MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 18-08

Distribution: Nursing Facilities, State Veterans' Homes, County Medical Care Facilities, Hospital Long-Term Care Units, Ventilator-Dependent Care Units

Issued: May 1, 2018

Subject: Michigan State Veterans' Homes Medicaid Reimbursement

Effective: June 1, 2018

Programs Affected: Medicaid

This bulletin describes changes to the Nursing Facility, MI Health Link, Medicaid Health Plans, Hospice and Billing & Reimbursement for Institutional Providers chapters of the Medicaid Provider Manual. A new nursing facility (NF) rate class will be established to allow Michigan State Veterans' Homes to receive Medicaid reimbursement for providing NF services. Medicaid-certified State Veterans' Homes will be reimbursed based on Resource Utilization Groups (RUGs) and have special billing requirements.

Customary NF billing, Provider Enrollment Type, and covered services requirements will apply to State Veterans' Homes except as described in this bulletin. To reflect this, references to NFs in the Medicaid Provider Manual will be updated as necessary. Per 42 CFR 488.330(a)(1)(i)(B), CMS certifies state-operated NFs; therefore, the Michigan Department of Health & Human Services (MDHHS) certification requirements do not apply to these providers. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Definitions

The following definitions will be added to the Definitions section of the Nursing Facility Cost Reporting & Reimbursement Appendix:

Class VII Facilities – State-owned and-operated veterans' homes as established under Michigan Public Act 152 of 1885.

Minimum Data Set (MDS) Assessment – Clinical assessment tool required for all Medicaid-or-Medicare certified long-term care facilities. The federally required Omnibus Budget Reconciliation Act (OBRA) MDS assessments listed in A0310A of the MDS 3.0 Resident Assessment Instrument (RAI) Manual are the only assessments that may be used to determine rates for Class VII facilities.

Resource Utilization Group (RUG) – Classifications which NF residents may be placed into based on their clinical needs as determined by the MDS. RUG classifications are used in the rate setting of Class VII facilities.

Rate Methodology

The following subsection will be added to the Rate Determination section of the Nursing Facility Cost Reporting & Reimbursement Appendix:

Class VII Nursing Facilities – State Veterans' Homes

Reimbursement rates to State Veterans' Homes will be prospective, per patient day, and based on the RUG classification of each resident. MDHHS will utilize the RUG-IV 66 group classifications as calculated by the MDS 3.0. Each RUG category will reflect a resident's needs and correspond to a specific payment rate.

The rate associated with an individual RUG category will be set as a percentage of the rate paid by the Medicare skilled nursing facility (SNF) Prospective Payment System (PPS). The percentage used to set rates will not exceed 100% of the corresponding Medicare PPS rate. MDHHS will notify the State Veterans' Homes of the percentage and specific payment rates upon the implementation of this bulletin and by October 1 of each year thereafter.

The RUG category used for payments will be based on the applicable MDS assessment(s) to the billing period. **Example:** Services were rendered from April 1 through April 30, and MDS assessments were conducted on January 15 and April 15. The payment to the provider would be based on the January 15 assessment for dates of services from April 1 through April 14, and would be based on the April 15 assessment for dates of services April 15 through April 30.

State Veterans' Homes are excluded from the reimbursement policy that requires Medicaid to pay the lower of the customary charge to the general public or the prospective rate determined by Medicaid.

In conformance with the Veterans' Health Programs Improvement Act of 2004, per diem payments received by State Veterans' Homes from the federal Department of Veterans Affairs will not be considered a third-party liability or otherwise used to directly reduce Medicaid payments to these providers.

State Veterans' Homes are excluded from the NF Quality Assurance Assessment Program (QAAP) and all supplemental payments funded by the QAAP.

The State Veterans' Homes will receive payment for services through gross adjustments.

Cost Reporting

The following subsection will be added to the Cost Reporting section of the Nursing Facility Cost Reporting & Reimbursement Appendix:

Exception for State Veterans' Homes

A State Veterans' Home is not required to submit a Medicaid NF cost report. The Medicare SNF cost report is used in place of the Medicaid cost report. The Medicare cost report is to be submitted electronically to the MDHHS Reimbursement and Rate Setting Section (RARSS) through File Transfer. The Medicare Principles of Reimbursement apply for cost reporting purposes rather than the allowable cost principles described in the Allowable and Non-Allowable Costs section of this Appendix. The cost reporting requirements in the Less Than Complete Cost Report, Cost Report Due Date, New Facility/Owner Requirements, Changing a Cost Reporting Period and Cost Report Delinquency subsections of this Appendix are still applicable.

