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State/Territory Name: MI

State Plan Amendment (SPA) #: 14-0016

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Additional Companion letter
- 3) CMS 179 Form/Summary Form (with 179-like data)
- 4) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Chicago Regional Office
233 N. Michigan
Suite 600
Chicago, Illinois 60601



June 22, 2015

Stephen Fitton, Medicaid Director
Medical Services Administration
Federal Liaison Unit
Michigan Department of Community Health
400 South Pine
Lansing, Michigan 48933

ATTN: Erin Black

Dear Mr. Fitton:

Enclosed for your records is an approved copy of the following State Plan Amendment:

- Transmittal #: 14-0016 – Therapy Limits
- Effective: October 1, 2014

If you have any questions, please contact Leslie Campbell at (312) 353-1557 or Leslie.Campbell@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519



June 22, 2015

Stephen Fitton, Medicaid Director
Medical Services Administration
Michigan Department of Community Health
400 South Pine Street, P.O. Box 30479
Lansing, Michigan 48909-7979

RE: Michigan SPA 14-016

Dear Mr. Fitton:

This letter is a companion to our approval of State plan amendment (SPA) 14-016 submitted October 1, 2014. The approved SPA language amends outpatient therapy service limits for occupational, physical and speech therapy by increasing the duration of the limits before prior authorization is required.

In response to our therapy companion questions, the state submitted on May 28, 2015 draft payment language for outpatient services. Our review of payments described in Attachment 4.19-B, Item 3, outpatient hospital services and other outpatient prospective payment system (OPPS) reimbursed facilities is complete. Although the subject of the amendment was therapies, we reviewed the entire outpatient page for comprehensive language.

From the materials presented by the state, we believe it pays therapies, hospital-owned ambulance services and outpatient hospital and free-standing dialysis centers under the outpatient prospective reimbursement system (OPPS) using the current Medicare fee multiplied by a state specific reduction factor. We have concluded the language lacks sufficient information to comprehensively describe payments for therapies provided in accordance with 42 CFR 440.110.

Our concern is that the state language is not compliant with regulations at 42 CFR 430.10 requiring a State plan be a comprehensive written statement containing "all information necessary for CMS to determine whether the plan can be approved as a basis for Federal Financial Participation (FFP) in the State program." To be comprehensive, payment methodologies should be understandable, clear and unambiguous. Our concerns are as follows:

In the first and last paragraphs, where plan language includes a Medicaid reduction factor (RF) and a Medicaid “outpatient” fee schedule reference, the state must add language to those paragraphs that include the effective dates and a web link for both the fee schedule and the Medicaid reduction factor. We are not able to approve the revised page without the effective date language. In the last paragraph, the state must add the state website at which the outpatient fee schedules can be found. If it is some other fee schedule, please identify the fee schedule and its website. Please note a submission of a State plan is required each time the RF and fee schedule changes.

1. Our understanding of the Medicare therapies, hospital-owned ambulance and end-stage dialysis payments is different than the payments described in the proposed page. We believe a conversation with the state to discuss the payments outlined in the proposed language is the most conducive means to resolve the comprehensive language concerns.

A. Therapies: Specifically, we believe Medicare OPPS excludes payment for ambulance, physical and occupational therapy, and speech language pathology services based on our read of the Federal Register pages 66800, 66788, 11/10/14-CY2015 OPPS Final Rule. .

1. Medicare OPPS includes therapy services by therapists or non-therapists during the perioperative period as adjunctive services and not therapy services as described in section 1834(k) of the Act. We are unable to determine from the state responses and plan language if the state includes therapy services described in section 1834(k) of the Act. Please confirm only perioperative period therapies are included in OPPS.
2. If other than perioperative period therapies are included in outpatient hospital payments, please clarify how the services are excluded for the outpatient upper payment limit (UPL) demonstration.
3. Please clarify how payments are made for speech-language therapy provided by University Speech-Language pathology graduate education programs. For example, do you pay under the physician fee schedule?

