STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Long Term Care Facilities)

L. SPECIAL PAYMENTS TO COUNTY MEDICAL CARE FACILITIES (CMCF) FOR UN-REIMBURSED MEDICAID COSTS

A SPECIAL PAYMENT TO COUNTY GOVERNMENT-OWNED NURSING FACILITIES WILL BE ESTABLISHED AND RENEWED ANNUALLY. THE PURPOSE OF THE PAYMENT IS TO COMPENSATE CMCFs FOR INCURRED UN-REIMBURSED ROUTINE COSTS. ALLOCATIONS FOR INDIVIDUAL FACILITIES WILL BE DETERMINED BASED UPON UN-REIMBURSED ROUTINE COSTS CERTIFIED AS PUBLIC EXPENDITURES IN ACCORDANCE WITH 42 CFR 433.51.

TO BE ELIGIBLE FOR THE SPECIAL PAYMENT THE FOLLOWING APPLY:

1. THE COUNTY MEDICAL CARE FACILITY MUST MEET MINIMUM FEDERAL REQUIREMENTS FOR MEDICAID PAYMENTS; AND
2. THE NURSING FACILITY MUST BE COUNTY-OWNED AND OPERATED.

DATA SOURCES UTILIZED FOR THE CALCULATION OF MEDICAID LOSS

ROUTINE COST AND REVENUE DATA REPORTED ON WORKSHEET 1 OF THE FILED MICHIGAN MEDICAID COST REPORT ARE THE BASIS OF ALL CALCULATIONS, ALLOCATIONS, AND ADJUSTMENTS USED TO CALCULATE MEDICAID LOSS. ALLOWABLE COSTS ARE DEFINED BY THE MICHIGAN STATE PLAN. MICHIGAN REIMBURSEMENT POLICY FOLLOWS MEDICARE REIMBURSEMENT PRINCIPLES. ONLY AUDITED COST REPORT VALUES ARE USED IN THE FINAL SETTLEMENT CALCULATIONS. WS2-G REPORTS ALLOWABLE ROUTINE COSTS, INCLUDING BASE, PLANT, AND SUPPORT COSTS FOR THE ROUTINE UNIT AND COLUMN 1A SHOWS ALLOWABLE TOTAL ROUTINE COST PER PATIENT DAY.

THE FOLLOWING MICHIGAN MEDICAID COST REPORT WORKSHEETS CONTAIN THE DATA USED. EACH IS DEFINED BY THE RELEVANT MICHIGAN STATE PLAN SECTION:

- PATIENT DAYS FROM WORKSHEET B.
- TOTAL REVENUE FROM WORKSHEET 1.
- BASE COSTS FROM WORKSHEET WS2-G AS DEFINED ON ATTACHMENT 4.19-D, SECTION IV, PAGE 13 C.2.
- SUPPORT COSTS FROM WORKSHEET WS2-G AS DEFINED ON ATTACHMENT 4.19-D, SECTION IV, PAGE 13 C.2.
- BASE /SUPPORT – PAYROLL RELATED FROM WORKSHEET WS2-G AS DEFINED ON ATTACHMENT 4.19-D, SECTION IV, PAGES 15 AND 16.
- PLANT COSTS FROM WORKSHEET WS2-G AS DEFINED ON ATTACHMENT 4.19-D, SECTION IV, PAGE 2.

THE MICHIGAN MEDICAID PROGRAM IS CLAIMING MEDICAID LOSS AS THE DIFFERENCE BETWEEN ALLOWABLE TOTAL MEDICAID ROUTINE COSTS BEFORE FORMULA LIMITATIONS AND TOTAL ROUTINE REVENUE RECEIVED (AS ACCRUED) FOR MEDICAID SERVICES FOR THAT SAME TIME PERIOD. ROUTINE SERVICES REVENUE TOTAL IS

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DEFINED AS THE SUM OF LINES 2 (ROUTINE SERVICES – NURSING, MEDICAID) AND LINE 4 (ROUTINE SERVICES – NURSING, MEDICAID M.O.U.), OF WORKSHEET ONE, TAKING INTO ACCOUNT ANY RECLASSIFICATIONS AND ADJUSTMENTS. NO FACILITY WILL RECEIVE PAYMENT GREATER THAN ITS COST FOR MEDICAID SERVICES.

