



Nursing Facility Guide to MI Health Link

1. Capitated Payments to the MI Health Link Health Plan

MI Health Link health plans [also known as Integrated Care Organizations (ICOs)] will receive capitated payments from Medicare and Medicaid which include care provided in a Michigan licensed nursing facility. Medicaid payments are based on a tier system with two sub-tier payments for enrollees in a nursing facility. The Tier 1B capitation payment is for County Medical Care Facilities (CMCF) which includes the Certified Public Expenditure (CPE) included in the capitated payment to the MI Health Link health plan. These enrollees are coded with a level of care code 15. The Tier 1A is for all other nursing facilities including county owned Hospital Long Term Care Units. These enrollees are coded with a level of care code 05. Medicaid capitated rates paid to the MI Health Link health plan also include the Facility Innovative Design Supplement (FIDS), when applicable.

For enrollees entering a nursing facility **after enrollment** in MI Health Link, the capitated payment will be as follows:

- Months 1-3, the health plan receives the community tier (Tier 2 or 3) capitation rate
- Months 4+, the health plan receives the Tier 1 capitation rate

For enrollees in a nursing facility with a level of care code 02 at the time of enrollment, payment will be at the Tier 1 capitation rate (B for CMCFs and A for all other nursing facilities).

2. Rates Paid to Nursing Facilities for a Traditional Medicare Day of Care

The MI Health Link health plan establishes the rate to pay to a nursing facility for a traditional Medicare day of care defined as a skilled or rehabilitation day. The nursing facility must follow the MDS PPS assessment schedule to determine the start and end dates of therapies or skilled care to identify traditional Medicare days of care.

3. Traditional Medicaid Days of Care for New Admissions

For new nursing facility admission, days paid to the nursing facility by the MI Health Link health plan for days 1-90 are considered ICO-Medicare days so nursing facilities will not receive QAS payments for these days nor will they be taxed for these days. MI Health Link health plan paid days 91+ are considered ICO-Medicaid days so nursing facilities will receive a QAS payment for those days and will be taxed on those days. The 90 days has no association with actual need for skilled level of care, it can actually be a combination of traditional Medicare days, coinsurance days, and traditional Medicaid days (without QAS).

4. Restarting the 90 day clock

If the enrollee is discharged to the community from the nursing facility and no return is expected, but the enrollee is admitted to the nursing facility at a future date, the 90 day clock restarts and does not continue from the previous stay.

5. Rates Paid to Nursing Facilities for a Traditional Medicaid Day of Care

The MI Health Link health plan is required to reimburse nursing facilities under the three-way contract as follows:

4.2.1.10. For Nursing Facility services covered under the traditional Medicaid benefit, the ICO shall reimburse monthly, at a minimum, nursing facilities equivalent to their Medicaid FFS rate, including the Quality Assurance Supplement (QAS), as established by the Long Term Care Reimbursement and Rate Setting Section of MDHHS, unless otherwise agreed to by the nursing facility and ICO through an alternative arrangement. Any such alternative arrangement must be approved by MDHHS.

The MI Health Link health plan would submit an e-mail containing an overview of the alternative payment agreement to the MDHHS Contract Management Team member for review and approval.

MDHHS will publish on a quarterly basis the Medicaid rates including the coinsurance daily rate, Quality Assurance Supplement (QAS), Certified Public Expenditure (CPE) and Facility Innovative Design Supplement (FIDS) amounts for all facilities in the demonstration regions, where applicable. MI Health Link health plans may also acquire the Medicaid rate from the nursing facility rate letter issued by MDHHS.

6. Quality Assurance Supplement (QAS) Payment

The MI Health Link health plan's Medicaid capitated rate includes the Quality Assurance Supplement paid to nursing facilities for Medicaid days of care. The health plan is required to pay the QAS to the nursing facility for a MI Health Link enrollee if the health plan received a Tier 1 rate for the enrollee **AND** the health plan is paying the nursing facility for a traditional Medicaid day of care.

If an individual who is residing in a nursing facility enrolls in MI Health Link, the health plan will be paid the Medicaid Tier 1 rate immediately by MDHHS. The Tier 1 rate includes the QAS funding so if the health plan is paying a Medicaid day to the nursing facility for that enrollee, the health plan should also pay the QAS to the nursing facility. If the MI Health Link health plan is paying the nursing facility a Medicare rehabilitation day for the enrollee, the health plan should not pay the nursing facility the QAS.

