

III. HOW NURSING FACILITIES ARE FUNDED

KEY POINTS

- **Today, nursing and rehabilitation facilities** are funded through four sources: Medicare, Medicaid, Quality Assurance Assessment Program and patient pay.
- **Medicare Part A - skilled nursing facility care** - is provided to recipients in need of skilled health care services that are rehabilitative or restorative. To qualify for Medicare Part A you must be discharged from a hospital to a skilled nursing and rehabilitation facility. Coverage lasts up to 100 days. The resident is required to pay a \$141 co-pay on the 20th day. If the resident cannot pay the co-pay Medicaid will cover.
- **Medicaid services are provided** to those individuals who are eligible and in need of skilled and rehabilitative services. It is funded through a combination of state general fund dollars and federal matching dollars.
- **The Medicaid program requires** that an individual seeking nursing facility care meet strict financial criteria and that they utilize available income to assist with paying for their care. This resident share of the cost of care is called the patient pay amount. It covers about 20 percent of the Medicaid rate.

Heritage Assisted Living Community, Battle Creek

Dear Ms. Stafford;

I would like to tell you how much my mom enjoyed living there. Helen McCarthy blossomed after she moved there. The facility and especially the staff made her feel welcome and a part of a family, "The Bishop Noa Home Family." She went on outings, got her hair done, had wonderful meals and of course the most important, she could go to daily mass.

Her whole being was cared for. Physical, mental and spiritual.

Sr. Therese was a God send for us during Mom's last weeks. We have found a wonderful friend.

The nurses and aides were always caring for Helen's needs and ours also. I am very grateful that the staff is so caring and kind and sincere. I want to also say thanks for allowing her to stay in her room and the midnight nurses for taking on extra duties. I can not thank all of your staff enough, they went above and beyond to make Mom's time left to us comfortable and loving.

Mom knew that she was loved and cared about.

Thanks Again.

Sincerely,
J. McCarthy

III. HOW NURSING FACILITIES ARE FUNDED

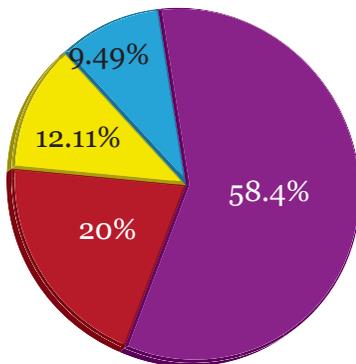
HISTORICAL PERSPECTIVE

Initially, the “county Almshouse” was established and funded through county dollars, private funds and attaching liens to property to pay for the care. As the demand grew in the 1950s and early 1960s family run businesses began supporting the needs of their families and communities by building nursing facilities.

In the 1960s, Medicare and Medicaid programs began funding long-term care services. Medicare was developed to primarily pay for hospitalization and Medicaid to pay for extended care needs. In Michigan, the first Medicaid rates were legislatively established without any cost reporting requirements. In 1975, facilities began reporting costs so reimbursement rates could be established to reflect the actual cost of care. Today, nursing and rehabilitation facilities are funded through four sources: Medicare, Medicaid, Quality Assurance Assessment Program and patient pay.

Medicare Program

Medicare is funded and regulated by the federal government. It is available to all citizens 65 and older. Medicare is separated into four distinct parts. Part A - inpatient services for hospitalization and skilled



Payment Sources for Nursing Facility Services

- Federal Matching Funds
- Patient Pay Amount
- Provider Tax Program
- State General

III. HOW NURSING FACILITIES ARE FUNDED

nursing facility services; Part B - outpatient services for doctor visits; Part C - Medicare Advantage Plans (HMO); and Part D - drug plans.

Medicare Part A - skilled nursing facility care - is provided to recipients in need of skilled health care services that are rehabilitative or restorative. The care must assist the individual to a higher, “better” health state to be covered. To qualify for Medicare Part A you must be discharged from a hospital to a skilled nursing and/or rehabilitation facility.

Skilled nursing facility Medicare Part A payments are based on the patient’s assessed level of care. There is one payment for all of the services needed by the resident except for physician and other professional services. Michigan’s Medicare Part A rates are about \$350 per day, which includes speech, occupational and physical therapy; drugs, nursing care, medical supplies; and room and board.

