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Medicaid Process Reform for Nursing Facilities:

Creating an Accurate, Consistent and Timely Reimbursement System

Introduction

The process for paying for nursing facility residents eligible for Medicaid is a cost-based reimbursement process—i.e., providers spend money to take care of Medicaid beneficiaries and are reimbursed through the state Medicaid system.

Recognizing the important roles of ensuring quality care for nursing facility residents and fulfilling its fiduciary responsibility to taxpayers, the state should ensure that its reimbursement process for providers is fair, responsive, efficient, timely, and free of unnecessary cumbersome requirements.

Unfortunately, this is not fully the case with the current nursing facility Medicaid reimbursement process.

Background

In February 2014 the Health Care Association of Michigan (HCAM), at the request of the Director of the Michigan Department of Community Health presented a "Medicaid Process Reform" document to the department that identified several inefficiencies in the reimbursement process and proposed solutions.

A series of meetings began with the department that continue to this day. Unfortunately, after over four years and numerous meetings, these issues are still not adequately addressed. HCAM, therefore, is working to reform the reimbursement process through SBs 1037, 1038, and 1039. The goal of this legislation is to create an accurate, consistent, and timely reimbursement process that maintains the need to ensure quality care and taxpayer accountability.

Since the legislative package was introduced in May of 2018, HCAM has met a number of times with the Michigan Department of Health and Human Services and Senator MacGregor in an effort to have the bills prepared for passage before the end of the 2017-18 legislative term.

SB 1037 (MacGregor) —Due Process and Improvements to Medicaid Reimbursement Policy

SB 1037 would ensure due process when the state changes how they interpret Medicaid policy, and make other important policy revisions.

Prohibit Retroactive Policy Reinterpretations

MDHHS publishes its Medicaid provider policies in the Medicaid Provider Manual, which is updated quarterly. New policies are established through a process that allows providers the opportunity to comment on the proposed policy, and are given a future effective date to allow for providers to prepare for the policy.

The department has often reinterpreted policy and applied the changes retroactively. This retroactive application of a "reinterpretation" of existing policy without provider knowledge violates fundamental principles of fairness and due process. SB 1037 would require reinterpretations to have a prospective effective date.

Encouraging the Modernizing of Skilled Nursing Facilities

Nursing facilities need the ability to respond to market demand by periodically reconfiguring room layouts for the purpose of creating more home-like environments and greater privacy. This often involves converting small rooms and multi-bed wards to private rooms, smaller and more intimate dining settings, and modernized rehabilitation areas. The reconfiguration and modernization of facilities significantly benefits residents. Current Medicaid policies, however, create two significant disincentives for modernization.

One disincentive is that the removal of a bed from a facility is limited to two years, and beds removed must be continguous. This arbitrary policy does not create the flexibility necessary to respond to market demand and acts as a disincentive to modernize facilities.

SB 1037 would update the current non-available bed plan to allow nursing facilities to place beds in the plan for up to 10 years, and also allow the beds to be noncontiguous. This will allow facilities to modify semi-private rooms to private rooms as the market dictates, and provide a more home-like setting for residents.

The second significant disincentive to modernization is how Medicaid treats capital costs. The Medicaid reimbursement rate includes a capital asset value limit, which is a cap on the reimbursement for the value of the facility. The determination of that capital asset value limit is extremely antiquated and does not reflect the cost of building or replacing today – in fact, the current calculation is a data base going back to 1975. This acts as a disincentive to modernize, because current replacement or modernization costs are much higher.

SB 1037 would update the capital asset value limit by establishing a 10 year rolling average to compute the capital asset limit, giving help to providers who invest in better facilities for residents.

Make Simple Fix to End Payment Delays

When a Medicaid beneficiary changes status by disenrollment from a health plan to fee for service, the "care code" in the state's payment system—CHAMPS—must be changed to reflect the new status to enable a provider to receive payment for services. Currently, one person at MDHHS makes this change. Thus, the process can take as long as 9 months to complete, which leaves the service provider unable to receive payment during this time.

SB 1037 would require the MDHHS to establish a process to automatically make this simple code change to enable the provider to receive timely reimbursement for the skilled care provided.

SB 1038 (Stamas) — Timely Medicaid Cost Reports, Audit, and Settlement Process

The Michigan Medicaid program reimburses skilled nursing facilities for Medicaid-approved services at a rate determined annually by the state Medicaid office each October.

Every facility in the state is required to submit an annual "cost report" to the state Medicaid office that contains the expenses incurred by the facility and the accounting for those expenses. These cost reports are audited by the state to ensure that the reimbursement to the facility throughout the year has been for Medicaid-eligible expenses and comply with Medicaid policy.

After completion of an audit, MDHHS will issue a "settlement," which is the matter of reconciling the annual cost report submitted by the facility with the audit done by the state. Settlements usually result in payment from the provider back to the state for costs the auditor determines are not reimbursable.

A fundamental ongoing problem is that audits and settlements are not being completed on a timely basis. Audits take several years to even begin, leaving facilities unaware of financial liability for years. SB 1038 establishes the following timelines to ensure efficiency and fairness in the process:

SB 1038 establishes a **25 month** timeframe for DHHS to complete and settle an audit:

- **2 months** for DHHS to accept a cost report after it is filed by the provider.
- **21 months** for DHHS to complete an audit of the cost report from the day the department accepted the filed cost report.
- **2 months** following a completed audit for DHHS to complete the settlement.

