DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SEP 19 2013

Stephen Fitton, Director
Medical Services Administration
Department of Community Health
400 South Pine
Lansing, MI 48933

RE: Michigan State Plan Amendment (SPA) 13-007

Dear Mr. Fitton:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-007. Effective for services on or after July 1, 2013, this amendment revises reimbursement methodology for capital interim payments (CIP). Specifically, this amendment changes the frequency of these payments from semi-monthly to monthly and clarifies the methodology for the final settlement to cost.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 13-007 is approved effective July 1, 2013. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Todd McMillion at (312) 353-9860.

Sincerely,

Cindy Mann,
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13 - 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, 2013

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

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $ 0
b. FFY 2014 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Page 25

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Page 25

10. SUBJECT OF AMENDMENT:
This State Plan Amendment removes language in the State Plan regarding the frequency of Capital Interim Payments (CIP)

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. SIGNATUE OF STATE AGENCY OFFICIAL:
Stephen Fitton

13. TYPED NAME:
Stephen Fitton

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
March 18, 2013

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:

18. DATE APPROVED: SEP 19 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2013

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPE NAME:
Penny Thompson

22. TITLE:
Deputy Director, Policy + Financial Mgt., CMCS

23. REMARKS:

FORM HCFA-179(07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods of Payment of Reasonable Costs - Inpatient Hospital Services

I. Capital

The initial reimbursement for capital will be paid as a separate Capital Interim Payment (CIP). CIPs will be made using a monthly schedule (12 equal payments per year). The CIP amount will be set using cost data from the most recently filed cost report and an estimated impact of any applicable limits on capital. For example, capital costs from a hospital's October 31, 2011 cost report would be used to calculate the CIP amount for the hospital's fiscal period that ends October 31, 2013. CIP amounts will be set annually at the beginning of the hospital's fiscal year by combining Medicaid routine and ancillary capital costs from the CMS 2552-10.

The CIP amount for the medical/surgical component of the hospital is established using the following lines (or comparable lines from succeeding cost reports) from the hospital's cost report. The routine capital costs are obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX Column 7, Lines 30-35 and 43. The ancillary capital costs are obtained from the CMS 2552-10 Worksheet D, Part II, Title XIX, Column 5, Lines 50-77 and 90-92.

The CIP amount for freestanding rehabilitation hospitals or distinct part rehabilitation units is established using the following lines from the hospital's cost report. The routine capital costs are obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX, Line 41. The ancillary capital costs are obtained from the CMS 2552-10, Worksheet D, Part II, Title XIX, Column 5, Lines 50-76.99 and 90-92.

CIPs may be adjusted due to significant changes in capital costs that are not reflected in the most recent cost report.

After the end of the facility's fiscal year, the total amount paid under CIP is compared with total capital cost as reported on the filed cost report for that year less any capital limits that apply. Differences are reconciled against the final capital amount for the applicable hospital fiscal period. Final settlements are calculated beginning 27 months after the end of a hospital's fiscal year end. Final capital costs for an applicable hospital fiscal period are calculated by combining Medicaid routine and ancillary capital costs from the CMS 2552-10 for the applicable hospital fiscal period. The same lines used to determine the hospital's CIP amount described above are used to determine the hospital's final capital amount.

If a hospital has a separate distinct part psychiatric unit, separate CIPs, comparisons to actual costs and determination of appropriate limits will be made for the distinct part unit and the balance of the inpatient hospital.

The Medicaid share of allowable capital costs is determined using Medicare Principles of Reimbursement.

The limits on capital described in this section apply for fiscal years beginning on and after October 1, 1990. The net licensed beds days calculation for hospitals whose fiscal year begins after September 30, 1990 and before January 1, 1991 and that reduce their licensed bed capacity by delicensing beds or using the rural banked beds option before January 1, 1991 will be made as if the reduction occurred on October 1, 1990.

Net licensed beds are used to determine net licensed bed days for capital reimbursement and include all beds temporarily delicensed, except for rural banked beds, with rural as defined under section 2 below. Net licensed bed days are:

Total Licensed Bed Days - Rural Banked Bed Days

A hospital may apply for a reduction in net licensed beds days to subtract bed days unavailable due to construction or renovation. Such a reduction is only available for beds which are taken out of service for construction or renovation for a limited period of time and which are returned to active inpatient service at the end of the construction or renovation project. Documentation of the construction or renovation project will be required.

Occupancy is: