimbursement Limit (not applicable if greater than zero)

DEFRA Application Limit is determined as:

[Allowable historical capital asset cost to the asset original owner (excluding land), for assets in the NF at the time of sale x 3.33% + [Allowable land value to the seller + Historical capital asset cost of the asset's original owner for assets in the nursing facility at the time of sale] - Purchaser down Payment x Purchase Mortgage interest rate] - Allowable interest expense of the seller for the rate period prior to the sale = DEFRA Application Limit

For purposes of the DEFRA Reimbursement Limit calculation, allowable acquisition cost is the cost to the original owner of the asset. An example of this calculation is available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

Increase in tenure and interest for the new ownership prior to DEFRA Limit is determined as:

Purchaser tenure and allowable interest after acquisition - Seller tenure and allowable interest in the Medicaid rate prior to the sale = Increase in tenure and interest for new ownership prior to DEFRA Limit

The calculation formula is defined for application when using annualized cost data (reflective of twelve month time period). Tenure refers to the purchaser's initial ownership year. Allowable interest refers to interest associated with a facility acquisition. If all of the data elements needed in the calculation do not include data for a twelve-month period, the data elements must be adjusted to reflect a time period of equal

duration to the cost report base period used in determining the "purchaser tenure and allowable interest after the sale."

The DEFRA Reimbursement Limit continues to apply to the new ownership annual Property Tax/Interest Expense/Lease Component rate using the Plant Cost Certification reimbursement settlement procedure until the limit amount is zero.

10.3.B. Return on Current Asset Value (CAV) Component

The Return on Current Asset Value Component is a per resident day amount representing a use allowance on facility assets. The return amount is determined by multiplying the "tenure factor" times a CAV calculated for the nursing facility. A nursing facility's CAV is determined by a formula using historical costs of the nursing facility's capital assets, as identified in the Allowable and Non-Allowable Costs section in this chapter, times the difference between an asset value update factor and an obsolescence factor. Assets purchased prior to 1960 are treated as assets brought into service in 1960. A nursing facility's CAV for rate reimbursement calculation cannot exceed the "current asset value upper limit" and will not be less than the "current asset value floor."

The calculation for the return on current asset value component is:

Lesser of NF CAV or NF CAV Limit	x	Tenure Factor	=	Total NF Return on CAV

Total NF Return on CAV	÷	NF Resident Days	=	Return on CAV Component Per Resident Days

10.3.B.1. Asset Value Update Factor

The asset value update factor used to calculate CAV depends on the type of capital asset. Land improvements, buildings, building improvements, and fixed building equipment are updated, using the Marshall Valuation Service Construction Cost Index for Class A Buildings in the Central United States, from the fiscal year the asset was brought into service until the most recent period for which cost report data is available for the respective rate year calculation. The asset value update factor is not applied to land and other assets not specifically listed above.

10.3.B.2. Asset Value Obsolescence Factor

The obsolescence factor is applied based on the classification category of the capital asset. Land has an obsolescence factor of zero. Land improvements, buildings, building improvements, and fixed building equipment have an obsolescence factor of .03 for each year the asset has been in service. Movable equipment and other capital assets have an obsolescence factor of .10 for each year the asset has been in service up to a maximum

of 10 years. The number of years that the asset has been in service is determined by subtracting the year the asset was put into service from the most recent fiscal year for which data is available under the standard rate setting timeframe.

10.3.B.3. CURRENT ASSET VALUE FORMULA

A nursing facility's CAV is determined by a formula using historical costs of capital assets. The current asset value for each asset is the historical cost of that asset times the difference between its Asset Value Update Factor and its Asset Value Obsolescence Factor. Assets purchased prior to 1960 are recorded as assets brought into service in 1960. Current asset values are updated annually based on the most recent audited or reviewed cost report. A nursing facility's current asset value is the sum of current asset values for the various asset types.

Example: Building assets with historical cost of $100,000 in service for 10 years through the cost report year used in the rate calculation; the update factor for the 10 years is 1.50; the obsolescence factor is .30 (10 years times .03); the amount included in the CAV compilation for the nursing facility for these assets is $120,000 [$100,000 times (1.50 minus .30)].

If the nursing facility Plant Cost Component is calculated based on Plant Cost Certification data, the new capital assets acquired in the current cost report year and the immediate prior cost report year will be included in the nursing facility historical asset costs for compiling the CAV. The update factor for these assets will be 1.0, and the obsolescence factor will be zero.

10.3.B.4. NURSING FACILITY CURRENT ASSET VALUE

The current asset value calculation process determines the CAV for the entire nursing facility since capital assets are used for all types of services delivery in that facility. Only the portion of the nursing facility assets having a use related to routine nursing resident care are included for reimbursement under the return on current asset value component. The reference to Nursing Facility CAV is defined as the nursing unit portion of the nursing facility's total current asset value applicable to routine nursing care. The apportionment, expressed as a percentage, of a total facility that is applicable to the routine nursing care unit is determined by means of the facility's annual cost report. The SMA cost reporting process apportions the nursing facility asset costs into the appropriate cost centers for reimbursement purposes.

The Nursing Facility CAV is calculated as:

Total CAV for the NF	x	Percentage representing the nursing unit apportionment	=	NF CAV

10.3.B.5. Class I Nursing Facility Current Asset Value Limit Per Bed

The current asset value upper limit is a maximum per bed dollar amount that will be used for calculating the individual Nursing Facility CAV. The per bed value of the upper limit is based on the historical costs of construction and other asset acquisition costs for nursing facilities opened on or after January 1, 1975. The historical costs are updated through 1983 using the U.S. Department of Commerce Composite Construction Index, and annual updates after 1983 are made using the Marshall Valuation Service Construction Cost Index for Class A Buildings. The update index does not apply an obsolescence factor. The current asset value limit is the sum of the updated historical costs for the facilities included in this calculation divided by the total number of beds in those facilities. The current asset value limit is recalculated annually to include construction costs of new facilities reported on the most recent calendar year filed cost report and the construction index update. The per bed upper limit is effective for the time period corresponding to the State rate year.

The current asset value floor is 30 percent of the current asset value upper limit.

Class I nursing facility current asset value limits per bed for each rate year are available on the MDCH website. Refer to the Directory Appendix of the Medicaid Provider Manual for website information.

10.3.B.6 Nursing Facility Current Asset Value Limit

A current asset value limit is determined by the individual nursing facility and is dependent on the number of beds in the Medicaid nursing unit for the time period corresponding with the respective rate effective date. The current asset value upper limit is a maximum dollar amount for the individual Nursing Facility CAV that will be used for calculating the return on current asset value. The Nursing Facility CAV Limit is the number of available beds in the nursing unit times the Class Current Asset Value Limit Per Bed.

The current asset value floor limit is a minimum dollar amount for CAV that will be used for calculating the return on current asset value for that nursing facility. The individual Nursing Facility CAV floor is the Nursing Facility CAV Limit times 30 percent.

10.3.B.7 Tenure Factor

The tenure factor is dependent on the nursing facility provider's number of full years of continued licensure as of the beginning of the Medicaid rate year, i.e., months of continuous licensure divided by 12 and ignoring fractions.

Continued licensure is based on the number of full years that have elapsed from the effective date of a nursing facility provider's license (issued by the State Survey Agency) to the beginning of the Medicaid rate year. For example, a provider that has been licensed for 42 continuous months has, for purposes of the tenure factor, been licensed for three full years. The provider’s years of ownership are translated into a tenure rate, and applicable rates are identified in the following table.

Years of Ownership At Start Of Provider Fiscal Year	Rate of Return on Current Asset Value
0-1	.0250
2	.0275
3	.0300
4	.0325
5	.0350
6	.0375
7	.0400
8	.0425
9	.0450
10	.0475
11	.0500
12 or more	.0525

The rate of return on current asset value is expressed as an annual return rate. Qualification for the total return rate requires that the time period included in the nursing facility cost report used as the basis for the facility plant cost rate include twelve calendar months. In cases where the nursing facility cost report does not include twelve calendar months, the following formula is used to calculate the return rate:

Number of calendar days in the cost report period	÷	365	X	Rate of return on CAV (for the respective years of ownership)	=	**Return Rate**

Example: A nursing facility has seven years of ownership and the cost report period used for plant costs in the rate calculation is for a nine month time period (275 days). The adjusted return rate is .030 (275/365 times .0400).

If a nursing facility is sold or totally replaced (regardless of facility ownership), years of ownership return to zero. If a facility is remodeled or expanded and facility ownership remains unchanged, the years of ownership remain continuous.

When licensure has changed but there has been no effective change in operator/provider, and there has been no transaction that would affect Medicaid reimbursement other than the tenure factor, the provider may request that Medicaid recognize the continuous tenure such that the licensure tenure schedule would not revert to zero years at the time of the licensure change. The provider's written request must be submitted at the time licensure is changed.

Exception: Where licensure does not change after a sale of nursing facility assets, the nursing facility provider (new owner) must choose either to retain the original licensure tenure schedule and forego increased reimbursement for interest expense, or to receive increased reimbursement for interest expense, subject to the DEFRA Reimbursement Limit, and allow the licensure tenure schedule to revert to zero years and a tenure factor of .0250. Should the provider elect to retain the previous licensure tenure schedule,

Medicaid will not recognize, for allowable cost and per diem rate determination purposes, any interest expense beyond the schedule of borrowings, principal amortization, and interest expenses that would have been incurred were the former owner's loans maintained or assumed by the new owner. This provision applies to all property transactions between lessors, lessees, and/or operators.

10.4 Plant Cost Component Class III Nursing Facilities

The prospectively established plant cost component for each county medical care facility provider and hospital long term care unit provider is the lesser of the allowable per resident day facility plant cost or the per resident day facility plant cost limit. Proprietary providers are permitted to retain, as part of the plant cost component, up to $.50 of the difference between allowable per resident day plant costs and the per resident day plant costs in effect on March 31, 1985 ($5.66 per resident day).

10.4.A. Facility Plant Cost Per Resident Day

The allowable per resident day plant cost is the sum of depreciation expense, interest expense, property taxes, and allowable lease costs divided by total resident days as determined from the provider's cost report. A facility with a change in facility asset costs may qualify for plant cost limit updates.

10.4.B. Facility Plant Cost Limit Per Resident Day

The individual provider facility Plant Cost Limit is dependent upon when facility beds were constructed and brought into service for Medicaid residents. Nursing facilities existing prior to July 1, 1978 were initially assigned the facility Class Plant Cost Limit for new construction as of that date. A nursing facility constructed after that date is initially assigned the facility Class Plant Cost Limit effective in the year facility beds are constructed and brought into service for Medicaid.

A facility's Plant Cost Limit, expressed as per resident day, is the sum of the per resident day component limits for depreciation expense, interest expense, financing fees and property taxes. The individual nursing facility Plant Cost Limit is updated for a nursing facility that undergoes a significant change in facility asset costs. The nursing facility must complete the Plant Cost Certification process to qualify for consideration of the update to the individual facility Plant Cost Limit. The provider must meet the qualifying provisions for Plant Cost Certification eligibility other than non-available bed designation or returning non-available beds to service, to be eligible for a revised plant cost limit. The non-available bed plan designation criteria does not qualify the nursing facility for an update to the facility plant cost limit. An existing provider with a change of facility class, major addition, renovation or new construction may be eligible for a Plant Cost Limit update to reflect the change in facility asset costs. An existing facility that chooses to become a Medicaid-participating provider may also qualify for an updated plant cost limit.

The updated plant cost limit is applicable to a nursing facility dependent upon the facility's capital asset project. A nursing facility that is a total new construction, a facility that incurs major capital asset renovation and/or addition, a facility newly participating in the Medicaid program, or a facility that experiences a change in facility class is eligible for updated depreciation, interest, finance fees and property tax components for the facility

Plant Cost Limit. The update in the limit is based on a compilation of the facility limit prior to the capital asset change and the Class Plant Cost Limit.

The individual facility updated Plant Cost Limit effective with the completion of the capital asset project is a weighted average of the historic individual facility Plant Cost Limit for the portion of the facility prior to the new construction and the current Class Plant Cost Limit applicable to the new capital asset project. The weighting factors used are the respective ratios of the allowable historic asset costs of the facility prior to the new construction, and the allowable asset costs of the new construction, to the combined allowable old and new asset costs of the nursing facility after construction. The current Class Plant Cost Limit used in the weighted calculation applicable to the new capital cost portion will be the class limit in effect for the year corresponding to the new asset acquisitions being placed into service.

Nursing facility providers that incur a capital asset change resulting from a facility sale of assets will use as a plant cost basis only those allowable costs identified in the Allowable and Non-Allowable Costs section in this chapter. The individual nursing facility updated Plant Cost Limit after the sale is only eligible for an update for the interest expense component limit to reflect changes in interest rates.

10.4.C. Facility Class Plant Cost Limit Per Resident Day

The Class Plant Cost Limit is the maximum reimbursement rate, expressed as per resident per day amount, for a nursing facility's new construction. The Class Plant Cost Limit is applicable to new construction nursing facilities dependent upon when facility beds were constructed and brought into service for Medicaid residents. The Class Plant Cost Limit is the sum of the per resident day component limits for depreciation expense, interest expense, financing fees and property taxes. The Class Plant Cost Limit components are updated annually to reflect changes in industry construction cost, interest rates and corresponding effect on financing fees and real estate taxes due to changes in capital costs. The new construction limit is used in determining the individual nursing facility limit in cases where the nursing facility is an entire new construction or an existing nursing facility has completed a significant capital improvement.

The per resident day Class Plant Cost Limit is the amount that would be paid for a recently constructed and prudently financed facility. Calculation of the plant cost limit is based on a survey of nursing facilities constructed between January 1, 1975 and December 31, 1977, and initially updated to June 30, 1978. The original Class Plant Cost limit individual components are updated annually using published economic indicators identified in the subsections addressing the specific component of the limit. The Class Plant Cost Limit annual updates are available on the MDCH website. Refer to the Directory Appendix of the Medicaid Provider Manual for website information.

10.4.C.1. Facility Class Plant Cost Limit Depreciation Expense Component

The value for the depreciation expense component is a sum based on the mean of the surveyed values of depreciable assets (referenced above) and the mean depreciation rate for assets of similar type using straight-line depreciation with useful lives determined in

accordance with Medicare Principles of Reimbursement. The per resident day depreciation expense component is updated each calendar quarter to reflect the change in costs of construction and changes in standards and regulations which have a direct impact on plant costs. The depreciation component is updated using the economic index release as published under U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts Tables, for Nonresidential Structures.

10.4.C.2. Facility Class Plant Cost Limit Interest Expense Component

The value for interest expense is based on the surveyed mean of interest rates paid (referenced above) and the mean asset values for facilities constructed during the initial three-year survey time period. The per resident day interest component is updated annually based on the changes in interest rates. The interest rate data used to calculate the interest component limit is updated by applying an index of change in interest rates for home mortgage loans (reflected in conventional new home mortgage rates, as published by the Federal Housing Finance Board for Newly Built Homes) to the interest rate used to calculated the original interest component limit.

A nursing facility that undergoes a change of ownership is eligible for an update to the individual facility Plant Cost Limit. The update will only include an adjustment to the interest component of the individual facility Plant Cost Limit in effect prior to the sale. The adjustment will be made to the interest component of that prior limit to reflect the change in the interest rate index between the time period reflected in the prior limit calculation and the date of the facility sale.