B. Hospital-Owned Ambulance: Section 4531(b)(2) of the Balanced Budget Act of 1997 added Section 1834(l) to the Social Security Act (the Act), which mandated the implementation of a national Ambulance fee schedule (FS) for Medicare Part B ambulance transport claims with dates of service on or after April 1, 2002. The Ambulance institutional-based provider FS applies to all ambulance transports.

Since Medicare OPPS excludes ambulances, we require the state to clarify why it includes hospital-owned ambulance services in the first paragraph.

We recommend that the last paragraph is clarified to include ambulance as a Medicaid fee schedule payment.

- C. Acute Dialysis: The payment language does not conform to the described Medicare methodology. Medicare distinguishes between the base dialysis rate for outpatient hospital and independent facility payments. Under Medicare OPPS, Medicare pays for acute dialysis payments when it is furnished to a hospital outpatient with ESRD in non-routine circumstances or when it is furnished to non-ESRD hospital outpatients. Medicare defines acute dialysis as dialysis that is unrelated to a diagnosis of ESRD. Here is the link to the Medicare July 18, 2012 guidance on payment for acute dialysis under the OPPS: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Acute-Dialysis-Site.pdf>

Please confirm that the OPPS includes only payments for acute dialysis that do not have a diagnosis of ESRD. Based on the state response, we may have further questions.

- D. End Stage Renal Disease Dialysis: Independent dialysis facilities would fall under the free-standing clinic benefit at 42 CFR 440.90. Regulations at 42 CFR 447.321 require that payment for clinic services not exceed a reasonable estimate of the amount that Medicare would reimburse for these services. We are concerned if the state follows the Medicare outpatient OPPS payments for the free-standing clinics, which is a higher payment than Medicare independent dialysis facilities under PPS, then the free-standing clinics do not conform to 42 CFR 447.321.
1. Even if the payment is the Medicare OPPS methodology, we require an annual clinic UPL that conforms to Medicare PPS. Please provide a date in which the ESRD clinic UPL will be submitted for 2014. Our clinic UPL guidance can be found at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Accountability-Guidance.html>
 2. When the state submits the outpatient page, we recommend adding a reference for the free-standing ESRD clinic to the clinic benefit portion of the State plan.
3. Services paid at cost under OPPS
- A. When the state submits the SPA language, please provide examples of services paid at reasonable cost under OPPS using a hospital specific or statewide average cost-to-charge ratio.
 - B. Additionally, please explain why the CCR ratios are updated with the inpatient operation ratios instead of outpatient ratios.

The state has 90 days from the date of this letter, to address the issues described above. Within that period the State may submit SPAs to address the inconsistencies or submit a corrective action plan describing in detail how the State will resolve the issues identified above in a timely manner. Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide any required technical assistance.

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Mr. Fitton

If there are any questions, please contact Leslie Campbell, of my staff, at (312) 353-1557.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Erin Black, Michigan Department of Community Health

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

14 - 0016

2. STATE:

Michigan

3. PROGRAM IDENTIFICATION:

TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

October 1, 2014

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.252

7. FEDERAL BUDGET IMPACT:

a. FFY 2015 _____ \$ 0

b. FFY 2016 _____ \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement to Attachment 3.1-A, Page 8, 27j and 27k

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Supplement to Attachment 3.1-A, Page 8, 27j and 27k

10. SUBJECT OF AMENDMENT:

Amends State Plan language to reflect changes in outpatient therapy service limits for occupational, physical and speech therapy by increasing the duration of the limits before prior authorization is required.

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:
Stephen Fitton, Director
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Stephen Fitton

14. TITLE:

Director, Medical Services Administration

15. DATE SUBMITTED:

December 16, 2014

16. RETURN TO:

Medical Services Administration
Actuarial Division
Capitol Commons Center - 7th Floor
400 South Pine Street
Lansing, Michigan 48933

Attn: Loni Hackney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

December 16, 2014

18. DATE APPROVED:

June 22, 2015

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

October 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:

/s/

21. TYPE NAME:

Ruth A. Hughes

22. TITLE:

Associate Regional Administrator

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy

2. OUTPATIENT HOSPITAL SERVICES

Professional fees for services provided in the outpatient department of a hospital will be paid only when such payment does not duplicate payment to the hospital.

