Legislative Analysis

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NURSING FACILITY MEDICAID REIMBURSEMENT

Senate Bill 1037 as enrolled
Vetoed by the Governor
Sponsor: Sen. Peter MacGregor

Senate Bill 1039 as enrolled
Vetoed by the Governor
Sponsor: Sen. Goeff Hansen

House Committee: Families, Children, and Seniors
Senate Committee: Oversight
Complete to 3-4-19

SUMMARY:

These bills were originally, with Senate Bill 1038, part of a package that, taken together, would have amended the Social Welfare Act to reinterpret existing Medicaid policy, modify eligibility for a nursing facility, and modify and create deadlines for completion of cost reports. Senate Bill 1038 was enacted as Public Act 612 of 2018.[1] Senate Bills 1037 and 1039 were vetoed by Governor Snyder on December 28, 2018. The vetoed bills are described in more detail below.

Senate Bill 1037

Currently, the Michigan Medicaid Provider Manual addresses all health insurance programs administered by the Department of Health and Human Services (DHHS). The DHHS also issues periodic bulletins as changes are implemented to the policies and/or processes described in the manual. Bulletins are also incorporated into the online version of the manual on a quarterly basis.

Senate Bill 1037 would stipulate that if the DHHS issues a new interpretation of existing Medicaid provider policy directly affecting nursing facility Medicaid cost reports, that change in policy must have a prospective effective date. However, a policy could have a retrospective effective date as part of a state plan amendment approval or waiver approval or if required by state law, federal law, or judicial ruling.

Medicaid Nonavailable Bed Plan Policy

By July 1, 2019, but no later than October 1, 2019,[2] the DHHS would have to revise the Medicaid nonavailable bed plan policy to allow a nursing facility to remove beds from service for up to five years. All of the following would apply to the revised bed plan policy:

- A nursing facility would not be required to remove all beds from a room.

[1] http://legislature.mi.gov/doc.aspx?2018-SB-1038
[2] The difference in meaning between "By" and "no later than" is unclear.

- The beds placed in a nonavailable bed plan could be from noncontiguous rooms.
- The DHHS would have to allow the entire nursing facility to be utilized during the period when the nursing facility has a bed in the bed plan, but the square footage associated with each bed would be nonreimbursable on the Medicaid cost report.

Program Enrollment Type

The DHHS would also have to establish a process to automatically change the program enrollment type and managed care enrollment status in the community health automated Medicaid processing system (CHAMPS) immediately when a filing has been made by a health maintenance organization (HMO) to disenroll a nursing facility resident from an HMO and the resident has completed 45 days of skilled care at a nursing facility. The DHHS could utilize a filing to disenroll a nursing facility resident from an HMO, admission and discharge data entered by a nursing facility in CHAMPS, or automated admission, discharge, and transfer transactions to verify the 45-day limit.

Secondary Review of Denied Rate Exception

Within 60 days after receipt of a request from a nursing facility, the DHHS would have to perform a secondary review of a denied rate exception, including rate relief, or application of a classwide average rate. The secondary review would have to be performed by DHHS staff who are separate from the staff who performed the initial review determination.

DHHS Quarterly Meeting

The DHHS would also have to offer a quarterly meeting and invite appropriate nursing facility stakeholders, including at least one representative from each nursing facility provider trade association, the Long-Term Care Ombudsman, and any other representatives. In conjunction with the DHHS, individuals who participate in these quarterly meetings could designate advisory workgroups to develop recommendations on the discussion topics, which should include at least:

- Seeking quality improvement to the cost report audit and settlement process.
- Improving auditors' and providers' quality and preparedness.
- Enhanced communication between applicable parties such as DHHS staff, consultants, and providers.
- Improving Medicaid providers' ability to provide auditable documentation on a timely basis.
- Promoting transparency between providers and DHHS staff, including applying regulations and policy in an accurate, consistent, and timely manner and evaluating changes that have been implemented to resolve any identified problems and concerns.

Proposed MCL 400.111n

Senate Bill 1039

Senate Bill 1039 would require the DHHS to ensure timely medical assistance eligibility determinations by doing all of the following:

- Allocating specific staff caseloads of nursing facility residents applying for medical assistance to ensure compliance with the federal standard of promptness (not more than 90 days for a disabled individual and not more than 45 days for a nondisabled individual). Staff allocated to receive caseloads could also receive caseloads for applications in setting other than nursing facilities.
- Collaborating with the nursing facility trade associations to provide periodic training on eligibility processes and requirements.
- Beginning October 1, 2019, reporting quarterly to the nursing facility trade associations on compliance with the federal standard of promptness timelines for medical-assistance-eligible nursing facility residents. The report would have to list compliance by county and identify measures necessary to meet the standard.

Annual Eligibility Redetermination

Beginning October 1, 2019, the DHHS would have to do all of the following:

- Implement an asset detection and verification process for a medical-assistance-eligible nursing facility resident.
- Provide to the recipient a prepopulated form reflecting information from the most recent Medicaid application and allow him or her to attest to the information to provide an accelerated redetermination process.
- Collaborate with the nursing facility trade associations to provide periodic training on medical assistance eligibility redeterminations.

Divestment Penalty Report

The DHHS would have to request, with the filing of the Medicaid cost report disclosure to the provider, the amount of debt incurred due to Medicaid divestment penalties. The DHHS would have to annually report the debt incurred by providers due to Medicaid divestment penalties to appropriate nursing facility stakeholders.

Outstation Worker

Under the bill, the DHHS would have to make available an outstation worker to facilitate Medicaid eligibility determination to a nursing facility that requests an outstation worker.

Recipient Court-Ordered Payment/Garnishment

If a recipient residing in a nursing facility had a court-ordered payment or garnishment, the DHHS would have to automatically apply the payment or garnishment before determining the patient-pay amount.

Proposed MCL 400.105g

FISCAL IMPACT:

These bills would increase DHHS information technology costs by an unknown amount to prepopulate Medicaid eligibility redetermination forms and to automatically change a Medicaid recipient's "program enrollment type" when a Medicaid recipient is disenrolled from a Medicaid managed care organization after residing in a skilled nursing facility for 45 days. The bills could also increase DHHS personnel costs related to allocating specific staff for Medicaid recipients who reside in a nursing facility and related to additional training costs for nursing facility trade associations on Medicaid eligibility.

Lastly, these bills could increase Medicaid nursing home costs related to the changes to the nonavailable bed policy. If Medicaid nursing home costs were to increase, the federal share of the increase would be 64.45% and the state share would be 35.55%.

***Vetoed 12-28-18*:**

In his veto message, Governor Snyder wrote: "The legislation has significant revenue and administration issues that need to be resolved before this can be considered appropriate policy in our state. Accordingly, I am returning these bills without signature in order to allow for more thorough evaluation of the revenue and administration impacts of the bills."

Legislative Analyst: E. Best
Fiscal Analyst: Kevin Koorstra

■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.