INTERIM PAYMENT OF MEDICAID LOSS

THE INTERIM MEDICAID LOSS WILL BE CALCULATED IN THE FIRST QUARTER OF THE STATE FISCAL YEAR USING EACH FACILITY'S LATEST AVAILABLE AS-FILED COST REPORT AND THE PATIENT DAY AND PAYMENT DATA PERTAINING TO THAT COST REPORTING PERIOD. THE TOTAL INTERIM MEDICAID LOSS AMOUNT WILL BE DISTRIBUTED IN FOUR QUARTERLY PAYMENTS IN THE MONTHS OF DECEMBER, MARCH, JUNE, AND SEPTEMBER.

TOTAL ROUTINE COSTS FOR EACH FACILITY ARE BASED ON WORKSHEET 2-G, LINE 35, COLUMN 1 OF THE COST REPORT. TOTAL PATIENT DAYS FOR THE ROUTINE UNIT ARE REPORTED ON WORKSHEET B.

THE FACILITY'S ROUTINE COST PER DAY IS COMPUTED BY DIVIDING TOTAL ALLOWABLE ROUTINE COSTS BY TOTAL PATIENT DAYS AND IS REPORTED ON WORKSHEET 2-G, LINE 35, COLUMN 1A. MEDICAID ROUTINE COST IS EQUAL TO THE ROUTINE COST PER DAY MULTIPLIED BY THE NUMBER OF MEDICAID DAYS FOR THE COST REPORTING PERIOD. THE QUALITY ASSURANCE ASSESSMENT IS NOT INCLUDED IN COSTS PER WORKSHEET 2-G.

MEDICAID ROUTINE SERVICES REVENUE TOTAL IS LISTED ON WORKSHEET 1. TOTAL REVENUE INCLUDES NET QUALITY ASSURANCE SUPPLEMENTAL (QAS) PAYMENTS.

3. QAS PAYMENT IS DEFINED AS THE PRODUCT OF THE NUMBER OF MEDICAID DAYS MULTIPLIED BY 21.76 PERCENT OF THE VARIABLE COST COMPONENT LIMITED TO VARIABLE COST LIMIT FOR CLASS ONE FACILITIES.
4. QUALITY ASSURANCE ASSESSMENT PROGRAM (QAAP) ASSESSMENT IS THE PRODUCT OF THE DIFFERENCE OF TOTAL INPATIENT DAYS MINUS THE SUM OF MEDICARE DAYS AND MEDICARE HMO DAYS MULTIPLIED BY THE APPROVED QAAP RATE. THE QAAP RATE IS THE APPROVED QAAP TAX RATE CHARGED TO EACH FACILITY.
5. NET QAS IS THE DIFFERENCE BETWEEN QAS PAYMENT AND QAAP ASSESSMENT IF THIS DIFFERENCE IS A POSITIVE NUMBER. ANY NEGATIVE NET QAS IS DISREGARDED FROM FURTHER CONSIDERATION IN THE CALCULATION OF MEDICAID LOSS. AS SUCH, A NEGATIVE NET QAS CAN NOT INCREASE THE MEDICAID LOSS FOR ANY PARTICIPATING FACILITY.

MEDICAID LOSS IS DEFINED AS TOTAL MEDICAID ROUTINE COSTS MINUS TOTAL ROUTINE REVENUE RECEIVED FOR THE SAME MEDICAID ROUTINE SERVICES. THE ROUTINE REVENUES THAT ARE OFFSET TO ARRIVE AT MEDICAID LOSS MUST INCLUDE ALL REVENUES RECEIVED FOR THE MEDICAID ROUTINE SERVICES EVEN IF THEY ARE REPORTED OUTSIDE OF WORKSHEET 1, INCLUDING MEDICAID BASE AND OTHER

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SUPPLEMENTAL/ENHANCED PAYMENTS (IF APPLICABLE) FROM THE STATE AND ALL PAYMENTS RECEIVED BY THE FACILITY FROM PATIENTS AND OTHER PAYERS FOR THE SAME MEDICAID ROUTINE SERVICES.