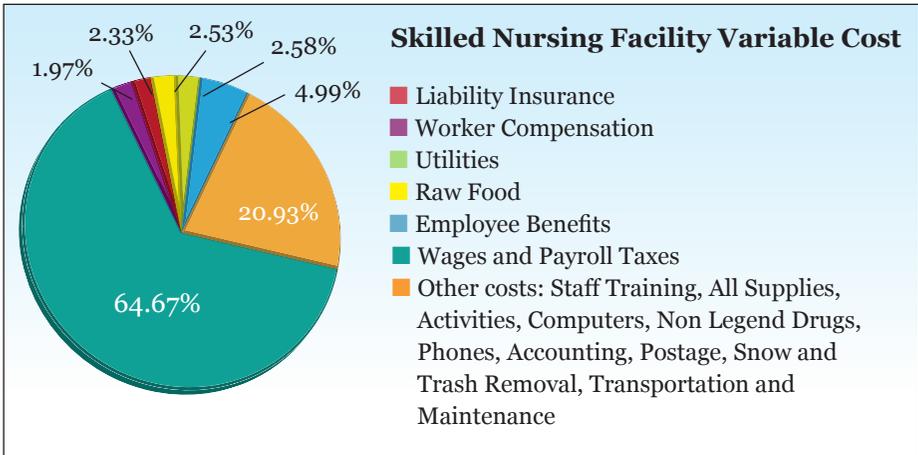
Skilled nursing facility Medicare Part A services can be provided for up to 100 days in a benefit period following a three-day stay in a hospital. The resident is required to pay \$141 co-pay on the 20th day. If the resident cannot pay the co-pay Medicaid will cover. The average Medicare Part A stay in Michigan is about 30 to 35 days of care. Michigan utilization of Medicare benefits is about 18 percent of the total days of care provided in a year.

Medicaid Program (Nursing Facility Services)

The state and federal governments share funding of the Medicaid program for citizens eligible for the program. Medicaid is regulated by the federal government and managed by individual states. Services are provided to those individuals who are eligible for Medicaid and in need of skilled and rehabilitative services. It is funded through a combination of state general fund dollars and federal matching dollars.

Michigan Medicaid does not limit the days of coverage as long as the individual is eligible and in need of the services. Medicaid pays for approximately 68 percent of the total days of care provided in Michigan nursing facilities.

III. HOW NURSING FACILITIES ARE FUNDED



MDCH establishes nursing facility rates for Medicaid services each October 1 in sync with the state fiscal accounting year. The rates are established based on historical costs from the prior year and paid prospectively without reconciliation to cost incurred during the fiscal year. For example: the rates set for October 1, 2009 through September 30, 2010, will utilize the cost data from a nursing facility’s filed cost report for the 2008 year.

The rate setting methodology utilizes historical costs and does not provide for an economic inflationary adjustor.

The costs are not adjusted to bridge the gap between cost data year and the end of the rate setting period. By the end of the rate period, the cost data is two years old and does not reflect the actual cost of care.

Michigan Medicaid, within their state plan for payments to nursing facilities separately classifies categories of providers to pay them different rates. The state has six classifications of payment methods and rates for nursing facilities. The two main classification categories are Class I — representing all “free standing” nursing facilities, both proprietary and non proprietary — and Class III for County Medical Care Facilities and hospital - licensed long term care units. The other classifications include hospital swing beds and beds for ventilator-dependent residents.

III. HOW NURSING FACILITIES ARE FUNDED

The Medicaid rate consists of three components of cost: plant or capital, variable or operating, and the provider tax or Quality Assurance Supplementation (QAS). The plant or capital costs are for the mortgage payments, related interest expense, property tax paid by proprietary facilities and depreciation for the Class III facilities. The variable or operating cost is all other costs which are further separated into base and support costs. Base costs are considered the “hands on care” or direct resident care costs mostly consisting of wages and benefits for nursing, dietary, laundry, activities and social services staff, along with food, linen, worker compensation and utility costs. All other operating costs are support costs including administration, business office, sales and Michigan Business Tax.

The allowable costs as filed on the nursing facility cost reports are subject to various limits based on the reimbursement methodology. Plant costs are limited by the size and age of the facility for interest and depreciation or its proxy called tenure.

