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State/Territory Name: MI

State Plan Amendment (SPA) #: 14-006

This file contains the following documents in the order listed:

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

September 19, 2014

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

ATTN: Loni Hackney

Dear Mr. Fitton:

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

- Transmittal: #14-006- FQHC APM
- Effective: January 1, 2014

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

Sincerely,

/s/

Alan Freund
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

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: 14 - 06

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
January 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 Part 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $ 2,487,000
b. FFY 2015 $ 3,327,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Pages 6c and 6c.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Pages 6c and 6c.1

10. SUBJECT OF AMENDMENT:

This SPA implements the use of an alternative payment methodology (APM) to reimburse Federally Qualified Health Centers (FQHCs) for medical and dental services.

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:
[redacted]

13. TYPED NAME:
Stephen Fitton

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
March 21, 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:
March 21, 2014

18 DATE APPROVED:
September 19, 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPE NAME:
Alan Freund

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates (Other than Inpatient Hospital and Long Term Care Facilities)

14. Federally Qualified Health Center Services

As set forth in Section 1902(bb), all FQHCs that provide services (defined in section 1905(a)(2)(C)) after January 1, 2001 are reimbursed under either a prospective payment system (PPS) or an alternative payment methodology (APM) as selected by the FQHC.

Effective for dates of service on or after January 1, 2014, FQHCs providing specific Non-FQHC procedures in the FQHC setting will be Reimbursed pursuant to the payment methodology described under Attachment 4.19-B, Individual practitioner services. These non-FQHC procedures will not be subject to the PPS per visit amount.

The following are considered non-FQHC procedures:

- Endometrial ablation, thermal, without hysteroscopic guidance
- Endometrial cryo ablation with ultrasonic guidance, including endometrial curettage, when performed
- Hysteroscopy with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermo ablation)
- Hysteroscopy with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants

Effective for dates of service on or after January 1, 2014, FQHCs administering specific vaccines and drugs in the FQHC setting will be reimbursed pursuant to the payment methodology described under Attachment 4.19-B, Individual Practitioner Services. The following vaccine and drugs that will not be subject to the PPS per visit amount include:

- Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use
- Rho(D) immune globulin (Rhlg), human, full-dose, for intramuscular use
- Human Papilloma virus (HPV) vaccine, types 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use (Applicable to adult beneficiaries age 19 years and over only)
- Physician administered drugs, including chemotherapy drugs (Commonly referred to as J-Codes)

FQHCs will be reimbursed under one of two methodologies as described below.

(a) an FQHC that is not reimbursed under (b) will have eligible encounters reconciled to the Medicaid prospective payment system (PPS), as described. Under the PPS, an FQHC will be reimbursed on a per visit basis. The per visit payment was based on the average of the FQHC's reasonable costs of providing Medicaid Services during FY 1999 and FY 2000. Reasonable costs are defined as the per visit amount approved by Medicare as of October 1, 2001 and then adjusted to reflect the cost of providing services to Medicaid beneficiaries that are not covered by Medicare.

The baseline per visit amount will be adjusted annually, beginning October 1, 2001, using the Medicare Economic Index as designated in Section 1902(bb)(3)(A).

The per visit amount may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by the FQHC. An adjustment to the per visit amount based upon a change in the scope of services will be prospective and will become effective when the change is approved by the State. The adjustment may result in either an increase or decrease in the per visit amount paid to the FQHC.

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive prospective, quarterly supplemental payments that are an estimate of the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received under the PPS. At the end of each FQHC's fiscal year, the total amount of the supplemental and MCE payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHC's contract with one or more MCEs would have yielded under the PPS. The FQHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount is less than the total amount of supplemental and MCE payments.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

14. Federally Qualified Health Center Services (continued)

OR

(b) An FQHC may agree in writing, through a Memorandum of Agreement, to be reimbursed under the alternate payment methodology (APM) described in this subsection. For an FQHC paid under the APM, the PPS base methodology described in Subsection (a.) will be maintained to ensure compliance with Section 1902(bb)(6)(B) of the Act.

Effective for dates of service on or after January 1, 2014, an FQHC paid under this APM in accordance with Section 1902(bb)(6) of the Act will receive 100% of their rate in effect as of this date as determined and described in (a) above, plus the following, as applicable:

1.) For FQHCs providing dental care, an amount will be added on to a dental encounter that includes restorative services, endodontics, or extractions to account for the additional costs associated with these non-preventive procedures. the per visit add on amount will be adjusted annually using the Medicare economic index as described in subsection (a.).

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive prospective, quarterly supplemental payments that are an estimate of the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received under the PPS. At the end of each FQHC's fiscal year, the total amount of the supplemental and MCE payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHC's contract with one or more MCEs would have yielded under the PPS. The FQHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount is less than the total amount of supplemental and MCE payments.

Newly Created FQHCs

An entity that first qualifies as an FQHC after fiscal year 2000 will be paid a per visit amount that is equal to 100% of the costs of furnishing such services during such fiscal year based on the rates established under the PPS for the fiscal year or other FQHCs located in the same or adjacent area with a similar case load. If there is no other FQHC similarly situated, the newly established FQHC shall be paid a per visit amount based on the statewide average of its reasonable costs of providing such services and will be cost settled at the end of its first fiscal year of operation. Reasonable costs are defined as the per visit amount approved and paid by Medicare as of October 1, 2001 and then adjusted to reflect the cost of providing services to Medicaid beneficiaries that are not covered by Medicare. In subsequent fiscal years, the newly established FQHC shall be reimbursed using (a) or (b), described above. A newly established FQHC is eligible for quarterly supplemental payments. The amount of the quarterly supplemental payment will be estimated based on available information.