HCAM Biller's Forum April 12, 2024

PRESENTATION:
MICHAEL BATTS
HCAM VICE PRESIDENT
OF
REIMBURSEMENT SERVICES

Agenda

Welcome, Format, Questions and Introductions – Michael Batts, HCAM

~~Questions sent to Mike's email address: michaelbatts@hcam.org~~

9:00 am – 9:15 am Welcome, Format, Questions, Chat and Introductions – Mike Batts, HCAM

Questions sent to my email address: michaelbatts@hcam.org

9:15 – 10:45 ECS Solutions, Tammy Davis, Tina Simmons
- Staying up to date with Beneficiary Notices
- Managing Medicare as a Secondary Payer
- Compliant Billing with Medicare Informational Claims
- Where we are with the Targeted Probe and Educate (TPE) Audit and other audit news.
- Managed Care Tips – New CMS Mandates for managed care plans & Other managed care news

Break 15 minutes

Agenda Continued

11:00 - Noon Michigan and Federal Update – Mike Batts
- Occupancy – National and State
- Enrollment – MHL, PACE, MI Choice, Medicare Advantage
- Budget FY 2024 Process and Status
- Pending Legislation – Med Tech, Agency Staffing, and more
- CMS PDPM Rule/Minimum staffing proposed rule
- Change Healthcare
- MHL Transition to HIDE
- New Reimbursement System for Medicaid

Agenda Continued

12:00 PM – 1:00 pm Luncheon

1:00 – 2:00 pm Medicaid & MI Health Link Issues, MDHHS staff
- Billing Issues/Top Billing Errors
- LOCD and Redeterminations
- Eligibility
- Bed Options – Medicare only, Licensed, NABP
- MHL – QAS ICO
- Special Needs Plans - Michigan
- Third Party Liability Update

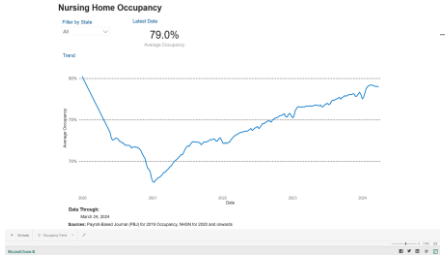
Agenda Continued

2:00 – 2:30 Aetna Better Health, Sharon Hamilton Griffin
- Health Plan Overview
- Helpful Contacts

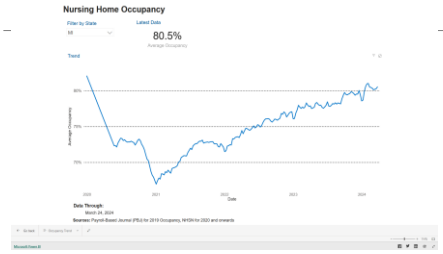
2:30-3:00 Meridian/Centene, Alli Leas
- Health Plan Overview
- Helpful Contacts

3:00 – 3:15 Open Discussion and Q&A
- Medicaid and Medicare Policy Issues
- Medicare Advantage Plans

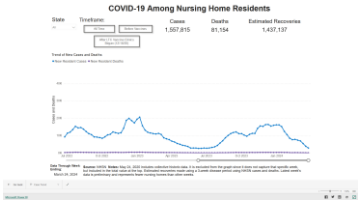
National Occupancy Trend



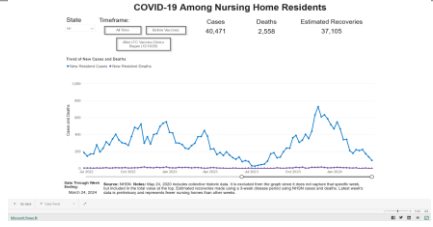
Michigan Occupancy Trend



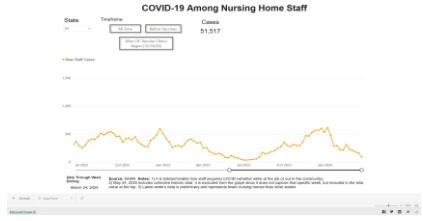
National COVID-19 Trend



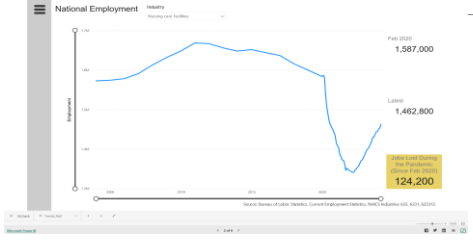
Michigan COVID-19 Trend



Michigan COVID-19 Trend Among Staff



Nursing Facility Staffing



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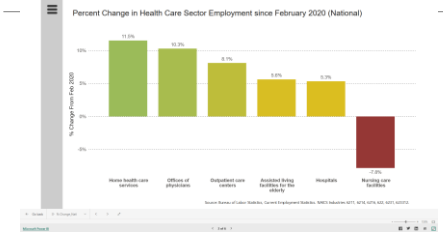
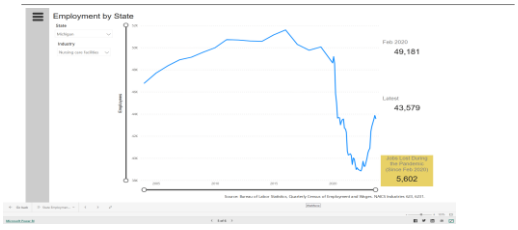
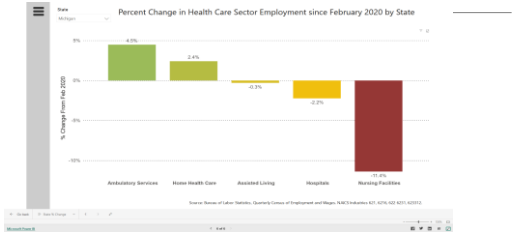


Nursing Facility Staffing



Nursing Facility Staffing



Enrollment Updates

MI Health Link

PACE

MI Choice

Medicare Advantage

MI Health Link

MI Health Link is a complete integrated health care program for Michigan residents that meet program requirements and that:

- Are aged 21 or over.
- Live in the Michigan counties of Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne or any county in the Upper Peninsula.
- Are enrolled in **both** Medicare and Medicaid.
- Are not residing in a state-operated veteran's home.
- Are not currently enrolled in hospice.

Began phase-in March 2015 through September 2015

MHL received CMS approval to operate until December 31, 2023

MI Health Link

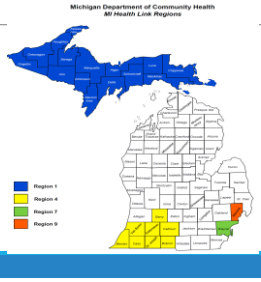
Offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care.

