Medicaid Long-Term Care Reimbursement

LeadingAge Michigan
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What is the Medicaid Cost Report?

Summary of a facility’s annual financial data and census. Disallowed Costs are removed from the cost report.

File Cost Report – 5 Months After FYE

Reviewed by MDCH - Rejection

Provider QAS Tax Issued

Lined up from lowest cost to highest cost – 80% sets VCL

Class I and Class III
Top 10 Reasons for Cost Report Rejections

1. CHAMPS Data
2. Prior Year Audit Adjustments
3. Statistical Basis is WRONG
4. QAS Revenue and Prior Year QAS Reconciliation
5. QAS Provider Tax is WRONG
6. Home Office Cost Report Rejected
7. Fixed Assets and Accumulated Depreciation = WS 3 and WS 5
8. Revenue – Should be Broken Out by Payor Type for all Services
9. Census – Bed Changes During the Year
10. Home Office – Number of Facilities in Each State

Our office strongly encourages all providers to request access to File Transfer for submission of cost reports as well as receipt of documents from this office including Rates, Settlements, MIP Reconciliations, QAS Reconciliations, etc. Please refer to our website at: http://www.michigan.gov/mdch/0,4612,7-132-2945-43261-42041-4244-42591-329364--00,00.html for additional information and instructions.

Medicaid Rate Setting

- All 2013 Medicaid cost reports are used to set Medicaid rate effective October 1, 2014 regardless of fiscal year end.
- For a provider with a March 31 year end the FYE 03/31/2013 cost report will be used
  - 18 month lag
- FYE 12/31/2013
  - 9 month lag
- MDCH RARRS uses a cost index factor to account for inflation which brings all providers to a September year end
  - 1.008 is applied to FYE 03/31/2013
  - 1.006 is applied to FYE 06/30/2013
  - 0.9968 is applied to FYE 12/31/2013
Cost Classification

Total Facility Costs

- Skilled Nursing "Routine" Costs
- Ancillary Costs
- Non-reimbursable Costs
- Plant Costs

Dietary, Nursing, Laundry, Housekeeping, etc.

Wages, Fringe Benefits and Payroll Taxes
- Nursing, Nursing Admin, Dietary, Laundry, Activities, Social Services
- Administrative, Housekeeping, Maintenance, Medical Records, Medical Director, Central Supplies

Supplies (Includes food and linen)
- Nursing, Dietary, Laundry, Activities, Social Services
- Administrative, Housekeeping, Maintenance, Medical Records, Medical Director, Central Supplies

Contracted Services
- Nursing Staff for Direct Patient Care
- Administrative, Housekeeping, Maintenance, Medical Records, Medical Director, Central Supplies
- Laundry, Dietary, Nursing Admin, Activities, Social Services - 77% Base and 23% Support Costs

Workers Compensation
- Nursing Staff for Direct Patient Care
- Administrative, Housekeeping, Maintenance, Medical Records, Medical Director, Central Supplies

Utilities Costs
- All Departments

Phone Office Costs
- All Departments

Minor Equipment and Repairs & Maintenance
- All Departments

Education, Travel, Phone, Taxes, Insurance, Advertising and Misc Expenses
- All Departments
Variable Cost Limits (VCL)

- Limits are set at the 80th percentile of the Indexed Variable Costs (IVC) for facilities in a particular class during the current calendar year.
- Class I – Proprietary and nonprofit nursing facilities
- Class III – Proprietary nursing facilities, hospital long-term care units, and nonprofit nursing facilities that are county operated medical care facilities
- Current Limits
  - Class I - $188.95/day
  - Class III - $263.64/day

VCL Trending

<table>
<thead>
<tr>
<th>Year</th>
<th>Class I</th>
<th>Class III</th>
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</thead>
<tbody>
<tr>
<td>2005</td>
<td>$136.89</td>
<td>$181.54</td>
</tr>
<tr>
<td>2006</td>
<td>$141.28</td>
<td>$192.92</td>
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<tr>
<td>2007</td>
<td>$147.68</td>
<td>$200.76</td>
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<tr>
<td>2008</td>
<td>$154.70</td>
<td>$226.79</td>
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<td>2009</td>
<td>$160.00</td>
<td>$229.20</td>
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<td>2010</td>
<td>$170.38</td>
<td>$235.14</td>
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<tr>
<td>2011</td>
<td>$174.15</td>
<td>$241.77</td>
</tr>
<tr>
<td>2012</td>
<td>$179.23</td>
<td>$248.23</td>
</tr>
<tr>
<td>2013</td>
<td>$186.76</td>
<td>$263.64</td>
</tr>
<tr>
<td>2014</td>
<td>$188.95</td>
<td>$</td>
</tr>
</tbody>
</table>
Exceeding the Limit

