MEMORANDUM

FROM: Richie Farran, V.P. of Government Services, Health Care Association of Michigan
DATE: April 2025
SUBJECT: Fiscal Year 2026 Budget Priorities

HCAM is requesting updates to Michigan's Medicaid Policy Manual to reflect changes to operations and care delivery as the profession transitions to post-pandemic realties. Below are five policies that can be updated through boilerplate in the state fiscal year 2026 budget legislation. Draft boilerplate is provided in each section.

1. Non-available bed plan policy MSA 21-43 extension

ASK: HCAM requests that the existing temporary non-available bed plan flexibilities under MSA 21-43 be made permanent. This policy allows providers to manage clinical and market demands while preparing for an increase in the utilization of nursing facility beds in the next 3-5 years as Michigan continues to age.

The Michigan Medicaid Policy Manual allows for nursing facility providers to place unused beds in a non-available bed plan (NABP) in order to manage clinical and market demands. This policy has been critical for providers reacting to infection control and census challenges. HCAM is grateful that MDHHS issued MSA 21-43 in October of 2021, which allows nursing facilities to be more selective in their non-available bed designations. These flexibilities were continued through state fiscal year 2025, and will remain in effect until September 30, 2025.

The NABP outlined in the Medicaid provider manual is much more restrictive than the temporary NABP guidelines outlined in MSA 21-43. The original policy requires providers keep beds out of service in an NABP through the end of the provider's fiscal year and the next, meaning beds could be unavailable for up to 23 months. The new flexibilities allow NABP's to be revisited every 6 months.

Along with the impacts of COVID-19, historic workforce challenges have brought a level of volatility not previously experienced, leading to difficulty for providers to determine future staffing levels, making occupancy expectations difficult to predict. The flexibilities under MSA 21-43 allow nursing facilities to respond to the changing occupancy demands more quickly and frequently.

The Medicaid provider manual policy also requires all beds in a patient care room be made non-available, along with requiring all beds in a NABP be located in contiguous areas. The temporary rules do not require that beds in a NABP be in a contiguous area, and allows non-available and available beds in the same physical room. This allows for more flexibility and more private room opportunities for residents.

Current Medicaid policy rate setting assumes an 85% occupancy rate. Actual state wide occupancy rates were below 80% since January of 2020, and are currently at 82.5% as of January 2025. Occupancy is expected to grow slowly for the next several years.

Non-available beds plans have not been overused by nursing facilities in Michigan, even after the implementation of MSA 21-43. As of 2023, approximately 17% of nursing facilities in the state of MI utilized the

non-available bed plan option. Only 3.4% of Medicaid beds across the state were placed in NABPs. NABP's are a valuable tool used judiciously by providers when appropriate.

COST: With about one-quarter of nursing facilities currently using the NABP, the cost to the state to implement the below policy change would be negligible.

Boilerplate: *The department shall modify Medicaid policy in the Medicaid Manual, Nursing Facility Chapter, Cost Reporting and Reimbursement Appendix, Section 9.13 and submit a Medicaid state plan amendment to CMS to seek approval to allow existing temporary non available bed plan flexibilities under MSA 21-43 to become permanent. The department shall modify Section 9.13 to include the follow provisions:*

- *Providers can designate individual beds within a room that are not being used for resident care as non-available. There are no discrete area or contiguous physical arrangement requirements for the designation of a non-available bed. The common physical space within a room containing both non-available beds and available beds will not be designated as a non-available bed area.*
- *Designated beds must remain non-available for a period of six months. Non-available bed designations will be effective on the first day of the month. If the notice is not received within the required 60 calendar day period, the plan will become effective on the first day of the month in which RARSS received the notice if the beds have not been utilized during that month. The 24-month ineligibility period that follows the expiration of the previously approved plan, during which providers cannot submit a new non-available bed plan, will be waived for the six-month non-available bed designation plans.*
- *Providers will be allowed continued renewals of the non-available bed plan every 6 months, if requested.*
- *This update to the non-available bed plan Medicaid policy will take effect on October 1, 2025.*

2. Home Office Costs

ASK: Require MDHHS to avoid unnecessary cuts to facilities' Medicaid rate by recognizing nursing staff covering multiple nursing facilities as a "base cost".

Michigan nursing facilities are required to report their costs to the Michigan Medicaid program annually on a cost report. These cost reports are audited annually by the Michigan Department of Health and Human Services (MDHHS) to ensure Medicaid payments to the facility were appropriately directed to patient care. Current Medicaid policy categorizes each facility's costs into base and support costs. Generally, base costs are directly related to patient care, while support costs cover expenses not tied to direct patient care. The ratio of these two categories serves as a limiting factor for Medicaid reimbursement – shifting expenses from base to support results in a lower Medicaid rate.