Those who are eligible for both Medicare and Medicaid and qualify for MI Health Link will be sent enrollment options through a letter from Michigan ENROLLS. 1-800-975-7630

Residents can "opt out" of MHL – need to respond to letter or will be automatically enrolled in program

Monthly plan change or dis-enrollment is available

MHL Regions Four Areas



MI Health Link-ICO's

MI Health Link services are provided to enrollees by these Integrated Care Organizations (ICO's):

- Aetna
- AmeriHealth
- HAP Empowered
- MeridianComplete
- Molina Healthcare
- Upper Peninsula Health Plan

Contracts needed to provide care with each ICO

ICO Care Coordinator will assist each enrollee to connect with the supports and services they need to be healthy and to meet personal goals.

MI Health Link Enrollment

Month	Total Enrollment	LOC DS NF/ALTCU	LOC DS MCF	Total DS & DS	Percentage DS & DS to Total	HCBS
February 2021	39,374	1,750	225	1,975	5.02%	2,263
March 2021	39,150	1,742	225	1,967	5.02%	2,210
April 2021	39,934	1,770	229	1,999	5.01%	2,265
May 2021	39,958	1,790	230	2,020	5.06%	2,280
June 2021	40,015	1,823	232	2,055	5.14%	2,408
July 2021	40,260	1,864	249	2,113	5.25%	2,414
August 2021	40,294	1,877	243	2,120	5.26%	2,443
September 2021	41,941	1,989	260	2,249	5.36%	2,467
October 2021	41,317	1,988	253	2,241	5.42%	2,464
January 2022	39,362	1,654	242	1,896	4.82%	2,510
February 2022	38,905	1,598	233	1,831	4.71%	2,503
March 2022	38,588	1,654	228	1,882	4.88%	2,496
April 2022	40,481	1,786	244	2,030	5.01%	2,500
May 2022	40,453	1,681	232	1,913	4.73%	2,491
June 2022	40,350	1,658	235	1,893	4.67%	2,548
July 2022	40,306	1,522	215	1,737	4.31%	2,562
Aug 2022	42,622	1,746	227	1,973	4.63%	2,579
Sept 2022	43,113	1,712	222	1,934	4.49%	2,575
Oct 2022	44,694	1,729	233	1,962	4.39%	2,554
Nov 2022	45,188	1,908	226	2,034	4.50%	2,565
Dec 2022	44,574	1,810	233	2,043	4.58%	2,551
January 2023	42,502	1,664	213	1,877	4.42%	2,471
February 2023	42,066	1,688	214	1,902	4.52%	2,282
March 2023	41,220	1,683	214	1,897	4.59%	2,261
April 2023	44,033	1,969	236	2,205	5.01%	2,487
May 2023	44,217	2,052	244	2,296	5.19%	2,488

Data Jan 5, 2023

MI Choice Waiver – HCBW

The MI Choice waiver provides home and community-based health care services for adults aged 65 or older and adults with disabilities. The program's goal is to allow persons, who would otherwise require nursing home care, to receive these services in their home and in the community.

MI Choice beneficiaries are not enrolled in a Medicaid health plan but still receive a comprehensive package of health care benefits including vision, dental, and mental health services. In addition, the waiver may provide other benefits to help the person remain at home.

MI Choice HCBW Providers

MI Choice Waiver Agents

Region 1A Detroit Area Agency on Aging
Service Area: *Cities - Detroit, Hamtramck, Highland Park, Grosse Pointe, Grosse Pointe Park, Grosse Pointe Shores, Grosse Pointe Woods, Grosse Pointe Farms, Harper Woods*

Region 1B Area Agency on Aging 1B and Macomb-Oakland Regional Center Home Care, Inc.
Service Area: *Counties - Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw*

Region 1C The Senior Alliance and The Information Center
Service Area: *Counties - Wayne County except the cities served by 1A*

Region 2 Region 2 Area Agency on Aging

Service Area: *Counties - Jackson, Hillsdale, Lenawee*

Region 3 Region 3B Area Agency on Aging/CareWell Services Southwest and Milestone Senior Services

Service Area: *Counties - Barry, Branch, Calhoun, Kalamazoo, St. Joseph*

Region 4 Region IV Area Agency on Aging and Region 3B Area Agency on Aging/CareWell Services Southwest
Service Area: *Counties - Berrien, Cass, Van Buren*

MI Choice Waiver Agents (cont.)

Region 5 Valley Area Agency on Aging
Service Area: *Counties - Genesee, Lapeer, Shiawassee*

Region 6 Tri-County Office on Aging
Service Area: *Counties - Clinton, Eaton, Ingham*

Region 7 A&D Home Health Care, Inc. and **Region VII Area Agency on Aging**

Service Area: *Counties - Bay, Clare, Gladwin, Gratiot, Huron, Isabella, Midland, Saginaw, Sanilac, Tuscola*

Region 8 Area Agency on Aging of Western Michigan, Inc. and Reliance Community Care Partners
Service Area: *Counties - Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Newaygo, Osceola*

Region 9 Northeast Michigan Community Service Agency (NEMCSA)

Service Area: *Counties - Alcona, Arenac, Alpena, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon*

MI Choice Waiver Agents (cont.)

Region 10 Area Agency on Aging of Northwest Michigan and Northern Lakes Community Mental Health/Northern Health Care Management

Service Area: *Counties - Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford*

Region 11 UPCAP

Service Area: *Counties - Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft*

Region 14 Senior Resources and **Reliance Community Care Partners**

Service Area: *Counties - Muskegon, Oceana, Ottawa*

MI CHOICE Waiver Enrollment

MI CHOICE ENROLLMENT

	FY 20	FY 21	FY 22	FY 23	FY 24
ALCONA	14	17	20	13	13
ALGER	27	28	30	26	19
ALLEGAN	218	218	201	194	145
ALPENA	110	123	118	98	79
ANTRIM	45	48	44	39	29
ARENAC	62	58	61	47	39
BARAGA	15	14	19	12	9
BARRY	64	62	59	57	58
BAY	520	515	532	527	469
BENZIE	51	53	56	55	43
BERRIEN	622	636	653	640	562
BRANCH	61	65	44	46	35
CALHOUN	237	275	276	273	255
CASS	108	111	106	105	89
CHARLEVOIX	43	48	46	47	35
CHEBOYGAN	63	75	64	72	54
CHIPPEWA	68	69	75	78	69
CLARE	188	211	221	213	172
CLINTON	124	118	125	143	128
CRAWFORD	28	38	32	34	20
DELTA	69	63	54	61	41
DICKINSON	59	57	58	62	55
EATON	230	245	263	268	244
EMMET	62	68	61	66	52
GENESEE	435	446	419	380	325
GLADWIN	113	118	111	115	84
GOGEBIC	66	65	67	64	55
GRAND TRAVERSE	279	275	271	261	218