- Exceeding S/B Ratio Limit results in lost reimbursement for costs that would otherwise be reimbursable.
- Key Considerations
  1. GL Coding of Salary and Wage costs
  2. Contracted Services
  3. Home Office Allocation
  4. Expensing Minor Equip – Under S/B Ratio and VCL

Non-Reimbursable Costs

- Certain costs that are normally incurred by nursing facilities are non-reimbursable.
  - Marketing
  - Public Relations
  - Bad Debt Expense
  - Provider Tax
  - Penalties
  - Lobbying
  - Barber & Beauty
  - Gift Shop
Plant Costs

- Interest, Property Tax, Lease Expense, Depreciation
- Reimbursed differently for Class I versus Class III Providers
- Class I
  - Property Tax/Interest Expense/Lease Component
  - Return on Current Asset Value (CAV)
  - Not Reimbursed for Depreciation Expense
- Class III
  - Facility Specific Plant Cost Limit
  - Depreciation Expense is Reimbursed

Class I – Interest/Property Tax/Lease

- Interest on allowable borrowings, property tax expense, and lease expense is reimbursed to providers based on the percentage applicable to LTC
  - Percentage applicable to LTC is based on square footage allocation
  - Ancillary, HFA, Barber & Beauty, etc. excluded from % applicable to LTC
- Interest Expense is reimbursed on allowable borrowing up to the Current Asset Value (CAV) Limit
- Total allowable cost is divided by total days to come up with per diem
Class I – Return on Current Asset Value (CAV)

- CAV – determined by a formula that takes a facility’s historical fixed asset costs and applies the difference between an asset value update factor and an obsolescence factor.
- CAV capped at $68,500 per bed currently
  - Lesser of actual CAV or CAV Limit is used to calculate return on CAV
- Return on CAV
  - 2.5% for a new facility
  - Increases by 0.25% each year
  - Capped at 5.25%

Class III – Plant Cost Limit (PCL)

- PCL – sum of the per resident day component limits for depreciation, interest, financing fees, and property tax
- Started at $5.66/day
- Capped at $15.65/day
- Plant Cost Certification MUST be filed whenever a facility undergoes a significant change in facility asset costs to increase PCL
  - NO PCCERT = NO INCREASED REIMBURSEMENT
Quality Assurance Supplement (QAS)

- Is issued every October 1 when rate letters are issued
- Add-on to Medicaid rate – paid once a month
- Calculated based on 21.76% of the lesser of a facility’s actual allowable variable costs or the Class I VCL
  - Class I VCL rule applies to Class III facilities also
- Ranges from $20 to $41 in additional payment
  - $188.95 x 21.76% = $41.11
- The monthly payment is estimated based on Medicaid claims paid for the prior period of June through May (June 2012 through May 2013 for payments effective 10/1/13)
- Settled to actual claims once rate year is over and to the AUDITED variable component

Michigan Medicaid Rates

- VCL – Class I Facility $188.95
- QAS Add-on @21.76 41.11
- Plant Cost Reimbursement 10.00

Total Rate $240.06

Many facilities in Michigan have higher Medicaid rates than private pay rates
Current Medicaid Rates

Cost Allocation

• Once all non-reimbursable costs are accounted for and removed from cost report, step-down process, takes place
• Statistical bases are assigned to each cost center
  • MDCH RARRS defines recommended basis for each cost center
  • Requests for alternative statistical bases must be submitted to RARRS prior to end of fiscal year for which the alternative statistical bases are to be applied
• Based on statistics cost are spread to all areas of facility that the costs apply to
Statistical Bases (Recommended)

- Plant Costs – Square Footage
- Employee Health & Welfare - Salaries
- A&G – Accumulated Costs
- Plant Operation & Maintenance, Utilities – Square Footage
- Laundry – Lbs. of Laundry
- Housekeeping, Nursing Admin – Hours of Service
- Dietary – Meals Served
- Nursing Admin – Hours of Service
- Central Supplies, Medical Supplies – Cost Requisition
- Medical Records, Social Service, Diversional Therapy – Time Spent

Things to Consider...