Many chain organizations employ nursing staff through their home office to efficiently serve nursing facility populations in multiple facilities. These nurses provide direct patient care and nursing administration services, and although they are paid by the home office, their costs are allocated to specific facilities based on time spent on-site.

According to Medicaid policy (NF Cost and Reporting and Reimbursement Appendix 9.2.A), payroll expenses for nursing, nursing administration, dietary, and other appropriate departments are classified as base costs. Additionally, consultant costs from related party organizations for base cost activities and nursing pool agency contract services for direct patient care nursing staff are also considered base costs.

However, under audit, these nursing costs—including home office-allocated nursing expenses—are frequently reclassified from base to support, leading to reduced Medicaid reimbursement. It is essential that nursing costs, including those allocated from the home office, are properly recognized as base costs.

COST: Allowing the classification of nurse consultants as base cost drives efficiencies and savings in the Medicaid program. Classifying these nurses as support cost will drive up Medicaid costs, as the nurse consultant would be unable to assist with care in multiple buildings.

Boilerplate: *The department shall apply current Medicaid policy (NF Cost and Reporting and Reimbursement Appendix 9/2/A) to recognize home office nursing costs attributable to patient care as base costs. These costs shall not be reclassified to support costs or purchased services. This update shall take effect October 1, 2025.*

3. Dialysis Services in Nursing Facilities

ASK: Allow for Medicaid reimbursement for the cost of providing dialysis services to residents in their nursing facility.

Over 23,000 Michigan residents are living with End Stage Renal Disease (ESRD), and more than 16,000 of these residents require dialysis services to subsist with the disease. With the prevalence of ESRD in the population as a whole, an increasing number of residents in Nursing Facilities throughout Michigan are in need of chronic dialysis services. According to CMS, an average of 1 in 7 ESRD patients are Nursing Facility residents, equating to approximately 2,300 Michigan Nursing Facility residents undergoing dialysis services at any given time. Traditionally, providers have transported residents to outpatient dialysis centers where they have received their required care.

Nursing facilities have found it advantageous for the dialysis provider to come to the facility to treat the residents. Offering home dialysis as a treatment option for nursing home residents addresses certain disadvantages of outpatient dialysis, such as excess transportation times and disruption of the resident's daily activities. Additionally, during times of COVID and influenza outbreaks, home dialysis in a nursing facility can lessen transmission risks.

When performing dialysis in a nursing facility, dialysis vendors typically furnish skilled certified staff that perform services that are billed back to the nursing facility. Alternatively, a nursing facility may also provide their own staff, if properly trained, to assist with the dialysis. Nursing facilities have attempted to include these fees or staffing costs as part of their reimbursable routine expenses that are reported to the state on their Medicaid cost reports.

These costs have been regularly disallowed from Medicaid cost reports, as current Michigan Medicaid policy as interpreted by MDHHS staff deems all cost attributable to dialysis as ancillary and not reimbursable by Medicaid.

COST: Allowing for reimbursement for staff time during in-home dialysis treatment will likely reduce cost to the state, as the transportation to an offsite dialysis center is much more costly and is currently reimbursed through the Michigan Medicaid program.

Boilerplate: *The department shall modify and update the Medicaid provider manual policy to recognize expenses incurred by nursing facilities for skilled staffing fees attributable to in-home dialysis services as reimbursable base cost, to take effect October 1, 2025.*

4. Nursing Facility Capital Cost Policy Update

ASK: Update boilerplate to clarify that the initial increase in the CAV limit may exceed 4%, with a 4% cap on subsequent year increases.

Recent state budgets included boilerplate that would change the Medicaid reimbursement limits for capital costs for nursing facilities – called the Current Asset Value (CAV) limit (Sec. 1645 – Nursing Home Capital Costs). HCAM worked closely with the State Budget Office and MDHHS in 2018 to update the reimbursement for nursing facilities' capital costs – the increase has already been agreed to by MDHHS, SBO, and HCAM.

The boilerplate called for new methodology to create this limit, which would allow for an initial jump in the limit the first year it is applied, then set a 4% cap for subsequent years. Unfortunately, the new CAV limit was implemented incorrectly by not allowing for the initial increase. The below boilerplate language would fix this for the 2026 fiscal year, and HCAM requests its inclusion in the budget. This update will not require additional funding as it is already included in the long-term care services line.

COST: This policy change would likely result in an annual increase to the long-term care services line of approximately $5 million, 65% of which would be covered by federal matching funds.

Boilerplate: *Sec. 1645. (1) The department shall update the Medicaid provider manual policy for the Class I nursing facility current asset value bed limit to use a rolling 15-year history of new construction when establishing a current asset value bed limit for the fiscal year beginning on October 1, 2025.*
(2) It is the intent of the legislature that, for the fiscal year beginning October 1, 2026 and subsequent fiscal years, the increase in the current asset value bed limit based on the rolling 15-year history of new construction shall not exceed 4% of the previous fiscal year's limit.