MI CHOICE Waiver Enrollment

MI CHOICE ENROLLMENT

	FY 20	FY 21	FY 22	FY 23	FY 24
GRATIOT	114	135	124	111	92
HILLSDALE	121	115	120	123	119
HOUGHTON	68	70	66	69	60
HURON	102	112	125	134	112
INGHAM	696	732	757	784	690
IONIA	122	126	117	115	83
IOSCO	69	76	72	67	53
IRON	33	31	31	32	25
ISABELLA	156	152	158	151	121
JACKSON	447	466	462	435	403
KALAMAZOO	343	353	364	374	335
KALKASKA	46	49	53	40	24
KENT	1,264	1,341	1,348	1,365	1,227
KEWEENAW	5	5	5	4	4
LAKE	25	27	27	29	22
LAPEER	18	21	27	30	24
LEELANAU	34	34	32	24	18
LENAWEE	219	213	215	222	179
LIVINGSTON	65	67	59	53	44
LUCE	6	7	8	7	6
MACKINAC	17	14	16	15	16
MACOMB	392	428	435	427	377
MANISTEE	88	79	83	85	65
MARQUETTE	113	112	131	128	108
MASON	50	46	50	48	35
MECOSTA	141	141	133	127	110
MENOMINEE	22	35	41	35	27
MIDLAND	220	244	245	232	202
MISSAUKEE	90	88	100	108	85
MONROE	67	81	78	64	48
MONTCALM	137	135	156	163	131
MONTMORENCY	35	38	34	32	26
MUSKEGON	651	644	669	643	546
NEWAYGO	83	87	81	80	57
OAKLAND	826	858	830	771	648
OCEANA	66	72	73	71	49

MI CHOICE Waiver Enrollment

MI CHOICE ENROLLMENT					
	FY 20	FY 21	FY 22	FY 23	FY 24
OGEMAW	55	53	54	57	41
ONTONAGON	11	12	16	18	15
OSCEOLA	69	66	65	77	65
OSCODA	18	20	21	18	14
OTSEGO	75	84	78	71	54
OTTAWA	486	521	522	526	427
PRESQUE ISLE	32	41	34	32	18
ROSCOMMON	42	63	64	66	58
SAGINAW	894	893	873	936	798
SAINT CLAIR	69	68	55	44	34
SAINT JOSEPH	82	77	74	55	57
SANILAC	107	110	100	101	84
SCHOOLCRAFT	8	8	16	16	13
SHIAWASSEE	87	83	85	71	61
TUSCOLA	173	180	187	186	141
UNKNOWN OR OOS	20	24	27	29	19
VAN BUREN	202	209	219	189	157
WASHTENAW	143	146	143	130	114
WAYNE	2,765	2,769	2,810	2,842	2,465
WEXFORD	200	212	198	174	151
TOTAL	16470	16992	17052	16812	14353

Program for All-Inclusive Care for the Elderly PACE

A capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing for frail, elderly individuals that meet Long Term Care (LTC) level of care criteria.

For most PACE participants (enrollees), the comprehensive service package permits them to continue living at home while receiving services rather than being institutionalized.

Participants must meet the following criteria:

- Medically qualified, must meet Medicaid's LTC eligibility criteria
- Must be at least 55 years of age or older
- Must live within the approved geographic area of the PACE organization
- Must be able to live safely in the community (not residing in a nursing facility) at the time of enrollment
- Must not be concurrently enrolled in the Medicaid MIChoice waiver
- Must not be concurrently enrolled in a Health Maintenance Organization (HMO)

The PACE organization receives referrals from providers in the community who believe a person meets Medicaid eligibility and LTC eligibility criteria.

PACE Enrollment

PACE Enrollment Michigan			Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
MI	H0390	Pace of Southwest MI	229	231	234	235	236	235	234	234	236	236	234	229	229
MI	H1310	Comprehensive Senior Care	562	565	565	567	569	576	579	586	584	593	595	596	602
MI	H2318	Pace of Southeast MI	1,461	1,476	1,504	1,527	1,546	1,561	1,574	1,598	1,604	1,625	1,620	1,644	1,639
MI	H2835	Cascade Pace	191	192	195	200	200	197	200	204	208	213	210	208	205
MI	H2882	Pace Central MI	166	174	178	184	189	193	190	196	201	198	197	197	196
MI	H2936	Lifecircles	379	378	381	381	384	387	390	391	391	394	388	386	389
MI	H4118	Washtenaw Pace	273	275	273	271	274	279	279	284	282	284	278	271	271
MI	H4256	Pace North	146	149	151	158	160	158	159	165	168	167	173	179	181
MI	H5085	Community Pace at Home	89	88	92	90	91	89	90	92	93	91	94	96	97
MI	H5610	Care Resources	297	304	308	315	319	321	327	324	328	328	326	328	330
MI	H6787	Visions Senior Community Care of Michigan	173	177	187	194	196	197	201	198	192	194	190	192	199
MI	H8769	Genesys Ambulatory Health Services	219	216	213	214	216	214	217	222	221	226	222	226	227
MI	H8952	Region VII AAA	40	43	44	45	46	50	51	52	52	52	47	47	45
MI	H9185	A&D Charitable Foundation	154	157	156	157	163	165	167	169	170	171	170	169	176
MI	TOTAL		4,379	4,425	4,481	4,538	4,589	4,622	4,658	4,715	4,730	4,772	4,744	4,768	4,786

Medicare : Original and Advantage

Original Medicare

•Original Medicare includes Part A and Part B.
•You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).
•You can use any doctor or hospital that takes Medicare, anywhere in the U.S.
•To help pay your out-of-pocket costs in Original Medicare (like your 20% coinsurance), you can also buy supplemental coverage, like Medicare Supplement Insurance (Medigap), or have coverage from a former employer or union, or Medicaid.

Medicare Advantage (also known as Part C)

•Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D.
•In most cases, you'll need to use doctors who are in the plan's network
•Plans may have lower out-of-pocket costs than Original Medicare.
•Plans may offer some extra benefits that Original Medicare doesn't cover — like vision, hearing, and dental services.