10.4.C.3. Facility Class Plant Cost Limit Financing Fees Component

The value for financing fees is based on the mean of financing fees of the surveyed construction (referenced above). The per resident day financing fees component limit is updated using the same update factor used for the depreciation expense component limit update. The update factor is applied to the original financing fees component limit.

10.4.C.4. Facility Class Plant Cost Limit Tax Expense Component

The value for property taxes is based on the mean of property taxes of the surveyed taxable properties (referenced above). The per resident day property tax component limit is updated using the same update factor used for the depreciation expense component limit update. The update factor is applied to the original property tax component limit.

10.5 Variable Cost Component (VCC) – Class I and Class III Facilities

The variable cost component of the nursing facility per resident day rate reflects the Medicaid determination for reimbursement for the nursing facility base and support costs incurred for routine nursing care. Base and support cost classifications are discussed in detail in the Cost Classifications and Cost Finding subsection of this chapter. The calculation of the component uses nursing facility historical costs and economic index application to adjust cost levels to coincide with the State rate year time

periods. The support costs and total variable (base plus support) costs are separately subjected to rate ceiling reimbursement limits dependent on individual facility bed size and facility class.

For Class I and Class III nursing facility rate setting periods beginning on or after October 1, 2003, the Variable Cost Component is a per resident day rate and is equal to the lesser of the facility's Variable Rate Base (VRB) OR the Class Variable Cost Limit (VCL), plus the Economic Inflationary Update (EIU).

VCC = (lesser of VRB or Class VCL) + EIU

10.5.A. VARIABLE RATE BASE (VRB)

The facility Variable Rate Base is the sum of the facility's indexed base cost component and the facility's indexed support cost component. For rate setting purposes, the per resident day amount used for the provider's Variable Rate Base is the lesser of the calculated Variable Rate Base or the Class Variable Cost Limit.

VRB = Base Cost Component + Support Cost Component

10.5.A.1. BASE COST COMPONENT (BCC)

A facility's BCC is the facility per patient day allowable base costs indexed to October 1 of the year that is one year prior to the rate year being calculated.

BCC = (base costs/total number of resident days) X Cost Index

Facility's base cost per day - the facility base costs divided by the total number of resident days for the cost reporting period.

10.5.A.2. SUPPORT COST COMPONENT (SCC)

A facility's support cost component is the facility's BCC multiplied by the lesser of the facility's support to base ratio or the support-to-base ratio limit for that nursing facility bed-size group.

SCC = BCC X applicable S/B ratio (Facility or Bed-Size Group Limit)

- Facility's support cost per day - the facility support costs divided by the total number of resident days for the cost reporting period.
- Facility Support-To-Base Ratio (S/B-Facility) - the nursing facility allowable support costs divided by the allowable base costs for the cost reporting period. The individual Provider's S/B ratio for rate calculation is limited to the Support-To-Base Ratio Bed Size Group Limit for the Provider's bed-size group. The individual nursing facility bed-size group classification is based on the number of nursing home licensed beds, Home for the Aged beds, or any other type of licensed beds where nursing care is provided. The Provider's S/B ratio is rebased annually from the most recent audited cost period, regardless of ownership.
- Support-To-Base Ratio – Bed Size Group Limit (S/B-Group) – the 80th percentile of the support-to-base ratios for nursing facilities in the same bed-size group for a cost reporting year. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+

nursing care beds in the nursing facility. The nursing facility bed-size group classification is based on the number of nursing home licensed beds, Home for the Aged beds, or any other type of licensed beds where nursing care is provided. The 80th percentile is determined by rank ordering the provider nursing facilities within the same bed-size group from the lowest to highest S/B ratio, then accumulating nursing facility Medicaid resident days of the rank ordered providers, beginning with the lowest, until 80 percent of the total Medicaid resident days for this group of providers is reached. The S/B ratio limit for the bed-size group equals the support-to-base ratio of the nursing facility in which the 80th percentile of accumulated Medicaid days occurs.

10.5.B. Cost Index (CI)

A facility cost index is the Global Insight's Skilled Nursing Facility Market Basket without Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Care Cost Review. The cost index will be used to index reported costs from the end of the facility's cost report period to October 1 of the year that is one year prior to the rate year being calculated.

Example: Cost report data used to set reimbursement rates for the October 1, 2003 to September 30, 2004 rate year will be indexed to October 1, 2002.

10.5.C. Class Average of Variable Costs (AVC)

The Class Average Variable Cost is defined as the total indexed variable costs for all facilities in the Class divided by the total resident days for all facilities in the class for a cost reporting year. An AVC is calculated for Class I and Class III nursing facilities. The Class AVC is used for rate calculations for nursing facilities that meet the qualifying criteria as a new provider for Medicaid participation and determining provider eligibility for Class I nursing facility rate relief.

AVC = (total Indexed Variable Costs for all NF's in the class) /
(total resident days for all NF's in the class)

- Facility's Variable Costs (VC) - the total allowable base and support costs for a facility to provide routine nursing care services to residents, as determined in accord with Medicaid allowable costs and reporting requirements.
- Indexed Variable Costs (IVC) – the facility's total VC indexed to October 1 of the year that is one year prior to the rate year being calculated.

Example: The AVC for October 1, 2003, which is used for the rate year October 1, 2003 to September 30, 2004, is based on variable costs reported in cost reports ending in calendar year 2002 indexed to October 1, 2002.

10.5.D. Class Variable Cost Limit (VCL)

The Variable Cost Limit for a class of nursing facilities is set at the 80th percentile of the Indexed Variable Costs (IVC) per resident day for facilities in the class during the current calendar year. The 80th percentile is determined by rank ordering providers from the lowest to the highest IVC per resident day, then accumulating nursing facility Medicaid

resident days of the rank ordered provides, beginning with the lowest, until 80 percent of the total Medicaid resident days for the facility class of providers is reached. The VCL for the class of providers equals the IVC per resident day of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs. A VCL is calculated for Class I and Class III nursing facilities.

- Facility's Variable Cost per resident day (VC/pd) - the facility VC divided by the total number of resident days for the cost reporting period.
- Indexed Variable Costs Per Resident Day (IVC/pd) – the facility's VC/pd indexed to October 1 of the year that is one year prior to the rate year being calculated.

Example: The VCL for October 1, 2003, which is used for the rate year October 1, 2003 to September 30, 2004, is based on variable costs per resident day reported in cost reports ending in calendar year 2002 indexed to October 1, 2002.

10.5.D.1. Class I Nursing Facility VCL Exception - New Provider Rate Relief

A Class I nursing facility that qualifies for rate relief as a new provider, as defined for rate relief, in a Medicaid enrolled nursing facility with a VRB less than or equal to 80 percent of the class AVC will have an exception VCL in the rebasing rate year. The rate Variable Cost Component for the initial rate year of accelerated rebasing is limited to the Class I Average of Variable Costs. Refer to the Rate Relief for Class I Nursing Facilities subsection in this chapter for additional information.

10.5.D.2. Class III Nursing Facility VCL Exception – New Hospital Long Term Care Units After July 1, 1990

Class III nursing facilities that are new long term care units of a hospital, and have a Certificate of Need (CON) approval from the Michigan Department of Community Health (MDCH, formerly Department of Public Health) dated on or after July 1, 1990, are reimbursed according to the method for Class III facilities except that the facility Variable Cost Component is determined as the lesser of the facility Variable Rate Base or the Class I Variable Cost Limit (VCL).

10.5.E. Economic Inflationary Update (EIU)

The economic inflationary update for a facility is the Economic Inflation Rate (EIR) for the class applied to the lesser of the Variable Rate Base or the Class Variable Cost Limit.

EIU = EIR X (lesser of VRB or Class VCL)

Economic Inflation Rate (EIR) - the State legislative appropriations process will determine the annual economic inflation percentage for Class I and Class III nursing facilities.

10.6 Class V Nursing Facilities – Ventilator Dependent Care (VDC) Units

The reimbursement rate for special nursing facilities caring for ventilator-dependent residents (Class V) is set prospectively as an individual nursing unit rate per resident day determined by Medicaid.

Reimbursement is made for prior authorized ventilator-dependent services/care for residents who have been transferred to a Medicaid contracted facility. The prospective rate covers all ventilator care requirements of the residents, including all the costs of benefits associated with Medicare Parts A and B while the resident resides in the special nursing facility. This includes, but is not limited to, all routine, ancillary, physician, and other services.

Factors used in the determination of the per diem rate include audited costs of facilities providing similar services, the inflationary factor for the effective period of the prospective rate, the supply response of providers, and the number of residents for whom beds are needed. The prospective rate does not exceed 85 percent, nor fall below 15 percent, of an estimated average inpatient hospital rate for currently placed acute care Medicaid residents who are ventilator-dependent. The prospective rate is periodically re-evaluated to ensure reasonableness of supply and demand for special care. A new VDC nursing unit that has not previously participated in Medicaid for VDC services will have a reimbursement rate in the initial two years of operations based upon the statewide average VDC unit reimbursement rate for the current year.

10.7 Nursing Facility Quality Assurance Assessment Program (QAAP)

The Quality Assurance Assessment Program (QAAP) was implemented by Medicaid in compliance with Michigan law. The QAAP provides a Quality Assurance Supplement to nursing facility reimbursement rates incorporating funds from the quality assurance assessment tax. The QAAP applies to Class I, Class III Non-Publicly Owned, and Class V nursing facilities.

10.7.A. Class I Nursing Facilities and Class III Non-Publicly-Owned Hospital Long-Term Care Units

The nursing facility will receive a QAAP payment as a monthly gross adjustment. The monthly gross adjustment for an individual nursing facility will be determined based on one-twelfth of the facility's annual historical Medicaid utilization (resident days) multiplied by the facility's Quality Assurance Supplement (QAS) per resident day. The facility's historical Medicaid utilization will include all routine nursing care and therapeutic leave days billed to Medicaid by the facility. A nursing facility that is experiencing a significant increase or decrease in its current rate year Medicaid utilization which will cause a difference of greater than five percent in the nursing facility's total QAS payments for the year must contact the SMA for consideration of adjustment to the facility's monthly QAS payment. Current year Medicaid resident census data must be provided to MDCH to document the change in order to revise the monthly QAS payment amounts. It is the desired intent of MDCH to assure accuracy of total QAS monthly payments and to approximate the annual reimbursement due the facility. MDCH reserves the right to adjust the individual nursing facility monthly QAS payment to reflect the current year Medicaid activity to achieve this goal.

A facility's QAS is equal to the lesser of the facility's Variable Rate Base or Variable Cost Limit times the Quality Assurance Assessment Factor (QAAF) determined by MDCH. A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization, changes to the variable rate from filed to audited cost report data, and to adjust the increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

The QAAF is determined based on the estimated pool of funds created by the quality assurance assessment tax and the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the quality assurance assessment fee may not exceed six percent of total industry revenue for the fiscal year.

It is the Department's intention that nursing facilities that provide hospice care for residents by contracting with a hospice provider also benefit from this quality program. Medicaid will reimburse hospice providers 100 percent of a nursing facility's Quality Assurance Supplement (QAS) rate add-on for Medicaid beneficiaries provided hospice care in Medicaid participating nursing facilities. It is the responsibility of the hospice provider to pay the room and board rate to the nursing facility as specified in their contract for services.

10.7.B. Class V Nursing Facilities - Ventilator Dependent Care (VDC) Units

Qualifying VDC units will receive a QAAP payment as a monthly gross adjustment. The monthly gross adjustment for an individual unit will be determined based on one-twelfth of the VDC unit's annual historical Medicaid utilization (resident days) multiplied by the unit's Quality Assurance Supplement (QAS) per resident day basis. The unit's Medicaid utilization will include all days billed to Medicaid by the VDC unit. A nursing unit that is experiencing a significant increase or decrease in its current rate year Medicaid utilization which will cause a difference of greater than five percent in the nursing unit's total QAS payments for the year must contact MDCH for consideration of adjustment to the unit's monthly QAS payment. Current year Medicaid resident census data must be provided to the SMA to document the change in order to make revision to the monthly QAS payment amounts. It is the desired intent of MDCH to assure accuracy of total QAS monthly payments to approximate the annual reimbursement due the VDC unit. MDCH reserves the right to adjust the individual VDC unit monthly QAS payment to reflect the current year Medicaid activity to achieve this goal.

The VDC unit QAS is equal to the Class I Variable Cost Limit times the Quality Assurance Assessment Factor (QAAF) determined by MDCH. A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization and to adjust the total increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

The QAAF is determined based on the estimated pool of funds created by collection of the quality assurance assessment tax and the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the quality assurance assessment tax may not exceed six percent of total industry revenue for the fiscal year.

10.8 Class II Nursing Facilities – Proprietary Nursing Facility for the Mentally Ill or Mentally Retarded

The Class II proprietary nursing facilities for the mentally ill or mentally retarded are reimbursed an all-inclusive prospective payment rate negotiated with the MDCH State Mental Health Agency on an annual basis. Rate ceiling limits are prospectively set for allowable costs and resident occupancy for determining final reimbursement for the annual services. Final reimbursement is retrospective cost settlement, not to exceed the ceiling limit. Nursing facility allowable costs included for reimbursement are determined in

accordance with Medicaid cost reporting requirements and allowable and non-allowable cost policies, including plant cost based on allowable depreciation expense. The Provider is paid a reimbursement efficiency allowance equal to the lesser of $2.50 per resident day or the difference between the prospective ceiling limit and the nursing facility actual allowable cost.

10.9 Class IV Nursing Facilities – Institutions for the Developmentally Disabled

State-owned and operated institutions, Intermediate Care Facilities for the Mentally Retarded (Developmentally Disabled – ICF/MR), and non-profit nursing facilities for the mentally retarded are retrospectively cost settled.

The State Mental Health Agency must submit rate information regarding the facility's expected costs for the prospective year in an Interim Rate Request letter to Medicaid at the beginning of the Medicaid rate year. Subsequent requests may be submitted during the rate year if rate adjustments are necessary. The reimbursement rate for the new Medicaid rate year will not be updated until the State Mental Health Agency submits the Interim Rate Request letter.

The provider is reimbursed an interim per diem rate based on the cost information submitted. The interim reimbursement is adjusted to actual allowable costs through annual cost settlement. Refer to the Cost Report and Reimbursement subsections of this chapter for additional information.

10.10 Class VI Nursing Facilities – Hospital Swing Beds

The reimbursement rate for hospital Swing Beds (Class VI) is set prospectively as a flat per diem rate determined by Medicaid.

The current calendar year per resident day rate is the weighted statewide average routine nursing care per diem rate for the previous calendar year. The average routine nursing care per diem rate is calculated by dividing the sum of Medicaid amount approved for payment for routine nursing care in Class I and Class III facilities by the sum of nursing care days paid in these facilities for the respective time period. The reimbursement rate calculation does not include Quality Assurance Supplement (QAS) reimbursement.