The only time a nursing facility would not receive the QAS payment for a traditional Medicaid day of care is when the MI Health Link health plan is receiving a community tier (Tier 2 or 3) payment for the nursing facility resident as Tier 2 and Tier 3 rates do not include the QAS.

7. Quality Assurance Assessment (QAA) Program

Nursing facilities will pay the quality assurance assessment for days paid by the MI Health Link health plan. QAA will be paid to the state following the current established process. The first 90 days of an enrollee's nursing facility stay will be exempt from the tax just as Medicare days are exempt under fee-for-service (FFS). The exception to this is for enrollees who have been in a nursing facility prior to joining MI Health Link.

8. Certified Public Expenditure (CPE)

The Medicaid capitated rate paid to the MI Health Link health plan for enrollees with level of care code 15 includes the CPE payment. The health plan is required under contract to pay the County Medical Care Facility the CPE in the daily rate for a traditional Medicaid day of care.

9. Facility Innovative Design Supplement (FIDS) Payment

The MI Health Link health plan is required to reimburse a nursing facility the FIDS rate for care provided in a FIDS approved bed. The nursing facility must verify with the nursing facility that the MI Health Link enrollee is in a bed approved to participate in the FIDS program.

10. Co-Insurance Days

The MI Health Link health plan will be responsible to pay a nursing facility for the co-insurance days beyond the 20th day of a traditional Medicare stay.

11. Paid Leave Days

- A. The MI Health Link health plan must reimburse the nursing facility for any therapeutic leave days in accordance with published Medicaid policy. Therapeutic leave days are reimbursed at the nursing facility's daily rate.
- B. The MI Health Link health plan must reimburse the nursing facility for any hospital leave days which meet the requirements for bed hold payment in accordance with published Medicaid policy. The CY2015 daily rate for hospital leave days is \$109.88. Additional details are available at http://www.michigan.gov/documents/Hospital_Leave_Day_Rate_39039_7.doc

12. Patient Pay Amounts (PPA)

The nursing facility remains responsible for collecting the PPA from the MI Health Link enrollee for traditional Medicaid days of care on a monthly basis. The MI Health Link health plan will adjust

the payment to the nursing facility by the PPA as the Medicaid Tier 1 rate paid to the health plan will be adjusted by the PPA amount. PPAs for partial month stays are paid to the nursing facility on a prorated basis, at the Medicaid daily rate until the PPA is exhausted. For example, a person with a PPA of \$650 residing in a nursing facility with a Medicaid daily rate of \$150 will exhaust the PPA on the 5th day of the Medicaid stay. If the person was discharged from the nursing facility on the 3rd day of the month, the resident would pay the nursing facility for two days of PPA (\$300) as the resident does not pay for day of discharge (unless it is the date of death).

13. PPA Offset

There are no co-pays, deductibles or premiums in MI Health Link, so there should be no need to offset the PPA with code 25. MI Health Link enrollees can continue to offset their PPA for non-program covered medical expenses (like Vision-Code 27, Dental-Code 28, and Hearing-Code 26) and use the appropriate codes to offset the PPA when billing the health plan for nursing facility services.

14. Reporting Days of Care

The nursing facility will include on its cost report the number of ICO-Medicare days (days 1-90) and ICO-Medicaid days (days 91+) provided to MI Health Link enrollees whom enter the nursing facility after they enroll in MI Health Link. For people living in the nursing facility prior to enrollment in MI Health Link, all days of care will be reported as ICO-Medicaid days for these enrollees. See #16 below for discussion of reporting days after a hospital stay.

15. MI Health Link Impact on Medicaid Interim Payment (MIP)

MIP will continue for the FFS Medicaid as usual but when the quarterly adjustments are made, MDHHS will use MI Health Link encounter data to adjust future MIP payments for ICO-Medicaid days.

16. Hospital Stays After 90 Days in the Nursing Facility

From the Medicaid perspective, the 90-day clock will not be reset to begin paying the health plan a Tier 2 or Tier 3 rate for residents returning from a hospital stay. The Tier 1 rate will continue to be paid to the health plan.

From the Health Plan and nursing facility perspective, the nursing facility should negotiate with the health plan to receive a skilled care rate for the days of care following a hospital stay. The nursing facility would not receive the Medicaid rate or the QAS payments. The nursing facility would report those days as ICO-Medicare days on the cost report. After the 90 day period, if the nursing facility receives a QAS payment from the health plan, the facility reports it as an ICO-

Medicaid day. If the nursing facility receives a skilled nursing payment, the nursing facility reports it as an ICO-Medicare day.