- Statistical Bases
- Contracted Services
- Allocations to AL/IL/HFA
Census and Occupancy

- Medicaid rate is determined by taking total allowable costs and dividing by total patient days.
- High occupancy results in lower Medicaid rate
  - Medicaid rate is at its highest when occupancy is right at 85%
- If Occupancy falls below 85% the rate is based on if a facility was at 85% occupancy
- Potential for lost reimbursement

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**Michigan Nursing Facility Occupancy**

<table>
<thead>
<tr>
<th>Year</th>
<th>Average Occupancy</th>
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<tbody>
<tr>
<td>2001</td>
<td>87.72</td>
</tr>
<tr>
<td>2002</td>
<td>87.75</td>
</tr>
<tr>
<td>2003</td>
<td>86.63</td>
</tr>
<tr>
<td>2004</td>
<td>87.18</td>
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<tr>
<td>2005</td>
<td>86.86</td>
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<tr>
<td>2006</td>
<td>87.62</td>
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<tr>
<td>2007</td>
<td>87.65</td>
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<tr>
<td>2008</td>
<td>85.75</td>
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<tr>
<td>2009</td>
<td>85.95</td>
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<tr>
<td>2010</td>
<td>84.87</td>
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<tr>
<td>2011</td>
<td>84.92</td>
</tr>
<tr>
<td>2012</td>
<td>83.10</td>
</tr>
<tr>
<td>2013</td>
<td>80.00</td>
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</table>

Source: MDCH Website
Example – 85% Occupancy Rule

- 100 Bed facility
- Total bed days available = 36,500 (100 beds x 365 days)
- Resident days needed to achieve 85% = 31,025 (36,500 x 85%)
- Total allowable variable costs at facility = $5 Million
- Actual resident days for the reporting period = 29,000
- Actual Occupancy = 79.45%
- How will this impact Medicaid rate?

Example – 85% Occupancy Rule (Cont’d)

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Per MDCH</th>
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</thead>
<tbody>
<tr>
<td>Occupancy %</td>
<td>79.45%</td>
<td>85.00%</td>
</tr>
<tr>
<td>Total Variable Cost</td>
<td>$5,000,000</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>Divide By: Patient Days</td>
<td>29,000</td>
<td>31,025</td>
</tr>
<tr>
<td>Cost Per Day</td>
<td>$172.41</td>
<td>$161.16</td>
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<tr>
<td>Variable Cost Differential</td>
<td>($11.25)</td>
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</tr>
</tbody>
</table>
Options to avoid 85% Occupancy Penalty

- Non-Available Bed Plan
- De-licensing Beds
- Setting up Licensed Only or Medicare Only Unit

Quality Assurance Assessment Tax

- Provider Tax
- Paid on all non-Medicare days of care
  - Medicare HMO is classified as “Medicare”
- Rates effective October 1, 2013
  - Less than 40 Beds - $2.00/non-Medicare day
  - Greater than 51,000 Medicaid Days - $16.00/non-Medicare day
  - All other providers - $23.70/non-Medicare day
Concerns in relation to cost report

• Worksheet B of Medicaid Cost Report is used to determine the number of days for which the tax is to be assessed.
• How are the Medicare HMO days being recorded in the census?
  • Are the non-RUG based plans lumped in with the RUG based plan?
  • Are the non-RUG based plans reported as “Other”

Medicaid Audit Concerns

• OA is more strict on certain issues
  • Time studies must be kept
  • Moving bariatric, physician, wound vacs, etc. to ancillary cost center (Establishing a Cost Center)
  • Medical Supplies over to Minor Equipment?
  • Payroll Taxes for Administrator
  • Swap Interest
  • Others?
In Summary

• Current Medicaid Rate Setting Concerns:
  • What is your occupancy?
  • Are you over the S/B Ratio?
  • Are you over the VCL?
  • Should you file a Plant Cost Certification?

• Medicaid Audit Concerns?
  • Look at prior year cost reports to determine if any of the items discussed may apply to your facility (a potential risk during future audits).
  • How long will Michigan Medicaid be cost reimbursed...very rare and is most likely to go away in the future
    • Acuity Based?
    • What are you actual costs?
    • What should you be looking at with contracts?
    • Compare costs to peer organizations.

Questions?

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