10.11 Add-Ons

10.11.A. Special Dietary

Nursing Facilities Coverages and Limitations Chapter, Dietary Services and Food section provides for program reimbursement to non-profit nursing facilities for special dietary needs for religious reasons. Interim payment reimbursement to the nursing facility will be made by inclusion of a per diem rate add-on amount to the nursing facility routine nursing care rate. The total special dietary add-on reimbursement to the nursing facility during the reimbursement year will be adjusted through the annual cost report reimbursement settlement. Refer to the Cost Report Reimbursement Settlement section of this chapter for additional information.

A qualifying nursing facility that has previous year cost history of special dietary costs will have the interim payment rate add-on based on special dietary cost center allocated cost and nursing facility resident census data determined in the nursing facility cost report.

The most recent annual filed or audited cost report that is used for determining the nursing facility current routine nursing care rate will be the source of the cost data for the current interim rate add-on.

A qualifying nursing facility that does not have previous year cost history of special dietary costs will have an interim reimbursement rate add-on based on estimated cost data. The nursing facility must submit a written request identifying the estimated costs to be incurred in food purchase and preparation associated with special dietary needs for religious reasons. The request must be submitted to the RARSS and must include a certification statement attesting to the accuracy of the data and signed by the nursing facility authorized representative. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) The written request must present the following data for the current cost report year:

- Estimated resident days (not less than 85% occupancy rate for all nursing facility resident units)
- Estimated raw food purchase costs including a detail listing of the types of food to be purchased for special dietary needs for religious reasons.
- Estimated cost for supplies, tableware, cooking utensils, etc., for food preparation and service associated with special dietary needs for religious reasons.

The submitted data will be subject to review and adjustment by Medicaid for consideration and calculation of the interim rate and the add-on reimbursement rate to the facility. The submitted data will be utilized for interim rate determination until annual cost reporting data has been filed and accepted by Medicaid.

10.11.B. Nurse Aide Training and Competency Evaluation Program (NATCEP) Add-on

Nursing Facility Certification, Survey and Enforcement Chapter, Staff Certification section provides for nursing facility Medicaid reimbursement for Medicaid's share of costs incurred by the nursing facility for approved Nursing Aide Training and Competency Evaluation Program (NATCEP) expenditures. Interim payment reimbursement to the nursing facility will be made by inclusion of a per diem rate add-on amount to the nursing facility routine nursing care rate. The total NATCEP add-on reimbursement paid to the nursing facility during the nursing facility's cost report reimbursement year will be adjusted through the annual cost report reimbursement settlement. Refer to the Cost Classification and Cost Finding section and Cost Report Reimbursement Settlement section of this chapter for additional information.

The interim rate add-on amount is limited to a maximum per diem of $0.80 per resident day, however the nursing facility cost reimbursement settlement for these training costs is not subject to a per diem limit. The interim payment rate add-on will reflect the nursing facility's prior year cost history of NATCEP costs utilizing the NATCEP cost center allocated cost and nursing facility resident census data determined in the nursing facility cost report. The most recent annual filed or audited cost report that is used for determining the nursing facility current routine nursing care rate is the source of the cost data for the current interim rate add-on, except where a more recent interim reimbursement request has been submitted by the nursing facility.

Effective October 2005 the interim rate add-on amount limit is increased to $1.00 per resident day.

A nursing facility that is notified by the State Survey Agency of loss of NATCEP or CEP, has been placed on NATCEP lockout status, or has a NATCEP approval withdrawal will be notified by Medicaid that its interim reimbursement NATCEP add-on amount will be deleted from the reimbursement rate. The nursing facility must submit a completed interim reimbursement request identifying expected NATCEP allowable costs, in accordance with policy provisions referenced above, for consideration of an interim reimbursement add-on amount for allowable NATCEP costs incurred during the lockout period.

A nursing facility is eligible to submit an interim reimbursement request for a change in the interim payment rate add-on amount in the following situations:

- The nursing facility is experiencing a change in its current year NATCEP cost level that would cause an per diem increase or decrease in excess of $.25 per day in the current period reimbursement rate add-on.
- The nursing facility does not have previous year cost history of NATCEP cost.
- The nursing facility has been identified a lockout facility for NATCEP or CEP, or has loss of approval of its NATCEP, and has made acceptable arrangements for securing approved nurse aide training for nursing facility staff.

The nursing facility must submit a completed Nurse Aide Training and Testing Program Interim Reimbursement Request (Form MSA-1324) identifying the estimated costs to be incurred in providing approved NATCEP training for the nursing facility staff and projected resident census data. The request must be submitted to RARSS and must include the signed certification statement attesting to the accuracy of the data and signed by the nursing facility authorized representative. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) Electronic copy of the request form and completion instructions can be accessed on the MDCH website. (Refer to the Directory Appendix for website information.)

The submitted data is subject to review and adjustment by Medicaid for consideration and calculation of the interim rate add-on payment to the facility. Medicaid will issue the provider a rate notice indicating the accepted cost level for interim rate determination, or a request denial and reason for such action. The submitted data will be utilized for interim rate determination until annual cost reporting data has been filed and accepted by Medicaid.

10.12 Special Circumstances – Rate Determination

10.12.A. New Facility and Provider

A new facility is a provider operating a nursing facility where there is not Medicaid historical cost. Examples include:

- A newly constructed facility.
- An existing facility that has never before participated in Medicaid.
- A facility that has participated in Medicaid in a different Provider class.
- An existing nursing facility that has not provided nursing care for Medicaid beneficiaries or billed Medicaid in the past two years (24 months).

10.12.A.1. New Provider Nursing Facility Per Resident Day Plant Cost

A new provider in the Medicaid program is eligible for the Plant Cost Certification process to reflect the facility asset costs and related plant costs. The Plant Cost Certification data submission will be used for calculation of the nursing facility Plant Cost Component as outlined in the policy for the respective nursing facility class. Refer to the Plant Cost Certification and Plant Cost Component sections of this chapter for additional information.

10.12.A.2. New Provider Nursing Facility Variable Cost Component

The Variable Rate Base for the new facility and provider will be determined using special methods. During the first two cost reporting periods, new facilities and facilities with a change of class will have a Variable Rate Base equal to the Class Average of Variable Costs. This rate base will be used in the calculation of the nursing facility Variable Cost Component as outlined in the policy for the respective nursing class. In subsequent periods, the nursing facility's Variable Rate Base will be determined using the methods described in "Variable Cost Component" subsection of this chapter.

A new provider that purchases an existing facility participating in the Medicaid program or a provider with an existing, participating facility that makes major additions, renovations, or new construction does not qualify for these special methods because there are historical variable costs on which to base rates. The Variable Rate Base will be determined in accordance with Medicaid policy identified in applicable subsections of this chapter.

10.12.B. Memorandums of Understanding (MOU) – Special Agreements for Complex Care

The Nursing Facilities Coverages and Limitations Chapter, Memorandums of Understanding (MOU) – Special Agreements for Complex Care section provides for program reimbursement for nursing facilities for providing specialized care beyond services covered by the usual Medicaid per diem rate. The payment rate for specially placed residents is a negotiated prospective rate per resident day. The rate is determined for a specified period of time, not to exceed 90 calendar days without review.

Reimbursement is made for prior authorized services/care to residents who have specialized and concentrated nursing and support service needs and who have been transferred from an acute care hospital setting to an approved skilled nursing facility. The negotiated rate provides reimbursement adequate to meet the unusual needs of this

type of resident in a less costly and more appropriate environment than an acute care hospital setting.

Factors used in Medicaid's negotiation of the per resident day prospective rate include, but are not limited to, complexity, type of equipment and supplies required, the resident's condition, and the market place availability of placement. Any authorized increase in the per diem rate represents only the cost of the service. The negotiated prospective rate is re-evaluated, in consideration of the resident's needs, prior to the last day of the approval period.

10.12.C. Hospice Owned/Operated Nursing Facility

Nursing Facilities Coverages and Limitations Chapter, Hospice Services section outlines the program policy regarding nursing facility beneficiaries eligible for hospice care services and reimbursement to the hospice care provider for room and board for beneficiaries in Medicaid or Medicaid/Medicare certified beds. The individual nursing facility per diem rate is determined in accordance with program policy outlined in this chapter, if the nursing facility operation is not a hospice owned/operated licensed nursing facility.

Reimbursement for daily room and board for hospice beneficiaries in a hospice owned/operated licensed nursing facility is also available to the hospice care provider. The program does not require annual cost reporting and does not determine individual nursing facility per diem rates for the hospice owned/operated licensed nursing facility due to the unique licensure requirements applicable to these nursing facilities. The program utilizes alternative cost data elements to calculate a nursing facility per diem rate that is specifically applicable to hospice owned/operated licensed nursing facilities. This per diem rate determination is the basis for setting the hospice owned nursing facility rate used for reimbursing the room and board services that will be billed to the program by the hospice provider for hospice beneficiaries cared for in its licensed nursing facility. The hospice provider will be responsible for billing the room and board services and will be reimbursed 95 percent of this "hospice nursing facility" rate.

The hospice owned nursing facility rate is made up of four components: plant cost component, variable cost component, economic inflationary update and quality assurance supplement. The rate calculation method for the hospice owned nursing facility rate will be in accordance with the rate determination process established for Class I nursing facility. Alternative data will be utilized for the cost data elements normally applicable to the specific nursing facility. The data elements for the rate calculation will be:

Plant costs:

Nursing Facility Current Asset Value (CAV) – Class I nursing facility CAV upper bed limit for the respective rate year time period

Nursing Facility Tenure Factor – equal to 12 years for a rate of return on CAV (.0525)

Resident Days – equals 310 (represents 85% minimum occupancy level per bed)

Variable costs:

Variable Rate Base (VRB) – Class I nursing facility Class Average of Variable Costs (AVC) for the respective rate year time period

Economic Inflation Rate (EIR):

Equal to legislative appropriated annual economic inflation percentage for Class I nursing facilities.

Quality Assurance Supplement (QAS):

QAS per diem amount – equal to the lesser of the variable rate base or Class I nursing facility variable cost limit times the Quality Assurance Assessment Factor (QAAF) determined by the Department for the respective rate year time period. Medicaid participating Hospice owned nursing facility providers will receive 100 percent of the nursing facility's Quality Assurance Supplement (QAS) rate add-on for Medicaid beneficiaries in their participating nursing facilities.

Hospice Owned/Operated Nursing Facility rates are available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

10.12.D. Hospital Leave Day

Nursing Facilities Coverages and Limitations Chapter, Hospital Leave Days section identifies the parameters for program reimbursement.

Reimbursement for a hospital leave day is a single rate paid to all nursing facility providers regardless of facility class. The rate is determined annually with an effective time period coinciding with the State fiscal year. The rate determination utilizes the Class I nursing facility Class Average Variable Cost (AVC) for the State fiscal year. The hospital leave day reimbursement rate represents a calculated salary and wage component of the room and board cost portion of the total AVC. The room and board portion is equal to 95 percent of the Class I nursing facility AVC, and the salary and wage component is determined as 66 percent of the room and board cost. The formula for calculating the hospital leave day rate is:

AVC (Class I NF)	X	95% (room and board portion)	X	66% (salary and wage component)	=	**Hospital Leave Day Rate**

Hospital Leave Day rate information is available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

10.12.E. Therapeutic Leave Day

Nursing Facilities Coverages and Limitations Chapter, Therapeutic Leave Days section identifies the parameters for program reimbursement.

The reimbursement rate for a therapeutic leave day is the nursing facility's established per diem rate in effect for the period coinciding with the leave day.

10.12.F. One Day Stay

Nursing Facilities Coverages and Limitations, One-Day Stay section identifies the parameters for program reimbursement.

The reimbursement rate for an approved one-day stay is the nursing facility's established per diem rate in effect for the period coinciding with the stay.

10.12.G. Out of State Nursing Facility (Nonenrolled Michigan and Borderland Providers)

Medicaid Provider Manual, General Information for Providers Chapter, Nonenrolled Michigan and Borderland Providers and Beyond Borderland Area subsections provide for reimbursement of nursing care services to out of state nursing facilities. The out of state nursing facility must comply with provisions outlined in the manual. There is no cost reporting or reimbursement settlement activity for out of state nursing facilities.

The routine nursing care per diem rate for the out of state nursing facility is the lesser of the individual Provider's home state Medicaid rate or the Michigan Medicaid out of state provider ceiling rate. The ceiling rate is effective for the time period coinciding with the State fiscal year rate period October 1 through September 30. The ceiling rate is the sum of three components: 1) Class I nursing facility Variable Cost Limit (VCL) for the corresponding rate year, 2) Economic Inflationary Update, and 3) most recent Plant Cost 80th percentile per diem amount. Out of State nursing facility rates do not participate in the Quality Assurance Assessment program.

The out of state nursing facility must submit a copy of the nursing facility's home state Medicaid program reimbursement rate to the RARSS to be assigned a reimbursement rate. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) Out of state nursing facility rate assignments will only be effective on a prospective basis for the first day of the month following receipt of the rate request by that office. The out of state nursing facility will be issued a written notice of the rate determination action. The reimbursement rate request and rate assignment for an individual nursing facility is limited to once per calendar quarter.

10.13 Rate Relief for Class I Nursing Facilities

Medicaid reimbursement rate relief for current and new nursing facility providers is determined on a case-by-case basis in accordance with specific criteria for evaluating eligibility for relief and rate methodology for determining the rate level. The following definitions of nursing facility providers are applied in this rate relief policy for Class I nursing facilities:

- Current provider is defined as the provider that operated the facility during the time period of the last cost report on which the normal rate setting would occur, and will operate the facility during the time period for which rate relief is requested.

- New provider is defined as a person or business entity that has purchased or is purchasing a nursing facility that had immediate prior Medicaid participation and the new provider ownership individual(s) or business entity are not related through family or business ties to the ownership individual(s) or business entity of the previous provider. A nursing facility sale between family members may be approved by Medicaid and the new owner may be considered a new provider under certain circumstances, as outlined in the Ownership Changes and Medicaid Termination section of this chapter.

10.13.A. Eligibility Criteria

The provider must be a Class I nursing facility:

- The provider must demonstrate that the current Medicaid reimbursement (Rate + QAS) does not provide adequate funding to deliver a level of care to Medicaid beneficiaries in the facility that assures "each resident attains and maintains the highest practicable physical, mental, and psycho-social well-being" as required by the Omnibus Budget Reconciliation Act (OBRA) of 1987.
- The nursing facility Variable Rate Base amount must meet the following criteria:
  - For a Current Provider – The facility's Variable Rate Base is at or below the corresponding Class Average Variable Cost. The Average Variable Cost used for the class is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested.
  - For a New Provider in a Medicaid-enrolled nursing facility –The facility's current Variable Rate Base is at or less than 80 percent of the corresponding Class Average Variable Cost. The Average Variable Cost used for the class is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested. A new Provider facility with a Variable Rate Base between 80 and 100 percent of the corresponding Class Average Variable Cost is eligible for accelerated rebasing and is treated as a current provider.
- A current Medicaid provider agreement for the facility is in effect. The rate relief period is applied to the facility, and not the owner, provider, or licensee. A change of ownership, provider, or licensee during the rate relief period does not end the agreement for rate relief under this policy as long as the new owner, provider, or licensee fully complies with the requirements of the rate relief agreement.
- The nursing facility provider must also meet at least one of the following five criteria:
  - 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 each of the two years prior to the first year of rate relief. This comparison to cost is a measurement to normal reimbursement rate calculation methodology and excludes the effect of Executive Order reimbursement actions. The provider must submit a per diem cost analysis using the outlined format presented as a reference titled "Form to Establish Criteria for Nursing Facility Class I Rate Relief". The required cost analysis information is available in electronic file format on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

- 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 a copy of the citation and an approved Plan of Correction outlining the action being taken by the provider to address the requirement(s).
- 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 MDS data. The provider must submit an analysis comparing resident acuity levels from the rate base year to current resident acuity levels. Minimum Data Set (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 and other nursing related costs or requirements likely to increase the operational costs. This does not include nursing administration staff.
- 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.
- Rate relief is needed to prevent closure of a Medicaid-enrolled facility due to a regulatory action by the 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.