17. Admission Requirements and Hospital Stay

The MI Health Link program waives the requirement for a three-day hospital stay prior to receiving rehabilitation or skilled care in a Michigan licensed nursing facility. Admission requirements include a physician-written order for nursing facility services, a completed Michigan Medicaid Nursing Facility Level of Care Determination (NFLOCD), and a completed Pre-admission Screening and Resident Review (PASRR).

18. Medicare Limitations

The traditional Medicare structure for skilled care days remains in affect under MI Health Link. The only Medicare requirement that was waived for MI Health Link is the requirement for a three-day hospital stay prior to receiving rehabilitation or skilled nursing care in a nursing facility.

19. Nursing Facility Level of Care Determination (NFLOCD)

The MI Health Link health plan will be responsible for conducting the Michigan Medicaid NFLOCD tool for enrollees seeking admission to a nursing facility. For existing residents at the time of enrollment, the existing NFLOCD will be adopted for capitation payment purposes. The health plan will complete a new NFLOCD tool within the first 90 days of enrollment. If a nursing facility resident is disenrolled from MI Health Link, the nursing facility will be responsible for conducting a new NFLOCD tool in accordance with published Medicaid policy.

20. Nursing Facility Provider Requirements

The MI Health Link health plan may only include Michigan licensed nursing facilities in its provider network to provide care in **beds certified for both Medicare and Medicaid**. If at the time of enrollment, an enrollee is in a nursing facility which is not part of the MI Health Link health plan network or if an enrollee is in a bed not certified for both Medicare and Medicaid, the MI Health Link health plan will adhere to the continuity of care requirements detailed below.

21. Continuity of Care Requirements

Enrollees residing in an out-of-network nursing facility at the time of enrollment into the MI Health Link health plan will not have to move from the facility. An enrollee has the right to live in an out-of-network nursing facility for the life of the MI Health Link program if the enrollee:

- Resides in the nursing facility at the time of enrollment in MI Health Link, or
- Resides in a bed not certified for both Medicare and Medicaid (applicable to both in network and out of network providers) at the time of enrollment in MI Health Link, or

- Requires nursing facility care and has a family member or spouse that resides in an out of network nursing facility, or
- Requires nursing facility care and resides in a retirement community that includes a nursing facility which is not in the health plan's network.

This continuity of care protection is available as long as the enrollee resides in the nursing facility. Continuity of care in a nursing facility is automatic. The enrollee does not have to make a request for continuity of care.

The health plan must enter into a single case agreement with the nursing facility and reimburse the facility as an in-network provider. Single case agreements are effective as long as the resident requires nursing facility care.

22. Care Coordination and Integrated Care Team Participation

The MI Health Link enrollee will have a Care Coordinator who will work with the nursing facility staff to assure all of the enrollee's needs are met and services are accessible. The nursing facility staff, at the request of the enrollee, may participate in the Integrated Care Team. Scheduling the ICT meetings in conjunction with quarterly care conferences at the nursing facility would result in effective coordination of all supports and services for the enrollee. The Care Coordinator can assist in the discharge planning process to assure the enrollee has appropriate care and services when returning to the community, following a short or long term stay. All coordination efforts must follow the person-centered planning process putting the enrollee's goals, needs and preferences at the center of all care planning.

23. Hospice Election by a MI Health Link Enrollee in a Nursing Facility

If a MI Health Link enrollee chooses to receive Hospice services, the enrollee can remain enrolled in MI Health Link. The enrollee should inform his or her MI Health Link Care Coordinator when choosing hospice services. The nursing facility should coordinate care with the hospice agency as with any resident electing hospice services. Medicare will pay the hospice agency for hospice services on a fee-for-service basis from the time of hospice election. The MI Health Link health plan will pay for services not related to the terminal illness including nursing facility room and board. The hospice agency must work with the MI Health Link health plan to get paid for the nursing facility room and board. The enrollee will still get the same benefits while enrolled in MI Health Link if he or she chooses to get hospice services. For more information, please see "How MI Health Link Works with Hospice," which is located in the MI Health Link Resources Toolkit.

24. Ventilator Dependent Care

The MI Health Link health plan is required to provide care for enrollees needing ventilator dependent care. These services are provided in some skilled nursing facilities including those with

a Medicaid contract to operate a ventilator dependent care unit (VDCU). If this care is not available in the demonstration region, the health plan must work to coordinate placement in an out-of-area facility. The health plan would be responsible for care until the enrollee is disenrolled from MI Health Link for being out of the service area.