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Medicare Advantage Plans Part C

Health Maintenance Organization (HMO) Plans

- In HMO Plans, you generally must get your care and services from providers in the plan's network, except:
- Emergency care
- Out-of-area urgent care
- Out-of-area dialysis

Preferred Provider Organization (PPO) Plans

- PPO Plans are offered by a private insurance company
- PPO Plans have network doctors, other health care providers, and hospitals.
- You pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network . You can also use out-of-network providers for covered services, usually for a higher cost

Private Fee-for-Service (PFFS) Plans

- A Medicare PFFS Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company
- PFFS plans aren't the same as Original Medicare or Medigap.
- The plan determines how much it will pay doctors, other health care providers, and hospitals, and how much you must pay when you get care.

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Medicare Advantage Plans Part C Special Needs Plans

Medicare SNPs are a type of Medicare Advantage Plan (like an HMO or PPO). Medicare SNPs limit membership to people with specific diseases or characteristics. Medicare SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve.

These groups are eligible to enroll in an SNP:

1) people who live in certain institutions (like nursing homes) or who live in the community but require nursing care at home, or
2) people who are eligible for both Medicare and Medicaid, or
3) people who have specific chronic or disabling conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia).

Plans may further limit membership to a single chronic condition or a group of related chronic conditions. You can join a SNP at any time.

# of Plans	Row Labels	Medicare FFS Enrollment	Total Medicare Enrollment	MA Enrollment %	FFS Enrollment %	Total Population	Medicare Enrollment % of Population
	Medicare Enrollment	Jan-24					
11	ALCONA	1,927	4,488	57%	43%	10,417	43%
7	ALGER	1,348	2,842	53%	47%	8,807	32%
19	ALLEGAN	6,986	26,121	73%	27%	121,210	22%
12	ALPENA	4,448	9,281	52%	48%	28,847	32%
12	ANTRIM	3,360	8,138	59%	41%	24,249	34%
15	ARENAC	2,056	5,155	60%	40%	15,089	34%
7	BARAGA	1,065	2,264	53%	47%	8,277	27%
14	BARRY	4,777	14,693	67%	33%	63,554	23%
20	BAY	10,872	27,996	61%	39%	102,821	27%
12	BENZIE	2,489	6,025	59%	41%	18,297	33%
18	BERRIEN	17,216	38,160	55%	45%	152,900	25%
12	BRANCH	4,440	10,225	57%	43%	44,531	23%
17	CALHOUN	14,063	31,191	55%	45%	133,289	23%
16	CASS	6,124	13,308	54%	46%	51,403	26%
12	CHARLEVOIX	3,818	8,270	54%	46%	26,293	31%
11	CHEBOYGAN	3,747	8,627	57%	43%	25,940	33%
8	CHIPPEWA	3,779	8,601	56%	44%	36,293	24%
16	CLARE	3,726	10,002	63%	37%	31,352	32%
15	CLINTON	5,091	16,900	70%	30%	79,748	21%
13	CRAWFORD	1,736	4,336	60%	40%	13,491	32%
7	DELTA	4,991	11,303	56%	44%	36,741	31%
8	DICKINSON	3,638	7,386	51%	49%	25,874	29%
17	EATON	8,023	25,567	69%	31%	108,992	23%
11	EMMET	4,886	10,013	51%	49%	34,163	29%
24	GENESEE	31,101	93,597	67%	33%	401,983	23%
16	GLADWIN	3,129	8,574	64%	36%	25,728	33%
8	GOGEBIC	2,316	4,586	49%	51%	14,319	32%
14	GRAND TRAVERSE	9,104	24,686	63%	37%	96,464	26%
17	GRATIOT	3,515	9,055	61%	39%	41,100	22%
17	HILLSDALE	4,534	11,414	60%	40%	45,762	25%
7	HOUGHTON	3,815	7,873	52%	48%	37,035	21%
17	HURON	4,984	9,924	50%	50%	31,248	32%

# of Plans	Row Labels	Medicare FFS Enrollment	Total Medicare Enrollment	MA Enrollment %	FFS Enrollment %	Total Population	Medicare Enrollment % of Population
	Medicare Enrollment	Jan-24					
17	HURON	4,984	9,924	50%	50%	31,248	32%
19	INGHAM	17,578	51,004	66%	34%	284,108	18%
12	IONIA	3,740	12,751	71%	29%	66,809	19%
17	IOSCO	4,047	9,384	57%	43%	25,521	37%
8	IRON	1,903	4,165	54%	46%	11,622	36%
15	ISABELLA	5,247	12,037	56%	44%	64,447	19%
18	JACKSON	16,296	36,933	56%	44%	160,066	23%
20	KALAMAZOO	17,929	52,477	66%	34%	261,173	20%
13	KALKASKA	2,012	5,078	60%	40%	18,182	28%
20	KENT	32,878	117,943	72%	28%	659,083	18%
5	KEWEENAW	460	837	45%	55%	2,180	38%
12	LAKE	1,489	4,236	65%	35%	12,594	34%
18	LAPEER	8,248	21,422	61%	39%	88,780	24%
12	LEELANAU	3,281	8,156	60%	40%	22,870	36%
15	LENAWEE	10,388	24,236	57%	43%	98,567	25%
21	LIVINGSTON	19,280	43,565	56%	44%	196,161	22%
6	LUCE	625	1,686	63%	37%	5,330	32%
8	MACKINAC	1,627	3,828	57%	43%	10,941	35%
27	MACOMB	79,914	189,298	58%	42%	874,195	22%
12	MANISTEE	3,350	8,249	59%	41%	25,287	33%
8	MARQUETTE	6,677	16,347	59%	41%	66,661	25%
11	MASON	3,231	9,022	64%	36%	29,409	31%
13	MECOSTA	3,677	10,361	65%	35%	40,720	25%
7	MENOMINEE	3,125	6,861	54%	46%	23,266	29%
15	MIDLAND	7,276	19,864	63%	37%	83,674	24%
13	MISSAUKEE	1,610	4,146	61%	39%	15,213	27%
22	MONROE	15,094	36,427	59%	41%	155,609	23%