10.13.B. Rate Relief Petition Process

All petitions for rate relief must be in writing and submitted to RARSS. An authorized representative from the entity that holds the nursing facility license must sign the petition.

Medicaid will make the final determination for the approval or disapproval of the rate relief request. Medicaid will provide a written response within 60 calendar days of Medicaid's receipt of the rate relief request. The response may a request for additional information. The 60 calendar day time period does not begin until the Provider has submitted all of the necessary documentation for Medicaid to evaluate the rate relief request. Once the nursing facility provider has complied with the request(s) for additional information, a written notice of the approval or disapproval is given within 30 calendar days of Medicaid's receipt of the additional information.

If Medicaid requests additional or supporting documentation needed to complete the evaluation of the rate relief request, the Provider must submit the documentation within 30 calendar days of the request. If Medicaid does not receive the documentation or the Provider has not received a one-time extension for 30 additional calendar days, the SMA will issue a denial notice for rate relief. Appropriate time allowances will be made in cases where the needed data is for time period that is not yet concluded. Subsequent rate relief request by the Provider will only be effective on a prospective basis following receipt of the new request and documentation for rate relief.

10.13.C. Rate Relief Agreement

If the rate relief petition is approved, Medicaid will prepare a rate relief agreement to be signed by the nursing facility authorized representative and an authorized representative of Medicaid. Once the agreement is approved, the provider's Medicaid rate is adjusted consistent with the relief granted. The agreement outlines the rate relief granted, the effective date and any conditions or requirements.

Requirements may include but are not limited to:

- Annual and interim cost reporting requirements during the period of rate relief.
- Appointment of a monitor, at facility cost, for oversight if, after consultation with staff in the SSA, such action is deemed appropriate.
- Follow-up surveys by the SSA.

10.13.D. Rate Relief Period

Rate relief is effective on a prospective basis beginning in the month after receipt of the request by RARSS. No retroactive rate relief will be approved.

Nursing facility providers may apply and receive rate relief under this policy once every seven years, i.e., 84 months. This seven-year period begins on the effective date of rate relief.

Example: If rate relief takes effect January 1, 2003, the facility would not be eligible for rate relief again until on or after January 1, 2010.

The rate relief period is based on the facility, not on the owner or licensee. A change of ownership does not void the seven-year period under this policy.

10.13.E. Withdrawal of Rate Relief Agreement

Medicaid may withdraw the rate relief agreement if the facility is cited by the SSA for serious certification violations while receiving rate relief. If the citation(s) is for serious and immediate threat or substandard quality of care; or the provider not spending the money in accordance to the plan filed for special rate relief the rate relief agreement may be withdrawn. Medicaid will review the nursing facility actions to determine if rate relief termination is warranted. If Medicaid terminates the agreement is by, the nursing facility's Medicaid rate will be recalculated in accordance with existing Medicaid

reimbursement policy without rate relief. The rate change would take effect at the beginning of the month following issuance of a 30 calendar day notice to the provider.

10.13.F. Rate Relief Appeals

Nursing facility providers that receive notices of denial for rate relief or are notified that a rate relief agreement has been withdrawn may file an appeal. Appeals are handled in accordance with the existing appeals process. Additional information appears in the Appeal Process Section in this chapter.

10.13.G. Rate Relief for a New Provider in a Medicaid-Enrolled Nursing Facility with a Variable Rate Base less than or Equal to 80 percent of the Class Average Variable Cost

A new provider in a Medicaid enrolled nursing facility with a Variable Rate Base less than or equal to 80 percent of the Class Average Variable Cost may request an increase in the current facility rate. The new provider must be operating in a facility that has previously participated with Medicaid.

10.13.G.1. Rate Relief Methodology

A new rate is calculated using the Class I Average Variable Cost for the appropriate year as the Variable Rate Base for the calculation of the facility Variable Cost Component, thereby increasing the facility per diem rate. This Variable Rate Base is in effect through the current State fiscal year rate period ending September 30.

Effective October 1 of the State fiscal year rate period starting after the new provider begins operation, the Variable Rate Base is determined using accelerated rebasing. The accelerated rebasing utilizes the new provider's first cost reporting period that reflects at least seven months of nursing facility operation. The cost reporting time period is based on the new 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 new provider Variable Rate Base is limited to the Class I Average Variable Cost for the corresponding rate year time period.

The new provider receiving rate relief in this category must utilize the standardized data to file a Class I Rate Relief Interim Cost Statement prior to September 15. 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 new provider's first cost reporting period (as referenced above). The facility's annual cost report may be used in lieu of the Interim Cost Statement if the cost report will be filed with Medicaid prior to September 15.

The Rate Relief Interim Cost Statement must contain the following completed schedules of the cost report in the 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 utilizing the accelerated rebasing provisions. The interim rate is revised when the acceptable annual cost report is submitted and used for accelerated rebasing.

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

Example: A new nursing facility provider begins operations on January 1, 2004, selects a September 30 year-end cost reporting period. Following request, the provider is approved for rate relief for rate year October 1, 2003 to September 30, 2004. The facility per diem rate is set using the Class I Average Variable Costs effective for the rate year beginning October 1, 2003 (effective for the new provider on January 1, 2004). The provider must complete an interim cost statement for variable costs for the period January 1, 2004 through September 30, 2004, that must be filed by September 15, 2004. Effective October 1, 2004 the Variable Rate Base is the lesser of the variable costs from the interim cost statement, indexed to October 1, 2003 OR the Class Average Variable Cost effective October 1, 2004. Following the filing of the annual cost report, the variable costs from the annual report are indexed to October 1, 2003 and the interim Variable Rate Base is recalculated.

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 handled 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.

10.13.G.2 Rate Relief Documentation

It is the provider's responsibility to present supporting documentation with the rate relief petition. Petition from a new provider must include:

- Identification of the criteria under which relief is requested.
- Supporting documentation for the criteria.

- Detail the circumstances causing the need for the rate relief request.
- The proposed effective date. The actual effective date of the rate relief is based on the date the petition is received by Medicaid. The earliest effective date would be the first day of the next month following the receipt of the request.
- The services time period that is the basis for which rate relief is requested.
- Specific details reflecting how the additional funds will be spent (i.e. staffing, consultants, medical supplies, etc.).
- Plans on how these changes will ensure the required level of resident care.

10.13.H. Rate Relief for a Current Provider or a New Provider in a Medicaid Enrolled Nursing Facility with a Variable Rate Base between 80 Percent and 100 percent of the Class Average Variable Cost

A current or new provider in a Medicaid enrolled nursing facility with a Variable Rate Base between 80 percent and 100 percent of the Class Average Variable Cost may request accelerated rebasing.

Rate relief applies only to the nursing facility's Variable Rate Base. The facility's qualification for adjustment of the Plant Cost Component in the Medicaid rate and Nurse Aide Training and Testing costs is handled in accordance with current Medicaid policy.

10.13.H.1 Rate Relief Methodology

Accelerated rebasing is the use of the Medicaid cost report data from the period ending in the current calendar year in the rate setting process, rather than using cost report data from the period ending in the previous calendar year under the standard reimbursement methodology. The nursing facility's allowable variable cost is indexed to October 1 of the year that is one year prior to the rate year being calculated, by applying the appropriate cost index.

Example: The provider's cost report for the period ending December 31, 2003 could be used to set the October 1, 2003 rate if approved for rate relief under this policy. 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 accelerated rebasing must have a reporting period end date prior to January 1 of the State rate year.

Example: A cost report time period ending after January 1, 2004 could not be used for accelerated rebasing of a rate effective during the State rate year October 1, 2003 through September 30, 2004.

10.13.H.2 Rate Relief Documentation

It is the provider's responsibility to submit supporting documentation with the rate relief petition. 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. For example, 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.

SECTION 11 - APPEAL PROCESS

A nursing facility participating in the Medicaid program may appeal an adverse action and certain determinations made by Medicaid. The provider will be given a written notice of the determination or action that outlines the proposed action, the provider's appeal rights, and the appeal process.

Adverse actions include, but are not limited to:

- A suspension or termination of a provider's Medicaid program participation;
- A reduction, suspension, or adjustment of provider payments;
- A retroactive adjustment following an audit or review of a facility's daily reimbursement rate or other services reimbursement.
- The prospective reimbursement rate determination.

Some elements of the Medicaid nursing facility reimbursement determination methodology are not appealed through an administrative process, but may be appealed to a court of appropriate jurisdiction. These are elements, where an administrative remedy, if permitted for a single provider, would imply or necessitate a change for all providers or for all providers in a class, and include, but are not limited to:

- The formula for the determination of the nursing facility cost factor.
- The Principles of Reimbursement and guidelines that define allowable costs.
- Medicaid Interim Payment (MIP) Program normal payment amount or reconciliation of payments and approved service billings.
- Non-Medicaid issues.
- Cost limits established in program policy.
- Medicaid's determination of allowable items and costs until an audit has been completed.

The review and hearings process for providers has been promulgated in the administrative rules and is explained in MDCH's Administrative Hearings Manual located on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

11.1 AUDIT APPEALS

Each nursing facility cost report is audited to ensure that expenses attributable to allowable cost were reported in adherence with Medicaid policy. Once the audit report is completed a Preliminary Summary of Audit Adjustments Notice. This notice outlines audit results and advises the provider of their appeal rights, including the right to an Area Office Conference.

If the provider or the provider's designee does not respond to the Preliminary Summary of Audit Adjustments within 15 business days of the date of the Notice, the provider will receive a Final Summary of Audit Adjustment Notice. The notice advises the nursing facility of subsequent appeal rights, up to and including an administrative hearing. The provider or their designee has 30 calendar days from the date of the Final Summary of Audit Adjustments Notice to request a formal hearing in accordance with DCH rules for hearings.

If a provider wants an Area Office Conference, the provider or the provider's designee must send a written request to the audit representative(s) within 15 business days of the Preliminary Summary of Audit Adjustments Notice date. The Area Office Conference is a forum for the provider or their designees to present documents and arguments contesting the Preliminary Summary of Audit Adjustments Notice. The audit representative(s) must schedule an Area Office Conference within 15 calendar days of the receipt of the provider's or provider designee's request. Within 15 calendar days after the Area Office Conference, the audit representative(s) must issue a Final Summary of Audit Adjustments Notice to the provider. The notice advises the nursing facility of subsequent appeal rights, up to and including an administrative hearing. The provider or their designee has 30 calendar days from the date of the Final Summary of Audit Adjustments Notice to request a formal hearing in accordance with MDCH rules for hearings.

If a provider does not appeal or does not respond to the Final Summary of Audit Adjustments Notice or other notices or processes related to a conference or hearing within the allotted timeframe, the provider has waived the right to any further administrative review.

11.2 Rate Appeals

Providers are notified in writing of their Medicaid reimbursement rate(s) at least 30 calendar days prior to the rate's effective date. The provider is given an opportunity for informal review of the rate determination by RARSS. The provider also may formally appeal issues of disagreement or dispute regarding the determined reimbursement rate. A notice of appeal rights, with instructions on how to request an appeal, is included in the final settlement Notice of Medicaid Reimbursement.

11.3 Reimbursement Settlement Appeals

A final settlement reimbursement determination is made to determine the aggregate Medicaid reimbursement to the nursing facility for the time period covered by the cost report. Providers are notified in writing of the final reimbursement settlement and given an opportunity for informal review of the settlement determination. The provider may formally appeal issues of disagreement or dispute of the reimbursement settlement determination. A notice of appeal rights, with instructions on how to request an appeal, is included in the final settlement Notice of Program Reimbursement.

11.4 Provisional Rates

A provider will be given a provisional rate for the new rate year if:

- Medicaid is responsible for a delay in determination procedures.
- An Area Office Conference or Administration Conference is in progress.
- The potential for an Area Office Conference or an Administrative Conference is still open at the beginning of the rate year that begins a year and a day after the end of the rate year that is being processed.

For this purpose, "delay in the procedures" means (if applicable):

- Medicaid failed to issue the Preliminary Summary of Audit Adjustments in a timely manner.
- Medicaid failed to conduct the Area Office Conference in a timely manner.

- Medicaid failed to issue the Final Summary of Audit Adjustments Notice, including a final determination notice, in a timely manner.

11.5 Provider Payment Adjustment Resulting From Appeal Decision

If the appeal result requires a change in a provider's rate or reimbursement level, the change will be made retroactively for service time periods coinciding with the effective dates of the original reimbursement rate notice. Payment adjustments will be made by an aggregate adjustment rather than by individual claim adjustments.

SECTION 12 - MEDICAID INTERIM PAYMENT PROGRAM

A Nursing facility has the option of selecting one of two payment methods:

- Payment directly related to claims submitted to and processed by the Invoice Processing system, or
- enrollment in the Medicaid Interim Payment Program (MIP).

Providers enrolled in MIP receive a pre-determined dollar amount in cycled payments. MIP payments represent the expected dollar amount that Medicaid would have paid to the nursing facility in claims reimbursement during a period of time. The MIP payment calculation is based on historical approved billings, current reimbursement rate and claims data. The Department may perform interim reconciliation(s) if a significant amount is due the program. After the end of the quarter, a comparison is made of the most recent pre-determined payment and the approved days activity billed. The result of the comparison could result in an increase or a decrease to the MIP payment amount. A reconciliation is done at the end of the provider's fiscal year.

12.1 ENROLLMENT IN MIP

To participate in MIP, a Medicaid participating provider must submit a written request to RARSS. New providers must submit the necessary information outlined in the New Provider Information Data format. Established providers may submit a written request. Providers must acknowledge and agree to the terms of participation in the MIP as outlined in this section. Requests to enroll in MIP must be received one month prior to the beginning of the calendar quarter for which enrollment is desired.

If enrollment is approved, RARSS will enroll the provider in MIP in the calendar quarter following the approval of RARSS. Once MIP payments begin, claims approved through the Claims Processing system regardless of date of service will not generate a separate or additional payment.

12.2 DISENROLLMENT IN MIP

To disenroll in MIP, the provider must submit a written request to RARSS. The request to disenroll must be received by RARSS one month prior to the end of a calendar quarter. Disenrollment is effective at the beginning of the calendar quarter following the receipt of the request by RARSS.

Providers terminating participation in the Medicaid Program will not receive a MIP payment in the final month of participation.

The final month's MIP payment is subjected to reconciliation to determine the status of MIP. Special arrangements may be made where there is guaranteed assurance the State can recover any payment difference that may exist as the result of MIP participation. A Provider interested in a special arrangement must contact RARSS for consideration.