INITIAL SETTLEMENT CALCULATION:

FOR EACH FACILITY, AN INITIAL SETTLEMENT OF THE INTERIM MEDICAID LOSS PAYMENTS MADE WILL BE CALCULATED EACH YEAR. THE INITIAL SETTLEMENT WILL BE DONE ONCE THE COST REPORT FOR THE EXPENDITURE PERIOD IS ACCEPTED INTO THE STATE'S RATE SETTING DATABASE. THE MEDICAID LOSS WILL BE CALCULATED USING THE METHODOLOGY DESCRIBED ABOVE BUT UTILIZING EACH EXPENDITURE PERIOD COST REPORT ONCE IT HAS BEEN ACCEPTED WITH INITIAL AUDIT ADJUSTMENTS AND RECLASSIFICATIONS, ACTUAL PATIENT DAYS FROM THE COST REPORT, ACTUAL MEDICAID DAYS FOR THE PERIOD AND ACTUAL MEDICAID RATE PAYMENTS AND OTHER APPLICABLE PAYMENTS. THE MEDICAID LOSS CALCULATED AT INITIAL SETTLEMENT IS RECONCILED WITH THE INTERIM MEDICAID LOSS PAYMENTS MADE FOR THE COST REPORTING PERIOD. THE FEDERAL SHARE OF ANY OVERPAYMENT IS CREDITED TO THE FEDERAL GOVERNMENT.

FINAL SETTLEMENT CALCULATION:

FOR EACH FACILITY, FINAL SETTLEMENT CALCULATIONS WILL BE CONDUCTED UPON COMPLETION OF THE FINAL AUDIT OF THE FACILITY'S COST REPORT.

THE MEDICAID LOSS WILL BE CALCULATED USING THE METHODOLOGY DESCRIBED ABOVE BUT UTILIZING EACH AUDITED EXPENDITURE PERIOD COST REPORT, ACTUAL PATIENT DAYS FROM THE COST REPORT, ACTUAL MEDICAID DAYS FOR THE PERIOD, AND ACTUAL MEDICAID RATE PAYMENTS AND OTHER APPLICABLE PAYMENTS. THE MEDICAID LOSS CALCULATED AT FINAL SETTLEMENT IS RECONCILED WITH THE INITIAL SETTLEMENT MEDICAID LOSS PAYMENTS MADE FOR THE COST REPORTING PERIOD.

ALL ADJUSTMENTS TO THE INITIAL PAYMENT WILL BE DONE VIA GROSS ADJUSTMENT AND PROCESSED THROUGH MICHIGAN'S CLAIMS PROCESSING SYSTEM. THE FEDERAL SHARE OF ANY OVERPAYMENT IS CREDITED TO THE FEDERAL GOVERNMENT.

OS Notification

State/Title/Plan Number: **Michigan 09-006**

Type of Action: **SPA Approval**

Required Date for State Notification: **January 23, 2012**

Fiscal Impact: **FY 2009 $17,000,000**
FY 2010 $21,250,000

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: **Effective for services on or after January 1, 2009, this amendment proposes payments to county-owned free-standing nursing facilities (NF) for unreimbursed Medicaid costs. Payments will be based upon unreimbursed costs certified as public expenditures (CPE). The non-Federal share of these payments will be funded using CPE. There are no issues with the UPL.**

Per requirements under Section 5001(g)(2) of ARRA and the SMD letter #10-010 dated June 21, 2010, the State has committed to obtaining, by January 15, 2012, certification from each of the participating County NFs that their contribution to the non-Federal share of the payments proposed under TN 09-006 is voluntary

This amendment proposes payments to licensed county medical care facilities, which are county-owned free-standing NFs, for unreimbursed Medicaid costs. Payments will be based upon unreimbursed costs certified as public expenditures (CPE). Providers certify and report the amount of their public expenditure for this program through the cost reporting process. The type of cost report being used as the source of cost data is a State-specific Medicaid cost report. The State has submitted an acceptable protocol, in the proposed plan language, that identifies the unreimbursed Medicaid costs.

The review process for this amendment was quite lengthy due to analyzing the State-specific Medicaid cost report to ensure it was a reasonable proxy for the Medicare cost report, developing a detailed CPE protocol to be added to the State

plan language, and development of political subdivision voluntary contribution language.

Other Considerations: **This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.**

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

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National Institutional Reimbursement Team