Medicare Enrollment	Jan-24					
# of Plans	Row Labels	Medicare+FFS Enrollment	Total Medicare Enrollment	MA Enrollment %	FFS Enrollment %	Total Population	Medicare Enrollment % of Population
	16 MONTCALM	9,084	15,252	67%	33%	67,433	23%
	13 MONTMORENCY	1,763	4,085	57%	43%	9,569	43%
	17 MUSKEGON	11,516	41,499	72%	28%	176,565	24%
	16 NEWAYGO	3,307	12,960	75%	25%	50,886	25%
	30 OAKLAND	121,420	263,338	54%	46%	1,249,631	21%
	12 OCEANA	2,623	7,397	65%	35%	26,973	27%
	15 OGEMAW	3,128	7,192	57%	43%	20,970	34%
	7 ONTONAGON	1,366	2,475	45%	55%	5,863	42%
	12 OSCEOLA	2,457	6,431	62%	38%	23,174	28%
	12 OSCODA	1,328	3,147	58%	42%	8,456	37%
	13 OTSEGO	3,376	7,037	52%	48%	25,644	27%
	16 OTTAWA	51,752	58,322	78%	26%	300,873	19%
	11 PRESQUE ISLE	1,569	5,172	55%	45%	13,561	38%
	13 ROSCOMMON	3,909	9,976	61%	39%	23,708	42%
	20 SAGINAW	33,993	47,034	67%	33%	188,930	25%
	22 SAINT CLAIR	36,076	60,147	60%	40%	160,151	25%
	16 SAINT JOSEPH	6,328	13,692	55%	45%	60,874	22%
	17 SANILAC	5,154	11,266	54%	46%	41,017	28%
	8 SCHOOLCRAFT	1,486	2,854	51%	49%	8,148	35%
	17 SHIAWASSEE	6,051	16,990	64%	36%	68,022	25%
	19 TUSCOLA	9,060	16,290	65%	35%	52,915	27%
	18 VAN BUREN	6,913	18,107	63%	37%	75,052	25%
	26 WASHTENAW	30,562	65,721	53%	47%	366,376	18%
	30 WAYNE	123,867	360,096	66%	34%	1,757,033	19%
	16 WEXFORD	3,464	8,385	61%	39%	34,196	26%
	Grand Total	831,777	2,216,969	61%	39%	10,036,113	21%

State Budget Process

Revenue Estimating Conferences – Jan and May

Governor proposes upcoming budget FY 2025

Legislature reviews proposed budget and adjusts

Governor final authority to sign pass budget bill and line-item veto

Effective October 1 to enable government to continue program spending according to the enacted budget

FY 2025 Budget Proposal

On February 7, Governor Whitmer presented her proposed budget for SFY 2025 (Oct 24-Sept 25)

- Included a continuation of the DCW at $3.20/hr for RN's, LPN's, CNA's and respiratory therapists
- Increase of .85/hr for non-clinical staff up to $1.70/hr for housekeeping, maintenance workers, plant operations, laundry, dining room assistants, dietary workers, and other non-direct care staff as classified.
- Did not include funding for a new reimbursement system, as a final system has not yet been agreed upon. This could be included in a final SFY 25 budget or a supplemental if agreement is reached.

Legislative Updates

HCAM continues to engage on important policy and budget legislation with key legislator and stakeholders. You may find bills affecting the sector using HCAM's bill tracker, which is found on our website https://www.hcam.org/advocacy/hcam-bill-tracker/

You may find issue briefs and testimony pertaining to legislation that HCAM is advocating for/against on our website https://www.hcam.org/advocacy/issue-briefs/

Legislative Updates

Below is a brief summary of the bills on which the association will be focused on in 2024.

- **HBs 4885 and 4923 (Public Acts 273 and 274 of 2023) – Medication Aides**
- **HB 4841 – AFC Licensing Act.**
- **Staffing Agency Licensing**
- **Medicare Advantage Legislation**
- **SB 717 – Cameras in Resident Rooms**

Legislative Updates

State Fiscal Year 2025 Appropriations – The legislature has begun work on the state fiscal year 2025 budget, which will take effect on October 1, 2024. This budget process impacts important issues including Medicaid rates, the direct care worker and non-clinical worker wage increase, transition to a new Medicaid reimbursement system, and Medicaid policies such as bed certifications and non-available bed plans. HCAM advocates with key legislators and the State Budget Office to ensure appropriations bills allocate adequate funding and reflect necessary policies for the state's nursing facilities.

Legislative Updates

Notable legislation HCAM is monitoring

- HBs 4550-4552 and SBs 334-336 – Hospital Nursing Ratios.
- SBs 678-681 – Death with Dignity Act.
- HBs 4909-4912, 5047 – Guardianship Licensing and Office of State Guardian.
- HB 4543 – Written Notice of Admission Denial.
- HB 4517 – Fall Prevention Training for Unlicensed Nursing Home Staff.
- SB 739 – Personal Service Agreements Avoiding Divestiture for Medicaid Purposes.
- HB 5199 – Expansion of Consumer Protection Act.
- HB 4935 – Nurse Licensure Compact.

CMS Proposed Staffing Rule for Nursing Homes

CMS released a proposed minimum staffing rule 9/1/23

- Required minimum staffing coverages for nursing facilities
  - .55 Hours per Resident Day (HPRD) for RN's
  - 2.45 HPRD for CNA's
  - Onsite RN 24/7
  - No acknowledgement of LPN
- Unfunded
- Nationwide AHCA study
  - 94% of facilities not meeting at least 1 of 3 requirements
  - Over 100k staff would need to be hired, at a cost of $6.8 Billion per year
- Efforts underway to halt, change rule.
- Final rule expected to be issued soon

CMS Proposed Payment Rule Effective October 1, 2024

The Centers for Medicare & Medicaid Services (CMS) has issued the proposed rule for the skilled nursing facility (SNF) prospective payment system (PPS) fiscal year (FY) 2024 payment update.

The proposed rule provides **a proposed net market basket increase for SNFs of 4.1 percent beginning October 1, 2024**.

The CMS net market basket update would increase Medicare SNF payments by approximately $1.3 billion in FY24.

- Final Rule expected in August 24

CMS Proposed Rule-Admin updates

- CMS proposes to update the SNF market basket base year from the current 2018 base year to a new base year of 2022 and to update the payment rates used under the SNF PPS based on the FY 2025 SNF market basket increase factor, as adjusted by the productivity adjustment and forecast error correction.
- CMS also proposes to update the SNF PPS wage index using the Core-Based Statistical Areas (CBSAs) defined within the new Office of Management and Budget (OMB) Bulletin 23-01 to improve the accuracy of wages and wage-related costs for the area in which the facility is located.
- CMS is proposing several changes to the PDPM ICD-10 code mappings for reporting during a Part A SNF stay.
- The proposed rule also includes a Request for Information (RFI) seeking comments on potential future updates to the Non-Therapy Ancillary (NTA) component of PDPM.

