

Summary of Policy

Replacement Asset

Medicaid policy mandates that the historical cost of a previously purchased asset that is being replaced by a new asset be removed from the Current Asset Value (CAV) calculation of a facility's Medicaid rate. Building and land improvements are included in the CAV calculation for the life of the asset. Equipment is included in the CAV calculation for 10 years.

Medicaid Manual Reference

Nursing Facility -  
Cost Reporting &  
Reimbursement  
Appendix           Section 9.4.A.1

Proposed Policy

Challenges

Current Asset Value Limit

The Current Asset Value (CAV) upper limit is a maximum per bed dollar amount that will be used for calculating the CAV portion of the Medicaid reimbursement rate. The current limit is \$53,500 per bed. The CAV limit is recalculated annually to include construction costs of new facilities reported on the most recent calendar year filed cost reports.

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Appendix           Section 10.3.B.5

Tenure Factor

The tenure factor is dependent on the number of full years of continued licensure. The tenure factor is used in the CAV calculation portion of the Medicaid reimbursement rate. The tenure factor ranges from 2.5% to 5.25%. A new facility's tenure factor is 2.5%. After two full years of continued licensure, the tenure factor will increase 0.25% each year until the maximum of 5.25% is achieved. If a nursing facility is sold or totally replaced, years of ownership return to zero and the tenure factor drops back down to 2.5%

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Two Year Lag

The Medicaid reimbursement system is a prospective payment system. Medicaid rates are calculated using the facility's cost report ending in the previous calendar year. For example, the Medicaid rate beginning 10/1/08 was set based on the filed 2007 cost report. There is currently no inflationary factor. The cost report must cover at least a seven month period to be used for rate setting purposes.

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Minimum Occupancy Requirement

Medicaid policy states that Medicaid reimbursement per diem rates are to be set based on a minimum of 85% occupancy. If a facility's occupancy rate falls below 85%, resident days will be imputed to 85% and the per diem costs will be calculated using the imputed days.

Section 3 -  
Nursing Facility - Per  
Cost Reporting & Resident  
Reimbursement Day Cost  
Appendix           Definition

Summary of Policy

Beds out of Service

Medicaid Manual Reference

Proposed Policy

Challenges

Nursing facilities may submit a non-available bed plan to MDCH requesting a temporary removal of beds from service. The facility still retains ownership of the beds but they are not taken into consideration when determining the number of available bed days during the cost reporting period. The beds must be located in a discrete area and consist of a contiguous physical arrangement of rooms. The rooms must not be used for resident care regardless of payor source. Non-available beds must be reported in the non-reimbursable cost center on the cost report. Overhead costs are allocated to this area. Non-available beds must remain offline for not less than the balance of the cost reporting year in which the beds are deemed non-available PLUS the entire following fiscal year. The only exception would be if the effective date of the plan is the first day of the facility's fiscal year. In this case the provider would only be required to keep the beds offline for the fiscal year. A facility may request two 12 month extensions of the plan if they would like. The plan may only be amended one time during it's life. Nursing facilities are non elig

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