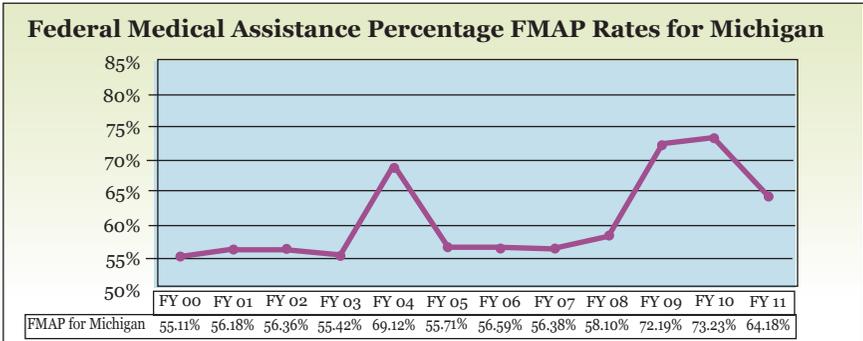
Variable costs have sub-limits and are administrative costs along with an overall cost cap set at 80 percent of the Medicaid days. The total variable cost limit mandates that 20 percent of the Medicaid days of care are in excess of the established limits. The plant and variable limits are established separately for Class I and Class III facilities. The greatest difference between the limits is in the variable costs, Class III have about \$30 per day higher limits which relates to their higher cost base.

The QAS or provider tax component of the rate is derived from the variable costs and is set at 21.76 percent of that cost. The Class III QAS is limited to the Class I overall variable cost limit and not their allowable variable cost component.

Quality Assurance Assessment Program

The Michigan Medicaid Quality Assurance Assessment Program (QAAP) or provider tax was enacted on May 10, 2002. Governor John Engler initiated the program (Public Act 303 of 2002) to secure additional federal dollars to provide

III. HOW NURSING FACILITIES ARE FUNDED



FY based on the state fiscal accounting year. FY 11 is an estimate based on the enhanced stimulus rate drop effective January 1, 2011. Health care reform may extend the enhanced rate and lessen the immediate “cliff” drop in the rate. Latest information as of December 2009.

rate increases to address the rising cost of care for Medicaid services. The program was implemented July 1, 2002, and provided increased rates for Medicaid nursing facility services. The increased rates were paid for by assessing providers a tax which is an allowable Medicaid cost. These allowable Medicaid costs are in turn matched by the federal government, creating the pool of funds to pay for the increased rates. Thirteen percent of the tax goes directly into the general fund as a state retainer amount. Although administered differently, the QAAP also applies to hospitals and Health Maintenance Organizations.

The provider tax is assessed based on the number of non-Medicare days of care the facility provides in a fiscal year. Facilities with less than 40 beds have a reduced rate and those who provide more than 51,000 Medicaid days also have a lower rate than the rest of the providers.

For Medicaid providers, the provider tax program has provided funds to address the rising cost of care for Medicaid services. Without this program, rates would have been flat in recent years because the economic inflation factor for Medicaid rates has been set at zero percent through the budget process.

III. HOW NURSING FACILITIES ARE FUNDED

Resident Pay Amount

The Medicaid program requires that an individual seeking nursing facility care meet strict financial criteria and utilize available income to assist with paying for care. The Medicaid client is allowed to retain \$60 per month from their income for non-covered personal items and the remainder assists in paying for their care. This resident's share of the cost of care is called the patient pay amount and is established by DHS during the Medicaid enrollment process. The patient pay amount is income derived primarily from social security and the resident's retirement benefits.

In Michigan, the patient pay amount covers about 20 percent of the Medicaid rate. The nursing facility must collect the patient pay amount from the resident each month, which is deducted from the amount Medicaid pays the facility. For example, if the Medicaid rate was \$170 per day and the patient pay amount is \$1,020 then a 30 day month payment would be broken out as follows: 30 days of care x \$170 = \$5,100, patient pays \$1,020 and Medicaid pays \$4,080.

Westland Nursing and Rehab Centre, Westland





Hoyt Nursing and Rehab Centre, Saginaw

The Medicaid portion of the payment is a federal matching cost which means for Fiscal Year 2010 with the federal match rate at approximately 70 percent -- 70 percent is paid by the federal government and 30 percent is paid with state general fund dollars. In the example detailed above, 70 percent of \$4,080 is \$2,856 and 30 percent state funds equals \$1,224. The payment sources for the care are: patient pay \$1,020, federal match \$2,856 and state general fund \$1,224 totaling \$5,100. The state general fund portion represents about 24 percent of the Medicaid rate.



Grayline
Housing & Care
TEAM

NO
Exit

Grayline
Housing & Care
TEAM