Educational costs associated with the outpatient department will be reimbursed to hospitals with approved training programs (as described in 404.1 of the HIM-15 manual).

Payment will not be made for services of staff in residence, e.g., interns and residents or medical staff functioning in an administrative or supervisory capacity (including physician - owners) who are paid by the hospital or other sources.

Outpatient services relating to routine examinations only, i.e., unrelated to a specific illness, symptom, complaint, or injury, are not covered, except when provided to eligible children under age 21 as part of a program of early and periodic screening, diagnosis and treatment. (See Item 4b.)

Outpatient hospital services include prenatal and postnatal care; and services listed below when medically necessary for the diagnosis or treatment of an illness or injury when ordered by and under the direction of a physician (M.D. or D.O.), and services performed by the physician and/or physical therapist for physical therapy only:

- 1) radium treatment
- 2) therapeutic x-ray
- 3) diagnostic x-ray
- 4) emergency treatment
- 5) physical therapy, provided in accordance with 42 CFR 440.110, and as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is required if services are medically necessary and exceed the time or frequency limits as described in Medicaid policy for:
 - initial treatment (144 units in 12 months) or
 - maintenance/monitoring (four times in the 90-day allowed period)
- 6) laboratory tests
- 7) electrocardiogram
- 8) electroencephalogram
- 9) basal metabolism
- 10) hemodialysis

NOTE: The patient who receives hemodialysis in his home is considered to be a hospital outpatient. Therefore, payment for the cost of hemodialysis supplies, such as plastic tubing, chemicals, disposable coils, etc., may be made under the Program.

Services are furnished in an institution that is licensed or formally approved as a hospital by an officially designated authority for state standard-setting and meets the requirements for participation in Medicare as a hospital.

TN NO.: 14-0016

Approval Date: 6/22/15

Effective Date: 10/01/2014

Supersedes

TN No.: 07-02

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Amount, Duration and Scope of Medical and Remedial Care
Services Provided to the Categorically and Medically Needy***

13. Other Diagnostic, Screening, Preventive and Rehabilitative Services (continued)
- d. Rehabilitative Service (continued)
- 11) Out Patient Therapy Services: Rehabilitative services do not include and FFP is not available for habilitation services.
- A. Physical Therapy
- 1) Services are provided in accordance with 42 CFR 440.110 and covered as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is required if services are medically necessary and exceed the time or frequency limits as described in Medicaid policy for:
- A) Initial treatment (144 units in 12 months); or,
B) Maintenance/monitoring (four times in the 90 day allowed period)
- 2) Services may be provided under the auspices of (and billed by) any of the following:
- A) Outpatient hospital;
B) Medicare-enrolled comprehensive outpatient rehabilitation facility as defined under 42 CFR 485.58;
C) Medicare-enrolled outpatient rehabilitation agency as defined under 42 CFR 485.717;
D) Commission on Accreditation of Rehabilitation Facilities (CARF) accredited outpatient medical rehabilitation program
- B. Occupational Therapy
- 1) Services are provided in accordance with 42 CFR 440.110 and covered as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is required if services are medically necessary and exceed the time or frequency limits as described in Medicaid policy for:
- A) Initial treatment (144 units in 12 months); or,
B) Maintenance/monitoring (four times in the 90 day allowed period)
- 2) Services may be provided under the auspices of (and billed by) any of the following:
- A) Outpatient Hospital;
B) Medicare-enrolled comprehensive outpatient rehabilitation facility as defined under 42 CFR 485.58;
C) Medicare-enrolled outpatient rehabilitation agency as defined under 42 CFR 485.717;
D) Commission on Accreditation of Rehabilitation Facilities (CARF) accredited outpatient medical rehabilitation program
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TN NO.: 14-0016

Approval Date: 6/22/15

Effective Date: 10/01/2014

Supersedes
TN No.: 05-06