

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 07 - 07
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
~~July 1, 2007~~ August 1, 2007

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 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 07 \$ (1,275,000)
b. FFY 08 \$ (5,100,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Section IV page 20a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
Attachment 4.19-D, Section IV page 20a

10. SUBJECT OF AMENDMENT:
Annual Quality Assurance Supplement payment reconciliation

11. GOVERNOR'S REVIEW (Check One):
 GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Paul Reinhart, Director
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:


16. RETURN TO:
Medical Services Administration
Program/Eligibility Policy Division - Federal Liaison Unit
Capitol Commons Center - 7th Floor
400 South Pine
Lansing, Michigan 48933

13. TYPED NAME:
Paul Reinhart

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
July 17, 2007

Attn: Nancy Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPE NAME:

22. TITLE:

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Payment Rates
(Long Term Care Facilities)***

C. Variable Cost Component

5. Special Provisions:

a. New Facility (continued):

facility that does not have a Medicaid historical cost basis, will be paid in accordance with Section c. below.

b. Change of Class: An existing enrolled nursing facility which becomes a Class I or III facility, will be paid in accordance with Section c. below.

c. Payment Determination:

- 1) During the first two cost reporting periods, rates for providers defined in Sections a. and b. above will be calculated using a variable rate base equal to the class average of variable costs.
- 2) In subsequent periods the provider's variable rate base will be determined using methods in Section IV.C.1. through IV.C.3. above.

6. Beginning August 1, 2007, Class I, and non-publicly owned Class III nursing facilities receive a monthly payment as part of a Quality Assurance Assessment Program (QAAP). A facility's QAAP payment is based on the facility's Medicaid utilization multiplied by a Quality Assurance Supplement (QAS). A facility's Medicaid utilization is the sum of all routine nursing care and therapeutic leave days billed to Medicaid by that facility during a 12-month period beginning in June of the previous calendar year. The per diem rates for nursing facility bed days where Medicaid pays room and board for hospice residents in nursing facilities includes the QAS amount. Hospice is responsible for reimbursing nursing facilities for room and board consistent with their contract. The QAS is reimbursed up to a maximum of 21.76% of the lesser of the facility's variable rate base or the class variable cost limit except for publicly owned facilities, in which, the QAS percentage is applied to the lesser of the Class III variable cost component or the Class I variable cost limit. The nursing facility's current fiscal year rate is based on the facility's cost report for the second fiscal year prior to the current fiscal year.

TN NO.: 07-07

Approval Date: _____

Effective Date: 08/01/2007

Supersedes
TN No.: 05-23