CMS Proposed Rule-NH Enforcement

- CMS proposes to expand the penalties that can be enforced through regulatory revision to allow for more per instance and per day CMPs to be imposed, permitting both types of penalties to be imposed, not to exceed the statutory daily limits.
- CMS proposes to allow for both PD and PI CMPs to be imposed for noncompliance findings in the same survey, as well as ensure that the amount of a CMP does not depend solely on the date that the most recent standard survey is conducted or the date that a finding of noncompliance was identified by surveyors.
- CMS proposes that it or the state could impose a PI CMP to address noncompliance that occurred in the past or prior to the survey, and a PD CMP beginning at the start of the survey and continuing until the facility has corrected its noncompliance.
- CMS proposes if multiple instances of noncompliance occurred prior to the survey, CMS or the state could impose multiple PI CMPs, as well as a PD CMPs.

CMS Proposed Rule-SNF Quality Reporting Program

- CMS proposes adding four new social determinants of health (SDOH) items and modifying one SDOH assessment item for the SNF QRP.
- CMS proposes that SNFs included in the SNF QRP participate in a process to validate data submitted under the SNF QRP through the Minimum Data Set (MDS) beginning with the FY 2027 SNF QRP.
- CMS is also seeking feedback on future measure concepts for the SNF QRP with a Request for Information (RFI) on quality measure concepts under consideration for future SNF QRP years.

CMS Proposed Rule-SNF Value Based Purchasing

CMS proposes to adopt a measure retention and removal policy to help ensure that the SNF VBP Program's measure set remains focused on the best and most appropriate metrics for assessing care quality in the SNF setting. The proposed policy is similar to the one currently used in the SNF QRP program.

- CMS proposes to adopt a policy to incorporate technical VBP measure updates, such as changes to risk-adjustment, using sub-regulatory processes. This policy would allow CMS to account for the upcoming transition to PDPM-based case-mix adjusting of Total Nurse Staffing Hours per Resident Day (HPRD) in July 2024.
- CMS is proposing administrative policy updates, including an update of the Review and Correction policy that it previously finalized for the program. This is to ensure that SNFs can review and correct Payroll-Based Journal (PBJ) data beginning with the FY 2026 program year and MDS data beginning with the FY 2027 program year.

Change Healthcare Cybersecurity Incident

On Feb 21, there was a security breach at the largest medical claims clearinghouse, Change Healthcare

8 terabytes of data, 85 million patient records disrupted

If your facility is affected

- Contact/Work with your IT/EMR vendor on work arounds
- Check with payers on accelerated payments
- CMS options on Part A/Part B advanced payments due to CHOPD (Change Healthcare/Optum Payment Disruption)

Michigan SIGMA Updates/Downtime

SIGMA upgrades arrive on April 24, 2024. The SIGMA system will be unavailable, from Friday, April 19th through noon on Wednesday, April 24, 2024. As part of this system upgrade, the Michigan Medicaid Fee for Service (FFS) cut-off for claim submissions and CHAMPS payments will be early.

Claim cut-off dates and times:

- For CHAMPS Direct Data Entry (DDE) the cut-off will be April 15, 2024, at 4:00 PM EST.
- Electronic 837 claim files, submitted via CHAMPS batch upload or File Transfer Service (FTS), the cut-off will be April 15, 2024, at noon EST.

CHAMPS pay cycle 17, pay date April 25, 2024, payment dates:

- Paper checks will be mailed on April 19, 2024.
- Electronic Funds Transfers (EFT) will be available on April 22, 2024.

MI Health Link Transition

Launched March 1, 2015

Eligibility includes dually eligible individuals 21 and older

LTSS coverage required, BH carved out

Medicaid BH, substance use disorder services, and HCBS waiver services for people with intellectual or developmental disabilities (I/DD) financed through Prepaid Inpatient Health Plans (PIHPs)

Operates in Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne counties and all counties in the Upper Peninsula

AHCA

Lessons Learned as Reported by MDHHS

Increased transitions from NF to Home
- Caveat higher functional status, lower LOC
- MI's takeaway opportunity to identify higher functioning individuals to transition to home

Opportunity to improve behavioral health coordination
- Challenges in data sharing and communication between ICOs and PIHPs

Lack of single source of truth for enrollment status

Source: Michigan's Transition Plan for MI Health Link

AHCA

Conversion of MMPs to D-SNPs

CMS CY2023 MA and Part D Rule Created Pathway for MMPs to Transition from Demo to Permanence

Current capitated MMP program to end December 31, 2025

States encouraged to convert their MMPs to integrated Dual Eligible Special Needs Plans (D-SNPs)
- CMS will work with States to develop a process for conversion

States choosing not to convert their MMP program to an integrated D-SNP will end by December 31, 2023.

Created additional requirements of D-SNPs to promote Medicare and Medicaid Integration
- Lessons learned from FAI

AHCA

Types of D-SNPs

CO D-SNP — Coordination Only D-SNP

- Must have a contract with the State Medicaid Agency
- Not required to provide coverage of Medicaid services but must share information about inpatient admissions for certain high-risk full benefit dually eligible enrollees.
- MAY cover LTSS and/or BH for eligible individuals

HIDE SNP — Highly Integrated Dual Eligible Special Needs Plan

- Provides a higher level of integration than CO-D-SNPs
- MA organization or MA organization's parent company must have a contract with the State Medicaid Agency
- Must cover LTSS or BH or both (consistent with State policy) under a capitated contract

FIDE SNP — Fully Integrated Dual Eligible Special Needs Plans

- Highest level of coordination and integration
- Single Managed Care Organization that holds both the CMS MA contract and is a Medicaid managed care organization contract under Section 1903(m) of SSA
- Must cover specified primary care, acute care, LTSS, BH, and at least 180 days of NF services during plan year (consistent with State policy) under a capitated contract

AHCA

Provisions	FIDE SNP	HIDE SNP	CO D-SNPs	MI Proposal
Enrollee Advisory Committee	Required	Required	Required	Will be included
Exclusively Aligned Enrollment	Required, 2025			Plans to pursue
Inclusion of LTSS and Behavioral Health & MH, medical supplies, equipment & appliances	Required, 2025	Either LTSS and/or BH		Intends to require that Medicaid LTSS, HCBS NF LOC, nursing facility services, and personal care
Service area overlap with Medicaid companion plan	Required, 2025	Required, 2025		
Unified Grievances and Appeals	Required, 2025	Specific HIDEs	Specific D-SNPs	Exploring inclusion
Continuation of Medicare benefits pending appeal	Required, 2025	Specific HIDEs	Specific D-SNPs	
Capitation for Medicare cost sharing, all dual eligible beneficiaries	Required	Recommended	Recommended	Plans to institute a policy of zero cost sharing
Single ID contract for D-SNPs with exclusively aligned enrollment	Option, 2024	Option, 2024	Option, 2024	
Integrated member materials	Option, 2024	Option, specific HIDEs	Option, specific D-SNPs	Exploring inclusion

AHCA

Highly Integrated Dual Eligible Special Needs Plan

To align with the new CMS rules, MDHHS intends to transition the MHL Program to a Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP).