Providers interested in re-enrollment in the MIP program must wait at least one full quarter before reapplying.

12.3 Claims Submission

Providers are expected to submit claims for services rendered in a timely manner. Although a provider enrolled in MIP does not receive payment directly from claims submission, future MIP payments are affected by claims submission. MIP payments are calculated for expected days to be reimbursed.

12.4 Calculation of MIP Payment

The MIP amount is recalculated on a quarterly basis. The recalculation is to update the MIP amount to reflect the current Medicaid billing activity for the facility and the provider's Medicaid per diem rate when necessary. A recalculation may occur any time during a calendar quarter due to a change in the provider's per diem rate. The quarterly recalculation is based on the approved claims activity over the most recent twelve months, regardless of the date of service, and Medicaid utilization during the same time period. At the end of each quarter, the recently completed quarter's approved claims are used to update the MIP payment calculation.

The annually projected State liability to the provider (total reimbursement less other insurance and patient payments) will be divided by 24 to determine the regularly scheduled payment amount that will be made twice a month. The other insurance and patient payment amounts are based on the most recent quarter payment data projected to an annual amount.

In the case of major problems to Medicaid data system where a significant change has occurred in the approved claims data for a quarter as a result of Medicaid data system, the MIP amount would continue as previously calculated or the provider may request that RARSS perform a recalculation. If a significant reduction in the MIP amount is due to a problem outside the provider's control, such as a payment system error, the provider may request that RARSS perform a recalculation as a special consideration. RARSS staff will analyze and review the request to determine if special consideration is warranted.

Interim recalculations requests as a result of provider delays in billing must be submitted to RARSS for approval or denial. Providers that have demonstrated repeated occurrences of delays in billing may not receive an interim recalculation.

12.5 Frequency of MIP Payment

The biweekly MIP payment is an estimate of one-half of the Medicaid liability for reimbursable services rendered in the previous month. The MIP payment will be paid on the first and third Wednesday of each month. This means a provider could receive 100 percent of the monthly payment as early as the 15th day of the month and no later than the 21st day. Providers enrolled in MIP will receive 6 regularly scheduled payments during a calendar quarter.

12.6 Annual Reconciliation

The reconciliation of approved claims and MIP payments is done annually generally 90 calendar days after the end of the Provider's fiscal year. If a provider changes their cost- reporting fiscal year, they must notify RARSS in advance in writing. Any change in a fiscal year could adversely affect a provider in the reconciliation.

If an underpayment has been made, the provider will receive a gross adjustment payment. If an overpayment is determined, recovery will be made by gross adjustment recovery against future

payments. The gross adjustment process follows the Initial and Final Settlement practices in the Settlement section of this chapter. A provider may submit a written request to RARSS for an extended repayment schedule to repay the Program. The request must provide adequate justification for the need for extended repayment.

MIP amount determination, reconciliation and adjustments are not subject to appeal under the administrative rules. The MIP Program does not determine the reimbursement rate; it is an interim payment mechanism substituting for Claims Processing payments. The provider is given advance notice of the MIP actions and can request a review with RARSS. The provider's action must be timely and specific to the problem.

12.7 NEW PROVIDERS

New providers, resulting from a change in facility ownership, may request MIP at the time of Medicaid Program enrollment by submitting the information in the New Provider Information Data format to RARSS.

New providers in facilities without historical Medicaid Program billing data are not eligible for MIP.

SECTION 13 – APPRAISAL GUIDELINES

Where historical cost records of a purchased asset are not available or are incomplete, or where fair market value or current reproduction cost must be established, a timely appraisal of the historical costs, fair market value, or depreciated reproduction cost (as appropriate) of the asset made by an independent, recognized expert is acceptable for depreciation and owner's equity capital purposes. The appraisal of the historical cost of assets should produce a value approximating the cost of reproducing substantially identical assets of like type, quality, and quantity at a price level in a bona fide market as of the date of acquisition. The appraisal must be conducted in accordance with "The Principles of Appraisal Practices and Code of Ethics" of the American Society of Appraisers.

For Medicaid program purposes, the term "appraisal" refers primarily to the process of establishing or reconstructing the historical cost, fair market value, or current reproduction cost of an asset. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

Appraisal Date	The date selected for establishing the value of fixed assets. For example, if December 31, 2002 was established as the appraisal date and the actual physical inventory of fixed assets was taken on February 1, 2003, any additions or dispositions of fixed assets between December 31, 2002 and February 1, 2003 must be taken into account in the appraisal values.
Appraised Book Value	The book value of an asset's appraised cost as of the date of acquisition less accumulated depreciation computed on an approved basis up to the appraisal date.
Appraisal Expert	An individual or firm that is experienced and specialized in multi-purpose appraisals of plant assets involving the establishment or reconstruction of the historical cost, fair market value, or current reproduction cost of such assets. The appraisal expert must employ a specially trained and well supervised staff with a complete range of appraisal and cost construction techniques; be experienced in appraisals of plant assets used by providers; and demonstrate a knowledge and understanding of the regulations involving reimbursement principles, particularly those pertinent to depreciation.

13.1 APPROVAL

Medicaid does not require the nursing facility representatives to get prior approval before an appraisal is made for Medicaid purposes. Medicaid requirements are that the appraisal be conducted in accordance with the provisions of these guidelines. Questions regarding the appraisal of the nursing facility should be directed to the SMA's LTC Reimbursement and Rate Setting Section. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.) The provider must make the appraisal agreement and final report available to Agency staff for audit review. The scope of the appraisal must conform to Medicare Principles of Reimbursement as modified by Michigan Medicaid for provider costs in effect on the appraisal date.

13.2 Need for Appraisal

An appraisal for Medicaid purposes should be made only where the nursing facility provider has no historical cost records, or has incomplete records of the depreciable fixed assets, or needs to determine an asset's fair market value or depreciated reproduction cost. The appraisal should develop the historical cost and related information that will assist in the construction, reconstruction, or revision of accounting records to enable the provider to make proper distribution of depreciation expense in cost reports. Normally, a proprietary provider will not need a historical cost basis of its assets. Where an appraisal is being performed to determine the current reproduction of an asset, the appraisal should represent the cost to reproduce the actual facility in like kind and should not be inflated by such factors as current or anticipated space needs or different construction types, e.g., masonry versus wood frame. Appraisals must be performed within the time limit specified in the proposed agreement and not on a piecemeal or intermittent basis.

13.3 Purchase of Ongoing Facility

In establishing the historical cost of assets, where an ongoing nursing facility is purchased through a bona fide sale after July 1, 1966 and prior to August 1, 1970, the purchase price or portion thereof attributable to the asset, must not exceed the fair market value of the asset at the time of the sale. For depreciable assets acquired after July 1970, the cost basis of the depreciable assets must not exceed the lower of the current reproduction cost adjusted for straight-line depreciation over the life of the assets to the time of the sale or the fair market value of the tangible assets purchased.

If the nursing facility was participating in the Medicaid program at the time of sale, the sale price used by the seller in computing gain or loss for the final cost report must agree with the historical cost used by the new facility owner (the purchaser) in computing depreciation. However, where the basis for depreciation to the purchaser for an asset acquired after July 1970 is limited to the lower of current reproduction cost (adjusted for straight-line depreciation from the time of asset acquisition to the time of the sale) or the fair market value, the basis for computing gain or loss to the seller is the sale price. The gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sale price among all the assets sold (including land, goodwill, and any assets not related to resident care), in accordance with the fair market value of each asset as it was used by the seller at the time of sale. If the purchaser and seller cannot agree on an allocation of sale price, or if they do agree but there is insufficient documentation of the current fair market value of each asset, the Agency will require an appraisal by an independent appraisal expert to establish the fair market value of each asset and will make an allocation of the sale price in accordance with the appraisal. In any case, the sale price must be allocated among all the assets sold, even if some of the assets will be disposed of shortly after the sale.

If a purchaser cannot demonstrate that the sale is bona fide, the seller's net book value will be used by the purchaser as the basis for depreciation of the asset. In such case, the purchaser must record the historical cost and accumulated depreciation of the seller recognized under the Medicaid program, and these must be considered as incurred by the purchaser for Medicaid purposes.

The cost basis for the depreciable assets of a nursing facility purchased in a bona fide sale on or after August 1, 1970 is limited to the lowest of the following:

- The total price paid for the facility by the purchaser as allocated to the individual assets;
- The total fair market value of the facility at the time of the sale as allocated to the individual assets;

- The combined fair market value of the individually identified assets at the time of the sale; or
- The current reproduction costs of the depreciable assets, depreciated on a straight-line basis over the life of the assets to the time of the sale.

The purchaser has the burden of proving that the transaction was a bona fide sale, and if the burden is not met, the cost basis may also not exceed the seller's cost basis less accumulated depreciation.

13.4 Fixed Assets Included in Appraised Values

Fixed asset values established by an appraisal must include all plant assets owned by the nursing facility provider that are used in resident care or in the overall operation and administration of the facility. Fixed assets used in research and other non-allowable cost areas or functions should be included so that depreciation is reflected in those departmental costs to provide a proper basis for allocating administrative and general expense. Fixed assets of a related organization not used by a provider in rendering resident care, assets acquired in anticipation of expansion, and assets held for investment and not used in the plant operation should not be included as a part of the appraised values.

Generally accepted accounting principles relating to improvements or betterments must be followed in determining the asset values established by the appraisal. Repair or maintenance of a nature that restores an asset to its original condition but does not extend its useful life is not betterment or improvement but an expense of that period.

The pricing of assets to establish historical costs is based on such actual supporting documents as vendor invoices and construction contractor completion statements. In the absence of invoices, such other records as revenue stamps, board minutes, contracts of purchase, and deeds recorded with the county's Recorder of Deeds may be used.

Other methods, such as manufacturer's catalogs, libraries of material prices, or techniques involving reverse trending and price indices may be used to establish acquisition costs and dates. Such methods may be used only when actual supporting documents are not available. When these sources and techniques are used, consideration must be given to the manufacturers and to quantity discounts. The determined value should closely approximate the actual historical cost of an asset at the date of acquisition.

13.5 Minor Equipment

Where minor equipment is concerned, the SMA recognizes that the inventory costs of such equipment may not truly reflect the cost of equipment purchased and in use by the nursing facility provider. Differences in the capitalization policies of providers and their desire to limit property record controls over certain classes of small assets cause variations in the recorded costs of assets generally considered depreciable. Medicaid will only recognize an appropriate amount for minor equipment costs where the original equipment acquisition cost was recorded in the accounting records as capital asset cost and had not previously recorded the minor equipment acquisition as current period operations expense..

Minor equipment includes but is not limited to such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, and buckets. The general characteristics of this type of equipment are as follows:

- The equipment is in no fixed location and is subject to use by various departments in the nursing facility;
- The items are comparatively small in size and unit cost;
- The equipment is subject to inventory control;
- There is a fairly large quantity of the items in use; and
- The equipment has a useful life of approximately 3 years or less.

However, where all other depreciable assets are concerned, such as buildings, building equipment, major movable equipment, land improvements, and leasehold improvements, the Medicaid program will not recognize a historical cost of such assets in excess of the historical cost used for federal income tax purposes. Nursing facility providers should be able to support this historical cost by reference to original documents such as contracts, vouchers, checks and other evidence. If the provider does not have such original documentation constituting primary evidence of the historical cost of assets, the Agency will consider the provider's federal income tax returns as secondary evidence to be used in establishing and verifying the historical cost of the assets. Further, it is possible that because of the effects of other provisions within the Medicare Principles of Reimbursement, such as "cost to related organizations," the historical cost under Medicaid might be less than that allowed and used for income tax purposes.

Under the Principles, nursing facility providers may change the useful lives of assets where this can be justified and appropriately adjust the accumulated depreciation applicable to the historical cost of the assets involved. The effect of such adjustments is to change the undepreciated amount of the historical cost for Medicaid purposes. The Principles do not permit providers to increase the historical cost basis of their assets to recognize elements of costs or expenditures that were not capitalized but were considered as expense items.

Example: If a provider determines that a physical modification of the building was a repair, and thus an item of expense not capitalized, and uses the historical cost so determined for federal income tax purposes, the provider may not change the historical cost basis to include that expenditure previously determined a repair and capitalize it, i.e., increase the historical cost basis of the building for Medicaid purposes.

Example: If a provider builds a facility and in establishing the historical cost of the building determines that material and labor used were not part of the historical cost of the building and charges the cost of such material and labor into expenses for federal income tax purposes, the provider may not then include such expenditures in the historical cost of the building for Medicaid purposes.

Costs in excess of the cost basis used for federal income tax purposes will not be recognized under Medicaid. Further, for cost reporting periods beginning on or after January 1, 1970, the Agency will also require a redetermination of allowable costs for the reporting period covered to reflect the effects of the adjustment in the historical cost basis of the assets. For cost reporting periods beginning before January 1, 1970, however, no redetermination of such allowable costs need be made for the reporting periods covered. Accumulated depreciation applicable to the depreciable assets under the Medicaid program will include the full amount allowed during those periods in which an increased historical cost basis was used. The net book value will be used for computations of gain or loss on the sale of assets and for any other reimbursement purposes under Medicaid.

13.6 Donated Assets

The fair market value for a donated asset is the price that the asset would bring by bona fide bargaining between well-informed purchasers and sellers at the date of acquisition. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

Exception: In cases where an asset has been used or depreciated under the Medicaid program and then donated to a provider, the basis of depreciation will be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program.

If the nursing facility provider's records do not include the fair market value of the donated assets as of the date of donation, an appraisal of such fair market value by a recognized appraisal expert will be acceptable for depreciation and owner's equity capital purposes.

Where material, labor, and services are donated in the construction of an asset, the asset value is the sum of the appraised cost of the material, labor, or services actually donated and the incurred cost of that part which was not donated. Labor costs should be determined in accordance with both the rates prevailing in the community at the time of construction and the type of labor incurred, i.e., if the labor donated was non-union labor, the cost would be at the non-union labor rate rather than at a union labor rate. If records are not available as to the actual labor, services, or material donated, the fair market value at the time of donation may be determined by the other methods shown in Medicare Principles of Reimbursement. Estimated labor costs provided by an owner or shareholder of a facility are not includable in the historical cost of constructed assets.

13.7 Assets Costing less than $100

Individual major movable assets costing less than $100, whether or not purchased in quantity prior to the appraisal date, may be capitalized at the time of appraisal at the purchase cost less accumulated depreciation from the date of acquisition regardless of the provider's past accounting practices. If an election is made to capitalize such assets, this policy must be applied consistently.

Nursing facility providers that have expensed such items while in the Medicaid program may not decide later to capitalize them. This also applies to those providers that eventually decide to have appraisals. The appraisal expert may group major movable equipment with a unit cost of $100 or less. However, the book value assigned to such grouped assets at appraisal may not exceed the book value of the assets if individually appraised. Identification of the individual assets comprising the group must be available.

13.8 Tagging of Equipment

For Medicaid program purposes, tagging of equipment is not mandatory. In the absence of tagging, however, alternate records must be maintained to satisfy audit verification of the existence and location of the assets.