5. Medicaid Ventilator Dependent Care Units (VDCU)

ASK: Update the payment amount for VDCU care from cost-reported data to a percentage of the average statewide Michigan Medicaid Long-Term Acute Care Hospital (LCTH) rate.

Michigan Medicaid currently provides ventilator care in 11 nursing facilities throughout the state. These VDCU's serve Medicaid beneficiaries in need of continuous ventilator support to maintain their respiratory function. Admissions to these units are prior authorized and payment is established based on historical cost reported data. Each VDCU has a facility specific rate that range from $580 to $895 per day with an overall average of $722.03 based on the rates effective October 1, 2024 including the QAS amount of $56.87. Total Medicaid days of care in these units in 2024 were 59,824.

Nursing facility VDCU payment for care is facility specific, and is set by utilizing the cost data from the Medicaid cost reports filed by each of these facilities. The rates lag in recognizing the actual cost of the care as they are set on October 1 each year based on the prior year's costs which creates the lag. For example the October 1, 2025 rates are based on the costs from reports filed for fiscal periods ending in 2024.

It would be administratively efficient to instead utilize the average Michigan hospital LTCH rate that is established each October 1 for payment in the VDCU. This rate would reflect the upcoming cost of care for the forthcoming year rather than historical costs. The average LTCH rate effective for October 1, 2024 is $1,184 per

day. The proposal is to pay the skilled nursing facilities at 80% of the LTCH average, or $947.20 per day, for all VDCU's in the Medicaid program.

COST: The Medicaid program would save about $237 per day and annually over $14.1 million based on 59,824 Medicaid days in the VDCU's per year by discharging the resident to the VDCU from the LTCH.

Boilerplate: The department shall update the Medicaid ventilator dependent care unit (VDCU) reimbursement to reflect 80% of the average statewide Michigan Medicaid Long-Term Acute Care Hospital (LTCH) rate. The rate shall be updated annually based on the annual LTCH rate. This update shall take effect October 1, 2025.

6. Dual Certification of Medicare Only Beds

ASK: Include boilerplate directing an update to the Michigan Medicaid Provider Manual to allow for dual certification of Medicare Only (MO) beds if the state survey agency finds that the facility is in substantial compliance with federal regulations at the time of application.

The SFY 2025 budget directed the Michigan Department of Health and Human Services (MDHHS) to update Medicaid Policy by easing restrictions on the process for dual certification of Medicare only beds. The previous existing Medicaid policy made it difficult for nursing facilities with Medicare only beds to become dually certified. There were several requirements, including an 8 quarter lookback on survey issues, which has limited Medicaid access throughout the state.

The implementation of the legislative boilerplate and MDHHS policy interpretation has been causing unintended consequences and in some cases denials for providers looking to obtain Medicaid certification for their Medicare only beds.

MDHHS is currently implementing the policy as follows:

- MDHHS checks with LARA to see if a facility is in substantial compliance at the time of application (which generally occurs before the quarter due date, which is 45 days before the start of a new quarter).
- If any survey activity occurs between the time of application, and the quarter due date, MDHHS will check to see if there is an approved plan of correction.
- If there is survey activity, and the facility has not received an approved plan of correction before the quarter due date, they will deny the application.

The MDHHS application of this policy means that a facility may be in compliance when they submit an application for dual certification of Medicare only beds, but may be denied based on subsequent survey activity that occurs after application submission. This was not the intent of the boilerplate, and is the result of the critical omission of the word "or" between the second and third bullet points of boilerplate Section 1805 of PA 121 of 2024. As the intent was to update the policy to allow for dual certification if the Department of Licensing and Regulatory Affairs finds that the facility is in substantial compliance with federal regulations at the time of application, the third bullet point should be stricken. Such a change will reduce the burden on MDHHS to administer the policy and achieve the agreed to intent of the updated policy.

COST: The updated policy will have a negligible impact on the budget compared to the current policy as the vast majority of beds are already dually certified and able to serve Medicaid.

Boilerplate: *The department shall modify Medicaid policy in the Medicaid Manual, Nursing Facility Chapter, Certification, Survey and Enforcement Appendix, Section 2.3 and submit a Medicaid state plan amendment to CMS to seek approval to allow the department to approve or deny any application seeking Medicaid bed certification and provider enrollment for dual certification of Medicare-only beds. The modified Medicaid policy must replace the current certification criteria. The modified Medicaid policy must provide that the department grant Medicaid bed certification if the application meets all of the following:*

(a) A verification from the state survey agency that the beds listed in the applications are Medicare-certified.

(b) The state survey agency finds that the facility named in the application is in substantial compliance with federal regulations at the time of application.

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