Example: Audits for cost reports covering calendar 2017 must be submitted by May 31, 2018. These cost reports must be audited and settled by June 30, 2020.

- DHHS estimates they are able to complete every 2017 cost report audit in 12 months.
  - After subtracting 9,939 hours for travel, DHHS claims 37,661 total hours available amongst its 25 auditors each year.
  - DHHS estimate: 37,800 hours to complete the audits of all 516 cost reports submitted in 2017.
  - SB 1038 gives the department 25 months to complete each of these audits – double the time required as estimated by DHHS.

Currently, the inefficiencies of the audit process have resulted in a backlog of 1,272 cost reports dating to 2013. SB 1038 mandates MDHHS to finish all audits outstanding on the date the new law becomes effective within **two years** of that date.

To ensure accountability, the cost report filed by the provider ***shall be accepted as filed*** for any of those audits not completed within the timelines established in SB 1038. Under current Medicaid policy, if providers do not produce auditable documents, the MDHHS can disallow the cost, requiring the facility to return payment to the state. SB1038 places similar consequences on the department for not fulfilling its responsibilities.

In addition to the timelines, SB 1038 makes a number of changes to ensure these timelines can be met. These provisions include placing timelines on onsite audits, requiring that a customer satisfaction survey be provided to the facility to give the nursing facility an opportunity to provide feedback on audit activity, and providing clarity to the documentation necessary to complete an audit to help streamline the process. Further, the department must establish an ongoing review of all audit adjustments to avoid different auditors applying policy in different ways, and require an independent analysis on the efficiency and cost effectiveness of the overall audit process.

SB 1039 (Hansen)—Streamline the Determination of Medicaid Eligibility

Senate Bill 1039 addresses several issues related to Medicaid eligibility: (1) initial eligibility; (2) annual redetermination of eligibility; (3) divestitures; and (4) outstation worker availability.

Initial Eligibility

The Medicaid program has a 45-day "Standard of Promptness" for determining Medicaid eligibility by verifying existing income and assets the potential beneficiary may own. This standard is not only required in the federal Medicaid guidelines, but is also required in the FY 2018 Appropriations Act for the Michigan Department of Health and Human Services (MDHHS)—PA 107 of 2017.

The problem is that the state is not meeting this 45 day standard when it comes to determining Medicaid eligibility for residents of many nursing facilities – in fact, for some areas of the state Medicaid nursing facility applications take ***far longer*** than the 45 day standard. During this time of pending eligibility, the nursing facility is providing all of the care needs for the resident without receiving any reimbursement; a cash flow burden which obviously increases the longer it takes to determine Medicaid eligibility.

SB 1039 would establish staff at the MDHHS county offices dedicated to Medicaid eligibility cases for residents of nursing facilities to ensure the eligibility standard of promptness is met. The MDHHS must report on the compliance of the standard of promptness by county to providers.

Annual Redetermination of Medicaid Eligibility

Federal law requires that all Medicaid beneficiaries—including nursing facility residents – be re-determined for Medicaid eligibility annually. For nursing facility residents, the current process is long, complicated, and often frustrating for the resident and the assisting family—in spite of the fact that rarely, if ever, has a re-determination for a long staying resident shown that the individual is no longer eligible. Oftentimes the complexity of the current process causes residents to be disenrolled from Medicaid – causing emotional, financial, and even physical hardship for the resident and family.

SB 1039 would create a simplified re-determination process, including electronic asset detection to verify income and asset status as mandated by federal law. The bill would also allow for the use of a pre-populated application to ease the burden on residents during the re-determination process. It would not only be as accurate as the current system, but it would reduce the burden on the resident and their family, and at the same time free time for state workers to fulfill other important duties.

Eligibility and Unknown Divestitures

Some individuals admitted to a skilled nursing facility who apply for Medicaid incur what is called a "divestiture penalty period." This refers to a period of time that Medicaid does not reimburse the facility for the resident's care, and is applied because the MDHHS has determined that the individual has improperly divested or transferred assets that should have been used to pay for the nursing facility stay prior to the use of Medicaid.

It is unfair to financially penalize the nursing facility provider for improper financial actions of the Medicaid applicant, particularly since the nursing facility has been providing care to the resident in good faith, was probably unaware of the imposition of the divestiture penalty period, and shouldn't become part of the Medicaid financial recovery process.

SB 1039 would create a fund to relieve some of the cost of care provided to residents under a divestment penalty. The rolling fund would be capped at $3 million and be dispersed annually to each facility claiming divestment penalty debt at a percentage covered by the fund.

Eligibility Assistance Contracting for Outstation Workers

MDHHS has a program in which certain state employees—called "Outstation Workers"—are assigned to assist a particular nursing facility with Medicaid eligibility processing. The facility is contractually obligated to reimburse the state for a significant portion of the costs related to this employee.

The problem is that the availability of these workers has varied over the past few years. SB 1039 would codify existing policy requiring an outstation worker to assist with Medicaid eligibility be made available to any facility that requests one.