13.9 Appraisal Programs

Since the condition of nursing facility provider asset records varies significantly, an appraisal program may be comprehensive or partial. For instance, a provider may engage an appraisal expert to appraise a part of its facility for which no historical records have been maintained, or a provider may need to have an appraisal made on a particular class of assets in a specific identified location.

Comprehensive appraisal programs are usually appropriate because of such complexities as lump-sum purchases of assets or a complete lack of historical cost records for all assets.

An appraisal program should include:

- A physical inventory and listing of pertinent data for all applicable assets in use or in standby status as of the appraisal date or report date. The physical inventory may be made by the provider or by the appraiser. If made by the provider, the appraiser must verify the inventory.
- The acquisition cost of each item or unit of property including but not limited to architect fees, installation costs, and freight.
- A classification of each item or unit of property in accordance with the American Hospital Association (AHA) Health Data and Coding Standards Group, Estimated Useful Lives of Depreciable Hospital Assets. These classifications are:
  - Land improvements;
  - Buildings, including building improvement, fixed equipment, building services equipment and other fixed equipment;
  - Major movable equipment;
  - Minor equipment; and
  - Leasehold equipment.

  Note: Refer to the Cost Classifications and Cost Finding section of this chapter for a comprehensive description for capital assets by category.
- Establishing an estimated useful life for each asset. The estimated useful life for purposes of the appraisal must be consistent with the estimated useful life for each asset used by the provider for depreciation purposes.
- Determining a salvage value for each asset.
- Selecting a depreciation method for each asset.
- Calculating depreciation provisions for the current reporting period.
- Calculating accumulated depreciation, using an approved basis, from the date of acquisition to the start of the Medicaid reporting period in which actual depreciation is first claimed.
- Determining square footage for each cost center to identify all rooms on a floor or within a building if the provider did not previously do this. This should be accomplished as explained in the AHA Cost Finding and Rate Setting for Hospitals.

- Reconciling appraisal results with provider records. For assets acquired prior to January 1, 1966, the provider's plant asset records, if any, and accounting records must be considered even though they may be inaccurate. This reconciliation must be made for land improvements, buildings, building services equipment, and where possible for other major asset classifications.

  Where applicable, differences discussed by the reconciliation must be reflected as adjustments in the provider' accounting and plant asset records.

13.10 Appraisal Report

The appraisal expert must prepare a letter of certification. The letter should state that, in the appraisal expert's judgment, the appraisal results were determined in conformity with Medicaid program regulations and requirements. This letter will include such information as:

- Name of the nursing facility provider for which the appraisal was conducted;
- Location(s) of the facility included in the appraisal;
- Appraisal date, the date up to which accumulated depreciation was calculated (if other than the appraisal date), and the period for which current depreciation is calculated;
- Contents of data supplied to the provider, i.e., summaries, schedules, plans, etc.;
- Appraisal program descriptions, including:
  - The extent of asset appraisal, i.e., assets physically inventoried,
  - Pricing basis, and
  - Other pertinent information not readily apparent in the detail results, such as depreciation methods.
- Policy for determining capitalizable assets;
- Depreciation policy in the year of acquisition and disposal; and
- Identification of material items included in the appraisal where the values of such items were obtained from outside sources without independent verification by the appraisal expert.

13.11 Listing of Assets Appraised

If a listing of assets that constitutes the nursing facility provider's Medicaid property records is supplied, it must contain all necessary and pertinent information, even if portions were determined solely by the provider. A listing of assets should include the following information for each asset:

- Building location;
- Cost center or department;
- Asset description, usually including manufacturer's name, model number, serial number, etc.
- AHA asset classification;
- Historical cost;
- Acquisition date;

- Estimated useful life to provider;
- Salvage value;
- Depreciation provision for current reporting period;
- Accumulated depreciation provision for current reporting period; and
- Pricing method necessary for adequate disclosure, where more than one method was used for various assets.

Reconciliations and comparisons with provider records must also be included, as well as square footage and other allocation basis information for buildings and cost centers within buildings.

13.12 Records

Appraisal work papers must be made available to SMA staff or their designees upon reasonable request.

13.13 Appraisal Expense

The expense of an appraisal to establish plant records for Medicaid program purposes, including the expense for appraisal of research and other non-resident departments, incurred by a nursing facility provider after entrance into the program, may be included as an allowable cost. The expenses will be considered as administrative costs in the period incurred, subject to apportionment to the Medicaid program. Appraisal expenses incurred relative to assets not connected with provider operations are not allowable costs.

Where providers have appraisals made for other business purposes, such as insurance coverage, tax values or financing, the incurred expenses for such appraisals may be included in allowable costs as part of administrative and general costs. However, appraisal expenses incurred to establish values for the sale or anticipated sale of the nursing facility or provider organization are not allowable costs.

Where the SMA determines that a provider has incurred appraisal expenses to establish the historical cost of assets, which were already adequately reflected in its books, records, or tax returns, the cost of performing the appraisal is not allowable.

SECTION 14 – COST REPORTING AND REIMBURSEMENT DESCRIPTIONS AND CLASSIFICATIONS

14.1 GENERAL

Refer to Cost Classification and Cost Finding section of this chapter for detailed discussion and description of Program cost categories for Plant, Variable Base, Support and Base/Support.

Plant 1	Depreciation cost category generally allocated to operational cost centers on the basis of square footage.
Plant 2	Depreciation cost category generally allocated to operational cost centers on the basis of square footage or asset dollar value.
Plant 3	Interest, real and personal property taxes, allowable lease rental and borrowing-related amortization cost category generally allocated to operational cost centers on the basis of square footage.

14.2 PLANT COSTS– RENT/LEASES

Leases

Underlying Cost – Depreciation ..... Plant 1
Underlying Cost – Interest ..... Plant 3
Underlying Cost – Property Taxes ..... Plant 3
Lease Rental Component ..... Plant 3
Other Nonallowable Costs ..... Support

Interests

Mortgage & Bond ..... Plant 3
Other ..... Plant 3
Paid to Owner(s) ..... Plant 3

Amortization

Interest Related ..... Plant 3

Property Taxes

Property Taxes ..... Plant 3

Depreciation

Building & Improvements (fixed) ..... Plant 1
Equipment (moveable) ..... Plant 2
Vehicles ..... Plant 2

14.3 EMPLOYEE HEALTH & WELFARE

FICA – Employer's Portion ..... Base/Support
Federal Unemployment Tax ..... Base/Support
MESC ..... Base/Support
Workers Compensation ..... Base/Support

Pension & Profit Sharing ..... Base/Support
Employees Group Insurance ..... Base/Support
Retirement ..... Base/Support
Other ..... Base/Support

14.4 ADMINISTRATIVE & GENERAL

Salaries & Wages – Officers ..... Support
Salaries & Wages – Administrator ..... Support
Salaries & Wages – Owner/Administrator ..... Support
Salaries & Wages – Clerical & Other ..... Support
Employee Benefits ..... Support
Workers Compensation ..... Base
Payroll Taxes ..... Support
Director's Fees ..... Support
Management Services ..... Support
Central Office Overhead ..... Support
Contracted Services ..... Support
In-service Training ..... Support
Education ..... Support
Advertising ..... Support
Promotion & Public Relations ..... Support
Telephone & Other Communications ..... Support
Dues & Subscriptions ..... Support
Insurance - Officer's Life ..... Support
Insurance – General ..... Support
Malpractice Liability Insurance ..... Support
Copier ..... Support
License Fees ..... Support
Quality Assurance Assessment ..... Support
Provider Donation for Outstationed State Staff ..... Support
Transportation ..... Support
Equipment Repair & Maintenance ..... Support
Vehicles ..... Support
Office Supplies ..... Support
Printing ..... Support
Postage, UPS, Freight ..... Support
Legal & Accounting ..... Support
Utilization Review ..... Support
Income Taxes ..... Support
Other Taxes ..... Support
General Travel ..... Support
Travel & Seminars ..... Support
Data Processing ..... Support
Amortization – Non-interest Related ..... Support
Employment Agency Fees ..... Support

Charitable Contributions.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Security Guard Services.....Support
Penalties.....Support
Miscellaneous.....Support
Bad Debt.....Support

14.5 Plant Operation & Maintenance

Salaries & Wages – Plant Operation & Maintenance.....Support
Employee Benefits.....Support
Workers Compensation.....Base
Payroll Taxes.....Support
Contracted Services.....Support
In-service Training.....Support
Education.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Deprecation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Repair & Maintenance – Building.....Support
Repair & Maintenance – Equipment.....Support
Repair & Maintenance – Grounds.....Support
Building Insurance.....Support
Supplies.....Support
Miscellaneous.....Support
Trash Removal.....Support
Snow Removal.....Support

14.6 UTILITIES

Gas & Fuel ..... Base
Electricity ..... Base
Water ..... Base
Miscellaneous ..... Base

14.7 LAUNDRY

Salaries & Wages – Laundry ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Contracted Services – Base ..... Base
Contracted Services – Support ..... Support
Contracted Services – Base/Support ..... Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest 7 Property Taxes ..... Plant 3
Repair & Maintenance ..... Support
Linen & Bedding ..... Base
Laundry Supplies ..... Base
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.8 HOUSEKEEPING

Salaries & Wages – Housekeeping ..... Support
Employee Benefits ..... Support
Workers Compensation ..... Base
Payroll Taxes ..... Support
Contracted Services ..... Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3

Repair & Maintenance.....Support
Housekeeping Supplies.....Support
Miscellaneous.....Support

14.9 DIETARY

Salaries & Wages – Dietary.....Base
Employee Benefits.....Base
Workers Compensation.....Base
Payroll Taxes.....Base
Contracted Services – Base.....Base
Contracted Services – Support.....Support
Contracted Services – Base/Support.....Base/Support
In-service Training.....Support
Education.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Repair & Maintenance.....Support
Raw Food.....Base
Miscellaneous – Base.....Base
Miscellaneous – Support.....Support

14.10 NURSING ADMINISTRATION

Salaries & Wages – Director of Nursing.....Base
Salaries & Wages – Other.....Base
Employee Benefits.....Base
Workers Compensation.....Base
Payroll Taxes.....Base
Office Supplies.....Support
Contracted Services – Base.....Base
Contracted Services – Support.....Support
Contracted Services – Base/Support.....Base/Support
In-service Training.....Support
Salaries & Wages – In-service Training.....Support
Employee Benefits – In-service Training.....Support
Payroll Taxes – In-service Training.....Support
Education.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2

Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support.....Support

14.11 Central Supplies

Salaries & Wages – Central Supplies.....Support
Employee Benefits.....Support
Workers Compensation.....Base
Payroll Taxes.....Support
Supplies.....Support
Contracted Services.....Support
In-service Training.....Support
Education.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous.....Support

14.12 Medical Supplies

Salaries & Wages – Medical Supplies.....Support
Employee Benefits.....Support
Workers Compensation.....Base
Payroll Taxes.....Support
Supplies.....Base
Contracted Services.....Support
In-service Training.....Support
Education.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous.....Support

14.13 Medical Records & Library

Salaries & Wages – Medical Director ..... Support
Salaries & Wages – Medical Records ..... Support
Employee Benefits ..... Support
Workers Compensation ..... Base
Payroll Taxes ..... Support
Supplies ..... Support
Contracted Services – Medical Director ..... Support
Contracted Services ..... Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous ..... Support

14.14 Social Services

Salaries & Wages – Social Services ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Supplies ..... Support
Contracted Services – Base ..... Base
Contracted Services - Support ..... Support
Contracted Services – Base/Support ..... Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.15 Diversional Therapy

Salaries & Wages –Diversional Therapy ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Supplies ..... Base
Contracted Services – Base ..... Base
Contracted Services - Support ..... Support
Contracted Services – Base/Support ..... Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.16 Ancillary Service Cost Centers

14.16.A. Radiology

Salaries & Wages – Radiology ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Contracted Outside Services ..... Support
Other ..... Support

14.16.B. Laboratory

Salaries & Wages – Laboratory ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support

Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Contracted Outside Services.....Support
Other.....Support

14.16.C. Intravenous Therapy

Salaries & Wages – Intravenous Therapy.....Support
Employee Benefits.....Support
Payroll Taxes.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Contracted Outside Services.....Support
Other.....Support

14.16.D. Inhalation Therapy (Oxygen)

Salaries & Wages – Inhalation Therapy.....Support
Employee Benefits.....Support
Payroll Taxes.....Support
Oxygen – Intermittent Use.....Base
Oxygen – Continuous Use.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3

14.16.E. Physical Therapy

Salaries & Wages – Physical Therapy.....Support
Employee Benefits.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2

Direct Allocation – Interest & Property Taxes ..... Plant 3
Payroll Taxes ..... Support
Contracted Outside Services ..... Support
Other ..... Support

14.16.F. Speech Therapy

Salaries & Wages – Speech Therapy ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Contracted Outside Services ..... Support
Other ..... Support

14.16.G. Occupational Therapy

Salaries & Wages – Occupational Therapy ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Contracted Outside Services ..... Support
Other ..... Support

14.16.H. Electroencephalography

Salaries & Wages – Electroencephalography ..... Support
Employee Benefits ..... Support
Payroll Taxes ..... Support
Electroencephalography ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2

Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3

14.16.I. PHARMACY

Salaries & Wages – Pharmacy.....Support
Employee Benefits - Pharmacy.....Support
Payroll Taxes - Pharmacy.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Contracted Outside Services.....Support
Pharmacy - Other.....Support
Drugs – Legend.....Base
Drugs – Non-Legend.....Support
Special Services.....Support

14.16.J. PHYSICIAN SERVICES

Salaries & Wages – Physician Services.....Support
Employee Benefits.....Support
Payroll Taxes.....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Contracted Outside Services.....Support
Other.....Support

14.17 NURSING SERVICE COST CENTERS

14.17.A. MEDICARE SNF UNIT

Salaries & Wages – R.N.....Base
Salaries & Wages – L.P.N.....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Workers Compensation.....Base
Payroll Taxes.....Base

Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.B. MEDICAID ROUTINE CARE UNIT #1

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.C. MEDICAID ROUTINE CARE UNIT #2

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support

Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.D. Medicaid Special Care Unit #1

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.E. Medicaid Special Care Unit #2

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2

Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support.....Support

14.17.F. Home For Aged Unit

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N.....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Payroll Taxes .....Base
Nursing Supplies .....Base
Contracted Services.....Base
In-service Training .....Support
Education .....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support.....Support

14.17.G. Non-LTC Apartment/Housing Unit

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N.....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Payroll Taxes .....Base
Nursing Supplies .....Base
Contracted Services.....Base
In-service Training .....Support
Education .....Support
Minor Equipment – Less Than $500.....Support
Minor Equipment – More Than $500.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3

Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.H. Non-Medicare And Non-Medicaid Licensed Only

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.17.I. Non-LTC Nursing Services

Salaries & Wages – R.N. ..... Base
Salaries & Wages – L.P.N. ..... Base
Salaries & Wages – Aides & Orderlies ..... Base
Employee Benefits ..... Base
Payroll Taxes ..... Base
Nursing Supplies ..... Base
Contracted Services ..... Base
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.18 Reimbursable/Non-Reimbursable Cost Centers

14.18.A. Non-Available Beds

Medicaid Non-Available Beds ..... Non-Reimbursable

14.18.B. Nurse Aide Training & Testing - LTC

Nurse Aide Training & Testing ..... Pass-Through

14.18.C. Special Dietary

Salaries & Wages – Special Dietary ..... Base
Employee Benefits ..... Base
Workers Compensation ..... Base
Payroll Taxes ..... Base
Contracted Services – Base ..... Base
Contracted Services – Support ..... Support
Contracted Services – ..... Base/Support Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $500 ..... Support
Minor Equipment – More Than $500 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest 7 Property Taxes ..... Plant 3
Repair & Maintenance ..... Support
Raw Food ..... Base
Dietary Supplies (Non-Ingested) ..... Base
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.18.D. Beauty & Barber Shop

Salaries ..... Non-Reimbursable
Other ..... Non-Reimbursable

14.18.E. Gift, Flower, Coffee Shop & Canteen

Salaries ..... Non-Reimbursable
Other ..... Non-Reimbursable

14.18.F. Physician's Private Office

Salaries ..... Non-Reimbursable
Other ..... Non-Reimbursable

14.18.G. Non-Paid Workers

Salaries.....Non-Reimbursable
Other.....Non-Reimbursable

14.18.H. Other

Other Salaries .....Non-Reimbursable
Other.....Non-Reimbursable

Nurse Aide Training and Competency Evaluation Program

Certified Nurse Assistant Training Reimbursement

PURPOSE: The Certified Nurse Assistant (CNA) must present this information to his/her Medicaid and/or Medicare certified nursing facility employer to apply for reimbursement of eligible CNA training and testing costs. Reimbursement is not available to CNAs working in other residential or patient care settings.