Hospice

The following subsection will be added to the Room and Board to Nursing Facilities subsection of the Hospice chapter:

State Veterans' Homes

MDHHS pays the hospice 100 percent of the beneficiary-specific RUG Medicaid rate for room and board in a State Veterans' Home, and payments will be made through gross adjustments. In addition to standard billing practices, hospice providers must follow the State Veterans' Home billing policy found in the Billing & Reimbursement for Institutional Providers chapter. The hospice must submit a separate claim from other services for the room and board provided in a State Veterans' Home. Hospice reimbursement for room and board must be outlined in the contract established between the hospice and the State Veterans' Home.

Audit

The following subsection will be added to the Audit section of the Nursing Facility Cost Reporting & Reimbursement Appendix:

Audit of State Veterans' Homes

The audit process described in this section is not applicable to State Veterans' Homes.

Covered Services

Except as specified below, the rate for a State Veterans' Home will include any of the services covered under the rates for Class I NFs. The Nursing Facility chapter will be updated to include the following exceptions:

Therapies

Non-routine occupational therapy (OT), physical therapy (PT) and speech-language pathology (SLP) services are included in the RUG rates paid to State Veterans' Homes. These providers are to bill for non-routine therapies on the same claims as daily care, and they are required to obtain prior authorization.

Billing

The Billing & Reimbursement for Institutional Providers chapter will be amended to include the following subsection:

State Veterans' Homes

In addition to customary billing requirements, a State Veterans' Home must report:

- Revenue code 0022,
- The five-digit Health Insurance Prospective Payment System (HIPPS) code,
- The Assessment Reference Date (ARD),
- The number of covered days for each HIPPS code, and
- Occurrence code 50.

Revenue code 0022 must be reported on the same service line as each HIPPS code. The HIPPS code consists of the three-digit RUG category followed by the two-digit Assessment Indicator (AI). The service units on the service line must contain the number of covered days for each HIPPS code. RUG categories and AIs are determined by the MDS 3.0 and can be found in the MDS 3.0 RAI Manual. The MDS 3.0 RAI Manual is available on the web at www.cms.gov >> Medicare >> Nursing Home Quality Initiative >> MDS 3.0 RAI Manual.

The federally required OBRA MDS assessments listed in A0310A of the MDS 3.0 RAI Manual are the only assessments that may be used for billing RUGs.

There must be an occurrence code 50 for each assessment period represented on the claim. The date of service with occurrence code 50 must contain the ARD associated with the applicable MDS assessment. The occurrence code 50 is not required with the default HIPPS code.

Providers must report the HIPPS code(s) and ARD(s) based on the applicable MDS assessment(s) to the billing period. **Example:** The provider is billing for April 1 through April 30, and MDS assessments occurred on March 15 and May 15. The HIPPS code and ARD would be based on the March 15 assessment since that was the assessment in effect when services were rendered.

Submitted claims will reject in the Community Health Automated Medicaid Processing System (CHAMPS), MDHHS will review the rejected claims and make periodic gross adjustments to the provider based on the claims data. MDHHS will adjust the gross adjustments as necessary to correct for past payments that do not conform to MDHHS billing and reimbursement policies.

These billing requirements apply to State Veterans' Homes billing for NF services and hospice providers billing for room and board in a State Veterans' Home.

MI Health Link

The following bullet will be added to the Eligibility and Service Areas section of the MI Health Link chapter under excluded populations:

- Individuals with Medicaid who reside in a State Veterans' Home.

Medicaid Health Plans

The following bullet will be added to the Services Excluded from MHP Coverage but Covered by Medicaid sub-section of the Medicaid Health Plans Chapter:

- Services provided to an individual with Medicaid who resides in a State Veterans' Home.

Manual Maintenance

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

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to 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 1-800-979-4662.

Approved

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