- A HIDE SNP is a specific type of Medicare Advantage plan that is designed to meet the needs of those dually eligible for Medicare and Medicaid.

The HIDE SNP will integrate long-term service and supports (LTSS) and contracted managed care plans will provide most covered benefits for their dual-eligible enrollees, but specialty behavioral health services will remain carved out.

- Benefits of moving to a HIDE D-SNP:
  - Permanent
  - Statewide expansion
  - Building off success of MHL

Beneficiaries

- For beneficiaries – no changes are happening until 2026. There is nothing beneficiaries need to do now.
- Beneficiaries will not experience any changes in their MHL benefits in 2024 or in 2025
- MDHHS expects any program changes to be small, and that beneficiaries will continue to receive similar services.

Procurement

- MDHHS will be conducting a competitive procurement process to select the new HIDE D-SNP plans.
- MDHHS intends to release a Request for Proposals in early 2024.
- Due to the nature of the competitive procurement process – there is limited information MDHHS can share at this time regarding exactly how the program will be structured.
- However, MDHHS is always interested in receiving feedback on what beneficiaries, caregivers, families, providers, and health plans would like to see in a new HIDE D-SNP program.

Nursing Facility Medicaid Reimbursement Reform

Michigan NF Medicaid Reimbursement- Auditor General Report

Auditor General Report issued November 2019 reviewed the Michigan Medicaid payment system to Nursing Facilities and determined reimbursement methodology:

- Complicated
- Labor intensive
- Ineffective
- Inefficient

Audit process

- Ineffective
- Overly time consuming

Nursing Facility Reimbursement Reform

MDHHS REIMBURSEMENT OBJECTIVES

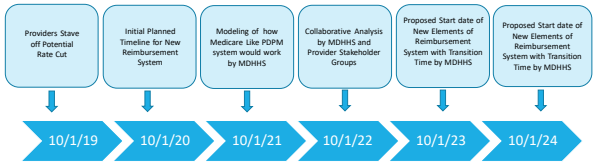
- Shifting Michigan's nursing facility reimbursement to acuity-based starting in FY2024
- Ensuring reimbursement supports safety and health for populations served
- Building a system which strongly supports workforce stability
- Elevating quality principles in nursing facility reimbursement

MDHHS has indicated that they want to simplify current add-on payments to current rates including the NF QAS, they want to incorporate acuity

MDHHS has targeted FY 2025 for implementation but has indicated willingness for Multi-year phase in

MDHHS has indicated the intention to maintain the Class I and Class III separation

New Reimbursement System? History/Timeline



Nursing Facility Rate Reform Timeline

Weekly Discussion	*Proposal Preparation*	*Finalization and Submission*	*Training, Updates, and IT System Changes*	*Rate Setting*	*Finalize Details of New Rate Structure*
• **April 12.** Continue discussion on Base Payment and Direct Care Costs. • **April 19.** Discussion on Plant Asset and Fair Rental Value. • **April 26.** Discussion regarding Quality Metrics. • **May 3.** Continued discussion regarding Quality Metrics.	• **Mid-May.** MDHHS prepares comprehensive proposal based on input. • **May 19.** MDHHS provides draft structure, decisions needed, and modeling to Director Hertel. • **Late May.** Director's input provided to stakeholders.	• **Early June.** Finalize proposal based on input. • **June 30.** Submit State Plan amendment. Note: CMS approval may take several months.	• Staff training will take place. • MDHHS provides training to providers.Changes will be made to the necessary IT system(s). ○ Rate setting. ○ Database updates. ○ Cost reporting. • Ongoing communication with stakeholders.	• Fiscal Year 2024 rate setting will be conducted.	• **Fiscal Year 2024.** New rate structure goes into effect.

Version date: April 13, 2023

HCAM Model Framework – Rate Components

Component	Summary
Operating	Direct Care Costs - Direct care nursing, nursing admin, diversional therapy, and social service wages and related payroll tax, and in-service expenses are cost reimbursed adjusted for Medicaid acuity. Price Other Costs - Indirect reimbursable costs are paid based on a average cost calculation. Quality Assurance Supplement- Maintain current QAS system with review of the overall program percentage reimbursement for all providers.
Capital	Capital costs are reimbursed using a fair market rental calculation. Property taxes will be paid as a pass through.
Quality	Maintain current Quality Measure Initiative system.

66

HCAM Proposed Model-Direct Care Cost Component

Includes the salaries, wages, payroll tax, and in-service training expense for direct care staff, including:

- RN, LPN, CNA
- Nursing administration (DON, MDS Coordinator, Infection Control, nurse scheduler, etc.)
- Diversional Therapy (Activities)
- Social Service
- Agency Nursing (RN, LPN, CNA)
- Home office cost associated with direct care nursing, nursing admin, diversional therapy, and social service

Reimbursed at 100% of cost (no limit)

Adjusted for acuity using case-mix

Class I average = $128.79

Class III average = $191.83

HCAM Proposed Model-Price Component

- Average cost per day across all providers used as the basis for the price rate component
- **Average based on FY 2022 cost reports = $118.45**
- Includes salaries, wages, payroll tax, for all departments not included in direct care cost component:
  - Admin & General, Plant Operations & Maintenance, Utilities, Laundry, Housekeeping, Dietary, Central Supply, and Medical Records
- Includes employee benefit and workers compensation costs for all departments, including benefit costs for direct care staff
- Includes contracted services and in-service training for departments excluded from direct care cost component
- Includes education, minor equipment, equipment rental, repairs & maintenance, and supplies for all departments, including direct care departments

Quality Assurance Supplement Add-on

Currently QAS Add-on is calculated by multiplying the lower of a provider's variable rate base (VRB) or the variable cost limit (VCL) by 21.76%.

Under HCAM's proposed model, the 21.76% will be applied to the combination of the direct care cost component and the price component.

Minimum Spend

MDHHS introduced the idea of applying a minimum spend concept to the variable portion of the rate, which is meant to direct the spending of providers on operational activities that are directly related to patient care.