CNA:

Last Name First Name Middle Initial

Social Security Number Birthdate Driver License/Identification

I incurred the following expenses to become a CNA (Certified Nurse Assistant).

TRAINING: *(Attach receipts)*

Approved Program Name: _____ Amount $ _____

Location _____ Date of Payment: _____

Completion Date of Training: _____

COMPETENCY EVALUATION: *(Attach receipts)*

Clinical Skills Test

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Knowledge Test

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Rescheduling Fee (No-Show) Date: _____ Amount: $ _____

Date: _____ Amount: $ _____

Date: _____ Amount: $ _____

Initial Registration Fee Date: _____ Amount: $ _____

Registration Document Renewal Date: _____ Amount: $ _____

Check appropriate box, sign and date*:*

☐ **I have not received any payment for any of these expenses from another source, such as another nursing home, a vocational training program, etc.**

☐ **I have received payment from another source for the listed expenses:**

Amount: $_____ Date: _____ Source: _____

Amount: $_____ Date: _____ Source: _____

Amount: $_____ Date: _____ Source: _____

I understand that the information I have provided may be audited.

CNA Signature: _____ Date: _____

NURSING FACILITY: (Retain this information for documentation of NATCEP costs.)

Facility Name: _____

Provider I.D. Number: _____ MDCH License Number: _____

EXAMPLE 1: CAV Excess Borrowings Limit Without DEFRA Limit

Determine the lesser of the NF CAV and the CAV Limit:

NF CAV = Total CAV in NF X Percentage of capital assets allocated to routine nursing care =$2,788,596

NF CAV Limit = Per Bed CAV Upper Limit X Total number of beds = $3,548,208

Identify the Average Borrowing Balance:

Average Borrowing Balance = $4,906,336

Lesser of NF CAV and CAV Limit:

NF CAV = $2,788,596 CAV Limit = $3,548,208

Divide:

2,788,596/4,906,336 = .568366 or 56.84%

Determine Allowable Interest:

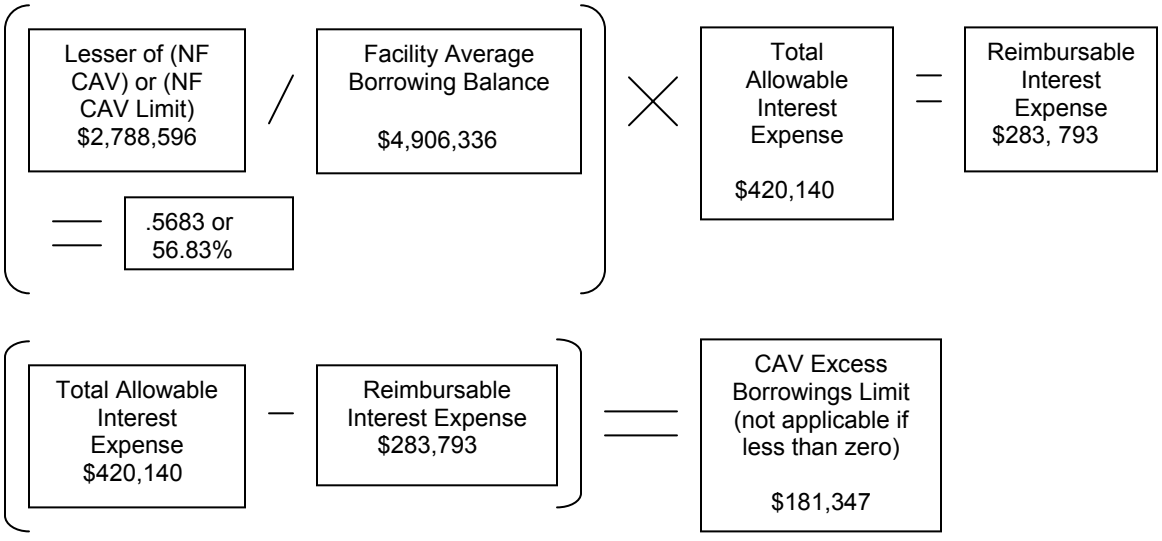
Total Allocated Expense (after step down from W/S 2-H) = $420,140

.568366 X $420,140 = $238,793

Determine Excess Interest:

$420,140 - $238,793 = $181,347

CAV Excess Borrowings Limit = $181,347



EXAMPLE 2: DEFRA Reimbursement Limit Determination

Step 1 - Determine DEFRA Application Limit

Determine the Allowable Historical Depreciable Assets Value of Previous Owners:

Allowable Historical Value = Allowable historical asset costs as of July 1, 1984 plus the cost of new asset acquisitions after July 1, 1984 for the allowable acquisition cost of the initial owner of such new assets, of assets in the NF at the time of the sale minus the original owner land value = Total Historical Asset Values – Historical Land amount ($1,116,922 – $67,329) = $1,049,593

Times (X)

Annual Depreciation Allowance = 3.33% = $34,951

Determine the Amount of Interest Expense the Purchaser Requires to Assume the Seller's Historical Asset Value After Down Payment:

Seller's Historical Value = Historical asset costs of the asset's prior owners assets in the NF at the time of the sale **plus** the seller's allowable land value. ($1,049,593+ $67,329) = $1,116,922

Minus (-)

Purchaser's down payment = $0

Times (X)

Purchaser's Interest Rate = 9.75% or .0975

Plus (+)

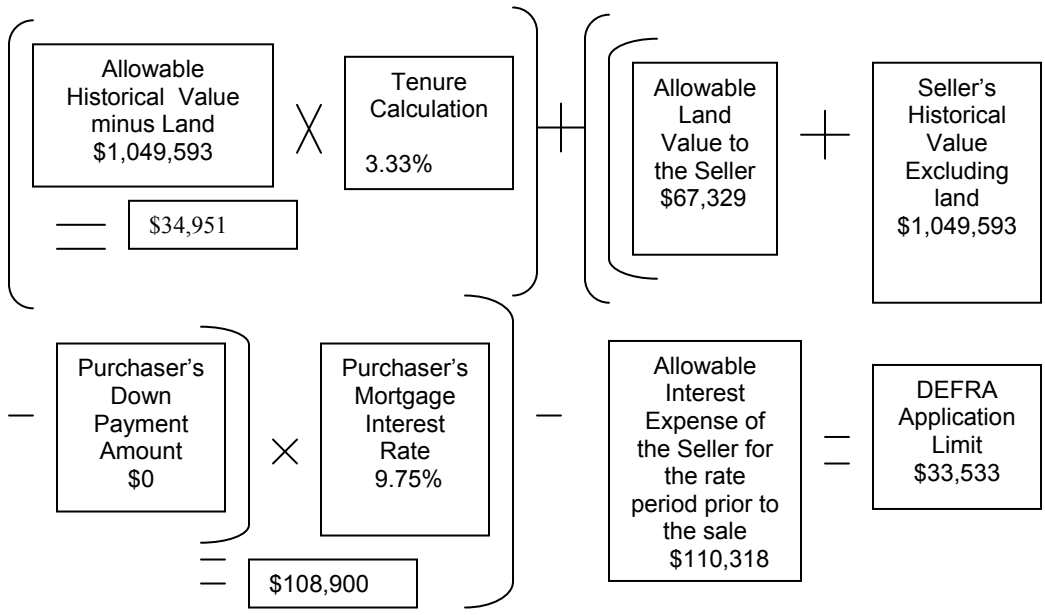
Annual Depreciation Allowance Based on Historical Depreciable Assets of Prior Owners = $34,951

[($1,049,593+ $67,329 - $0) x 9.75%] + $34,951= $143,851

Identify the Seller's Interest Expense Amount for the Rate Period Prior to the Sale:

Allowable Interest Expense of the Seller for the rate period prior to the sale $110,318

A provider has a 12/31/04 cost report end date. In July of 2005, the facility sells. The audited allowable interest expense amount included is from the cost report year-end date 12/31/03.



EXAMPLE 2: DEFRA Reimbursement Limit Determination

Step 2 - Determine Increase in Tenure and Interest

Compute Increase in Tenure and Interest Prior to DEFRA Limit or Excess Borrrowings Limt:

A comparison of the Purchaser's and Seller's Tenure amounts and Audited Interest Expense is used as determined by Medicaid.

Seller: Prior Rate Year Tenure = $31,460.
Prior Rate Year Allowable Interest Expense = $110,318.
($31,460 + $110,318 =141,778)

Purchaser: Tenure = $14,299.
Audited Allowable Interest = $267,384.
($14,299+ $267,384= $281,683)

Purchaser's tenure and allowable Interest Expense after the sale	—	Seller's tenure and allowable Interest Expense after the sale	=	Increase in tenure and interest for new ownership prior to DEFRA Limit or Excess Borrowings Limit
$281,683		$141,778		$139,905

Step 3 - Determine DEFRA Reimbursement Limit

Compute the Non-Reimbursable Interest :

The DEFRA Application Limit determined in step one and the increase in tenure and interest comparison in step 2 are used to determine the DEFRA Reimbursement Limit.

DEFRA Limit Application	—	Increase in tenure and interest for new ownership prior to DEFRA Limit or Excess Borrowings Limit	=	DEFRA Reimbursement Limit (not applicable if greater than zero)
$33,533		$139,905		($106,372)

Step 4 – Determine the Reduction to NF Average Borrowings

The DEFRA Reimbursement Limit determined in step three (as a positive number); the Audited Allowable Interest from step two; and the total Borrowings Balance are used to determine the borrowings dollar amount represented in the DEFRA Reimbursement Limit.

DEFRA Reimbursement Limit Amount	/	NF Total Allowable Interest Expense	×	Nursing Facility Average Borrowings Balance	=	Reduction to NF Average Borrowings Balance
$106,337		$267,384		$2,539,142		$1,010,134

Step 5 – Determine Total Interest Expense After DEFRA Reimbursement Limit

Total Allowable Interest Expense minus DEFRA Reimbursement Limit = $267,384 - $106,372 = $161,012

EXAMPLE 3: CAV Excess Borrowings Limit With DEFRA Reimbursement Limit

Determine the lesser of the NF CAV and the CAV Limit:

NF CAV = Total CAV in NF X Percentage of capital assets allocated to routine nursing care =$1,436,590

NFCAV Limit = Class I NF CAV Limit per bed X Total number of available beds = $3,082,000

Identify the Allowable Average Borrowing Balance:

Total Average Borrowings Balance $2,539,142

Minus (-)

Reduction to NF Average Borrowings Balance $1,010,134

Average Allowable Borrowing Balance = $2,539,142 - $1,010,134 = $1,529,008

Determine Reimbursable Interest:

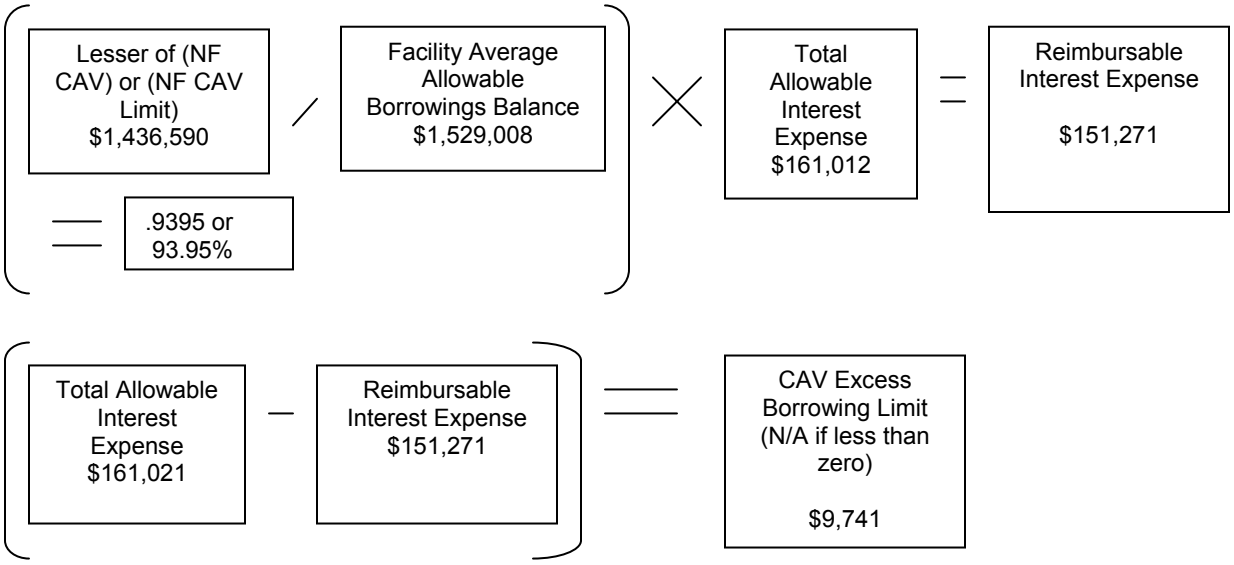
Total Interest Expense after DEFRA Limit = Total Allowable Interest Expense minus DEFRA Reimbursement Limit = $267,384 - $106,372 = $161,012