MDHHS proposed 90% spend on direct care and 10% on "discretionary" activities

Ignoring the fact that the definitions of direct and indirect are very loosely defined currently, 90/10 results in a negative impact for the majority of providers throughout the State of Michigan.

HCAM has used an 80/20 minimum spend for modeling purposes, which limited the negative impact to only a few providers.

HCAM Proposed Model-Plant Cost Component – Fair Rental

HCAM's proposed model uses a fair rental system to reimburse providers for their physical plant. A fair rental system typically applies a percentage return on a valuation of the asset or building, which can be based on an appraisal or some alternative valuation measure.

For modeling purposes, HCAM's proposed model is applying the percentage return to the already established current asset value (CAV), which is part of the current reimbursement system, in lieu of an appraisal.

Class I facilities are reimbursed at 8% of the lower of their appraisal/CAV

Class III facilities are reimbursed at 4% of the lower of the appraisal/CAV

Per bed limit of $175,000 for facilities built within the last 10 years

Per bed limit of $112,500 for all other facilities

HCAM Proposed Model-Plant Cost Component – Property Tax

Property tax paid by for-profit providers will be reimbursed to facilities at cost as a pass-through rate add-on.

MDHHS Proposed Model

MDHHS Model intended to solicit stakeholder feedback, not rate reform decision-making.		
MDHHS continues to solicit and review received stakeholder feedback.		
Layer	Summary/Notes	~ % SNF Funding
Base Layer – 4 Components and Minimum Care Ratio		~70%
A: Direct Care Work Component	Reflects Direct Care Worker costs.	
B: Direct Care Premium Pay	DCW wage increase funding, which MDHHS is still assessing how best to incorporate into MDHHS' Model Rate. No funding included in current model.	
C: Bedside Care	Food, housekeeping, etc. Costs capped to maintain budget neutrality between status quo and MDHHS Model rates.	
D. Routine Care	Durable Medical equipment, central supply, etc. Costs capped to maintain budget neutrality between status quo and MDHHS Model rates.	
Minimum Care Ratio	Modeling reflects facility-specific 90% Minimum Care Ratio (MCR) amounts. MCR would require facilities to report Base Layer and Patient Acuity Layer spend towards patient care. If that spend is below the MCR, funds would be recouped. MDHHS is still assessing this proposal and its associated implementation parameters. The 90% threshold is for illustrative purposes only.	Target % TBD
Patient Acuity Layer	Modifies Medicare acuity reimbursement to fit Medicaid's service mix. This component is included as part of MCR.	~25%
Plant Add-On Layer	Incents investment in current facilities/new builds. MDHHS still assessing components and associated funding level.	~5%
Quality	Modeling includes QAS (built into layers described above) but not QMI payments. MDHHS is also assessing other quality initiatives. Model withholds $25M for potential quality reinvestment.	TBD

Proposed System Comparisons

MDHHS Model	HCAM Model	Comments
Layer 1 Base A Cost settled nursing wages B Wage Enhancement – on hold C Bedside Care – food, A&G salary, and more D Discretionary – property taxes, building mortgage interest, and more Cost Matrix used to define costs in each component	Direct Wages and Price Nursing wages paid at cost within limit for occupancy and acuity weighted by Medicaid residents per MDS scoring data. All other costs except capital paid based on a price set at tiers by facility Class I and III. Price component would have limits within each facility class to minimize under spending and over paying. Includes QAS payment funded by provider tax program	Both models support paying nursing wages (RN, LPN and Cert NA) as a cost settled component of the rate. Both models recognize Class I and Class III distinctions remain in system. MDHHS model defines cost between bedside care, routine patient care and discretionary care. Costs defined based on a matrix to show what costs in each of these three categories. Then it includes a minimum spend requirement of 90% on bedside and routine care with 10% for discretionary spending. HCAM model attempts to minimize re-distribution of payments to limit losers and winners in a new reimbursement system.
Layer 2 Acuity Use parts of Medicare PDPM elements to address care levels	Acuity – not separate, included in direct Acuity of Medicaid residents factored into the cost settled nursing wages.	MDHHS acuity adjustment not clearly defined at this time. HCAM model includes acuity with cost settled nursing wages
Layer 3 Plant Add-On Plant asset add-on based on accelerated depreciation with a 20 year life with minimum spend requirement	Capital Reimbursement Fair Market Value – Capital Pay a rate of return based on a replacement cost appraisal. Covers mortgage interest, lease payments, amortization costs. Property taxes paid as a pass-thru cost. Provide limits per bed and higher per bed limits for new constructions and major renovations.	MDHHS model only pays if continuous spending on asset improvement to the building. Interest expense and property taxes considered discretionary spending. HCAM model is used in over 20 other states and simpler to administer. Rewards facility investment as reflected in the appraisal.
Layer 4 Quality Add-On Originally looked at Kansas PEAK program focus on person-centered care	Quality Measure Initiative Separate Funds Utilize current QMI program criteria while working on refinements to elements and maintain resident satisfaction survey. Paid outside the rate structure like current system.	Both models support using the current QMI program to begin with and later make adjustments. MDHHS originally wanted to pilot the PEAK program prior to implementation. HCAM supports adjusting the QMI program to reflect long-stay resident measures per CMS 5-Star system.

Initial Settlements

FY23 Initial Settlement Plan

For FY23 cost reports, MDHHS will offer FY23 initial settlements. There will be no option for modified/early initial settlements. FY23 initial settlements:

- Will use the updated Variable Cost Limit.
- Will be paid at 100%.
- Must be requested by August 2, 2024, through DARS@michigan.gov.

Revised FY22 Initial Settlement Plan

MDHHS will be offering a revised FY22 initial settlement option for October 1, 2022-December 31, 2022 to reflect the updated VCL. Revised FY22 Initial Settlements:

- Will be paid at 100%.
- Must be requested by August 2, 2024, through DARS@michigan.gov.

Non-Available Bed Plan

Non-Available Bed Plan Extension Policy Issued

On February 6, the Michigan Department of Health and Human Services (MDHHS) issued a proposed policy for updating the current non-available bed plan flexibilities. The proposal:

Extends the current NABP flexibilities from September 30, 2024, to September 30, 2025.

Allows skilled nursing facilities two additional 6-month extensions.

There is a public comment portion of this policy promulgation process during which HCAM advocated for three additional extensions as well as potential permanent implementation of the more flexible policy. Please email any comments you have on the proposal to MDHHS's Kristi Walker.

Questions or Comments?