.9395 x $161,012 = $151,271

Determine Non-Reimbursable Interest

$161,012 - $151,271= $9,741

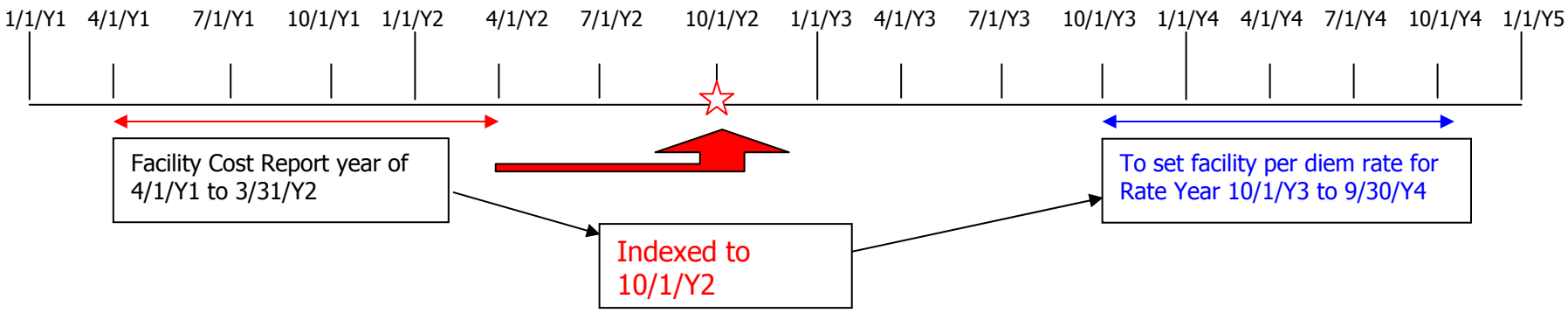
CAV Excess Borrowing Limit Calculation with DEFRA



MDCH Nursing Facility Reimbursement

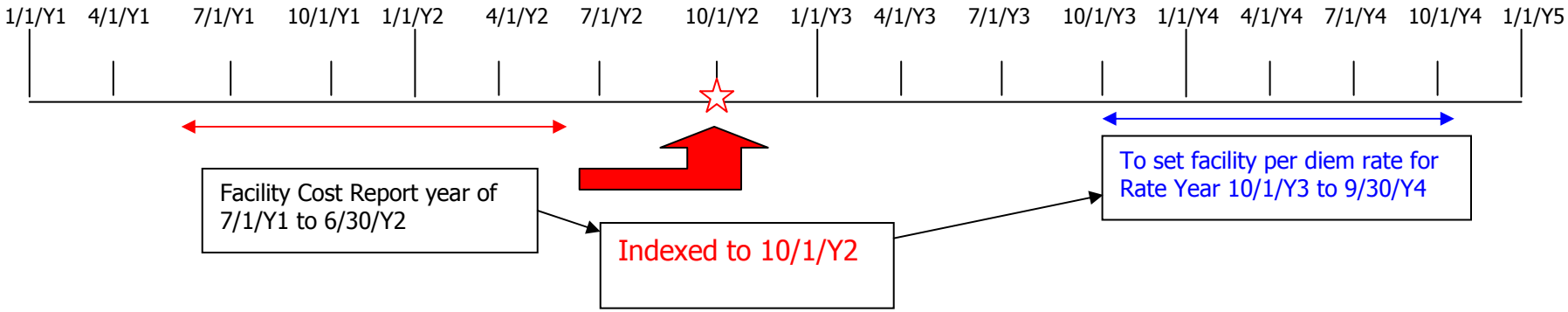
Timeline for Per Diem Rate Setting Process for Nursing Facilities with

Cost Reporting Year from April 1 through March 31

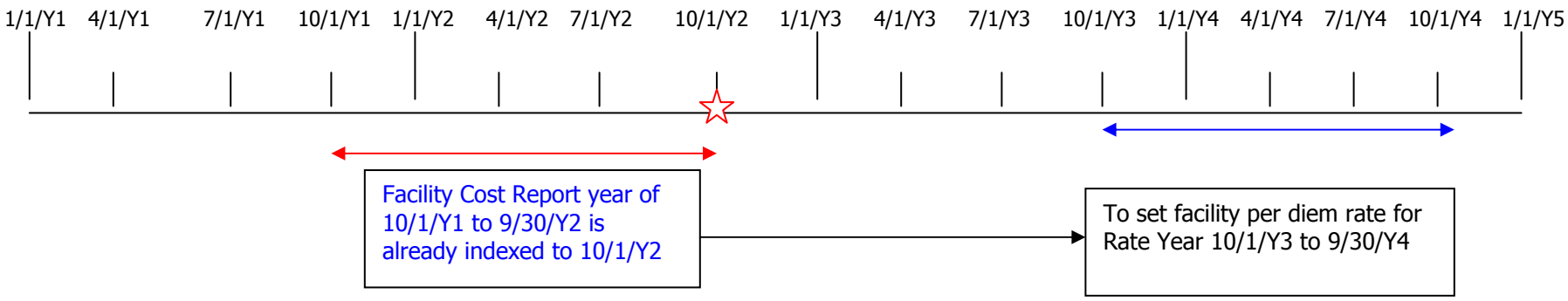


Timeline for Per Diem Rate Setting Process for Nursing Facilities with

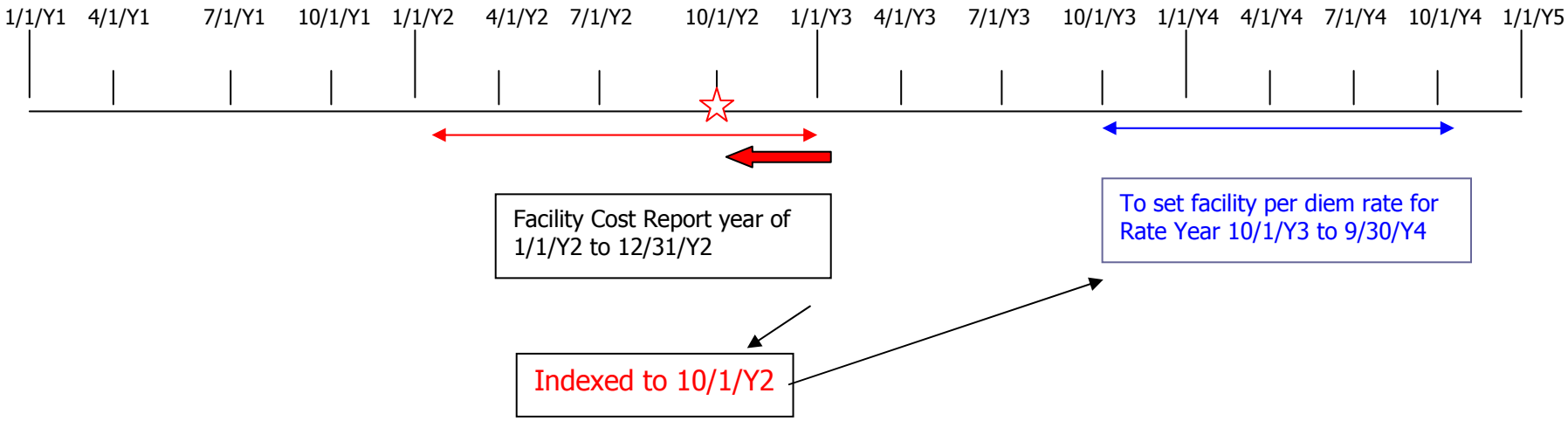
Cost Reporting Year from July 1 through June 30



Timeline for Nursing Facility Per Diem Rate Setting Process for Facilities with Cost Reporting Year October 1 through September 30



Timeline for Nursing Facility Per Diem Rate Setting Process for Facilities with Cost Reporting Years from January 1 though December 31



Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate

Class I-Provider Type 60

Date:	9/1/03
Provider Name:	Sample Nursing Facility #1
Provider Number:	60-1111111
F.Y.E:	December 31
Effective Date:	10/01/2003

I. Calculation Of Variable Rate Base (VRB)

			Total Beds:	120
			Medicaid-certified LTC Beds:	100
A.	Variable cost per day	Filed Period End: 12/31/02		102.632807
B.	Base cost per day			76.092223
C.	Support cost per day			26.540584
D.	Provider's support/base ratio			0.348795
E.	Support/Base ratio limit per bed size group			0.340100
F.	Cost Index (CI)	From: 12/31/2002	To: 10/01/2002	0.992754
G.	Indexed base cost component (BCC) (base cost per day times CI)			75.540859
H.	Indexed support cost component (SCC) (lesser of Provider's S/B ratio or S/B limit times indexed base cost)			25.691446
I.	Variable Rate Base (VRB) (base cost component plus support cost component)			101.232305
J.	Variable Cost Limit (VCL)	As of: 10/01/2003		123.750000
K.	**Lesser of Variable Rate Base or Variable Cost Limit**			**101.232305**

II. Economic Inflationary Update (EIU)

A.	Economic Inflation Rate (EIR)	From: 10/01/2002 To: 09/30/2004	0.00%
B.	Lesser of Provider's Variable Rate Base or Variable Cost Limit		101.232305
C.	Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

III. Quality Assurance Supplement (QAS)
(Calculated for Informational Purposes Only-Not part of rate)

A.	Lesser of Provider's Variable Rate Base or Variable Cost Limit	101.232305
B.	Quality Assurance Assessment Factor (QAAF)	21.76%
C.	Quality Assurance Supplement	22.02815

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate

IV. Property Tax/Interest Expense/Lease Component

Filed Period End: 6/30/02

	Total Days:	17,761
	Plant Costs:	58,431
A. Allowable borrowings limitation		
1) Average borrowings balance		496,600
2) Interest deduction for excess borrowings		0
3) DEFRA sales disallowance		0
4) Net property tax/ interest/ lease component		58,431
B. Per patient day plant component		**3.289849**

V. Return On Current Asset Value Component

Tenure: 20

A.	Updated Building and Land Improvements	1,736,925
B.	Depreciated Moveable Equipment	95,691
C.	Land	51,996
D.	Total current asset value	1,884,612
E.	Percentage applicable to LTC unit	100.00%
F.	LTC unit current asset value x percent	1,884,612
G.	Current Asset Value upper (ceiling) limitation	2,193,000
H.	Current Asset Value lower (floor) limitation	657,900
I.	Tenure factor	0.0525
J.	Limitation or asset value x tenure factor	98,942
K.	**Limitation or asset value x tenure factor/patient days**	**5.570753**

Rate Calculation

Prospective Reimbursement

A.	Lesser of Variable Rate Base of Variable Cost Limit	101.232305
B.	Economic Inflationary Update	0.000000
C.	Variable Cost Component (Line A Plus Line B)	101.232305
D.	Plant Cost Component	8.860602
E.	Reimbursement Rate Prior to Add-Ons	**110.0929**

OBRA Training & Testing Cost Settled

Period End: 6/30/02 W/S 8 Costs: **Filed** 5,644 **0.317775**

Special Dietary

Medicaid Reimbursement Rate **110.4107**

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate

Class III-Publicly Owned-Provider Type 61

Date:	9/1/03
Provider Name:	Sample Medical Care Facility
Provider Number:	61-6666666
F.Y.E:	December31
Effective Date:	10/01/2003

I. Calculation Of Variable Rate Base (VRB)

		Total Beds:	204
		Medicaid-certified LTC Beds:	204
A.	Variable cost per day	Filed Period End: 12/31/02	145.079291
B.	Base cost per day		114.513735
C.	Support cost per day		30.565556
D.	Provider's support/base ratio		0.266916
E.	Support/Base ratio limit per bed size group		0.329600
F.	Cost Index (CI)	From: 12/31/2002 To: 10/01/2002	0.992754
G.	Indexed base cost component (BCC) (base cost per day times CI)		113.683968
H.	Indexed support cost component (lesser of Provider's S/B ratio or S/B limit times updated base cost)		30.344078
I.	Variable Rate Base (VRB) (base cost component plus support cost component)		144.028046
J.	Variable Cost Limit (VCL)	As of: 10/01/2003	169.280000
K.	**Lesser of Variable Rate Base or Variable Cost Limit**		**144.028046**

II. Economic Inflationary Update (EIU)

A.	Economic Inflation Rate (EIR)	From: 10/01/2002 To: 09/30/2004	0.00%
B.	Lesser of Provider's Variable Rate Base or Variable Cost Limit		144.028046
C.	Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

III. Calculation of Plant Cost Component

Filed Period End: 12/31/02

A.	Depreciation and Interest Expenses	359,738
B.	Total Days	73,098
C.	Plant Costs per Day	4.921311
D.	Plant Cost Limit	5.410000
E.	**Lesser of Plant Cost or Plant Cost Limit**	**4.921311**

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate

Rate Calculation
Prospective Reimbursement

A.	Lesser of Variable Rate Base or Variable Cost Limit	144.028046
B.	Economic Inflationary Update	0.000000
C.	Variable Cost Component (Line A plus Line B)	144.028046
D.	Plant Cost Component	4.921311
E.	Reimbursement Prior to Add-Ons	148.949357

OBRA Training and Testing Cost Settlement

Period End: 12/31/01 W/S 8 Costs: **Filed** 24,026 **0.328682**

Medicaid Reimbursement Rate **149.278039**

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate

Class III-Non-Publicly Owned-Provider Type 62

Date:	9/1/03
Provider Name:	Sample Hospital LTC Unit
Provider Number:	62-7777777
F.Y.E:	June 30
Effective Date:	10/01/2003

I. Calculation Of Variable Rate Base (VRB)

		Total Beds:	48
		Medicaid-certified LTC Beds:	40
A.	Variable cost per day	Filed Period End: 6/30/02	201.403421
B.	Base cost per day		152.625018
C.	Support cost per day		57.778403
D.	Provider's support/base ratio		0.378564
E.	Support/Base ratio limit per bed size group		0.378600
F.	Cost Index (CI)	From: 6/30/2002 To: 10/01/2002	1.007353
G.	Indexed base cost component (BCC) (base cost per day times CI)		153.747270
H.	Indexed support cost component (lesser of Provider's S/B ratio or S/B limit times updated base cost)		58.203248
I.	Variable Rate Base (VRB) (base cost component plus support cost component)		211.950518
J.	Variable Cost Limit (VCL)	As of: 10/01/2003	169.280000
K.	**Lesser of Variable Rate Base or Variable Cost Limit**		**169.280000**

II. Economic Inflationary Update (EIU)

A.	Economic Inflation Rate (EIR)	From: 10/01/2002 To: 09/30/2004	0.00%
B.	Lesser of Provider's Variable Rate Base or Variable Cost Limit		169.280000
C.	Economic Inflationary Update (EIU)	To: 09/30/2004	0.000000

III. Quality Assurance Supplement (QAS)
(Calculated for Informational Purposes Only-Not in rate)

A.	Lesser of Provider's Variable Rate Base or Variable Cost Limit	169.280000
B.	Quality Assurance Assessment Factor (QAAF)	21.76%
C.	Quality Assurance Supplement (QAS)	36.835328

Michigan Department of Community Health
Calculation of Medicaid Reimbursement Rate

IV. Calculation of Plant Cost Component

Filed Period End: 6/30/02

A.	Depreciation and Interest Expenses	75,221
B.	Total Days	14,030
C.	Plant Costs per Day	5.361440
D.	Plant Cost Limit	5.410000
E.	**Lesser of Plant Cost or Plant Cost Limit**	**5.361440**

Rate Calculation
Prospective Reimbursement

A.	Lesser of Variable Rate Base or Variable Cost Limit	169.280000
B.	Economic Inflationary Update	0.000000
C.	Variable Cost Component (Line A plus Line B)	169.280000
D.	Plant Cost Component	5.361440
E.	Reimbursement Prior to Add-Ons	**174.64144**

OBRA Training and Testing Cost Settlement

Period End: 6/30/02 W/S 8 Costs: **Filed** 12,000 **0.800000**

Medicaid Reimbursement Rate **175.4414**