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State/Territory Name: Michigan

State Plan Amendment (SPA) #: MI 19-0008

This file contains the following documents in the order listed:

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

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

Financial Management Group

November 25, 2019

Ms. Kate Massey
Acting Medicaid Director
State of Michigan, Department of Community Health
400 South Pine Street

RE: Michigan State Plan Amendment (SPA) 19-0008

Dear Ms. Massey:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 19-0008 effective for services on or after November 1st, 2019, this SPA provides updates to nursing facility cost reporting audit & reimbursement process.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 19-0008 is approved effective November 1st, 2019. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,

for

Kristin Fan
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: 19 - 0008

2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
November 1, 2019

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 2020 $0
b. FFY 2021 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4 19-D Section I Page 1
Attachment 4 19-D Section II Page 1
Attachment 4 19-D Section III Pages 1 and 2
Attachment 4.19-D, Section IV Pages 3, 7, 11, and 19
Attachment 4 19-D Section VIII Pages 1-4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4 19-D Section I Page 1
Attachment 4 19-D Section II Page 1
Attachment 4 19-D Section III Pages 1 and 2
Attachment 4.19-D, Section IV Pages 3, 7, 11, and 19
Attachment 4 19-D Section VIII Pages 1-4

10. SUBJECT OF AMENDMENT:
This SPA provides updates to nursing facility cost reporting audit & reimbursement process.

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:
Kate Massey, Director
Medical Services Administration

12. SIGNATUE OF STATE AGENCY OFFICIAL:
K. Mm

13. TYPED NAME:
Kate Massey

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
September 4, 2019

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

Attn: Erin Black

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18 DATE APPROVED:
NOV 25 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
NOV 01 2019

20. SIGNATURE OF REGIONAL OFFICIAL:
for

21. TYPE NAME:
Kristin Fan

22. TITLE:
Director, FMG

23. REMARKS:

FORM HCFA-179(07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES (LONG TERM CARE FACILITIES)

1. Cost Finding, Cost Reporting and Records Maintenance

   The specific methods of cost finding and cost reporting utilized by the single state agency are defined in the state agency's cost reporting forms and instructions. Providers shall be notified of the cost reporting form or format and acceptable cost finding methods and notified promptly of change

   A. Beginning with cost reporting periods ending after September 1, 1973, all participating skilled nursing and intermediate care providers are required to submit to the state agency an annual cost report within 5 months of the close of the providers cost reporting period. The provider will be notified of the delinquency and ~~given 15 calendar days to submit the cost report or,~~ if the cost report is not submitted WITHIN THE TIMEFRAMES ESTABLISHED BY MDHHS, the provider's interim payments will be reduced by 100 percent. Restitution of withheld interim payments will be made by the state agency after receipt of an acceptable cost report. (Exception: A provider's cost report is due 5 months after a sale of a facility or termination of the provider agreement.)

   B. All cost reports must be submitted on the state agency's uniform reporting form or an approved replica thereof, covering a 12 month cost reporting period. An exception is made for Class VII facilities; they are to submit the Medicare skilled nursing facility cost report in place of the state agency's reporting form. Any changes in reporting periods or exceptions to the number of months covered must be approved by the state agency.

   C. Each provider's cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the provider.

   D. The accrual method of accounting is mandated for providers and generally accepted accounting principles must be followed by providers of care under the plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES (LONG TERM CARE FACILITIES)

II. Auditing and Availability of Records

A. Each cost report submitted is verified for completeness, accuracy, reasonableness, and consistency through a desk audit, AN ON SITE AUDIT ~~and/~~or a computer check. ~~It is expected that on-site audits will be conducted no less than once every four years.~~ THE STATE AGENCY SHALL ENSURE AN AUDIT OF A COST REPORT IS COMPLETED NO LATER THAN 21 MONTHS AFTER FINAL ACCEPTANCE OF A COST REPORT, A COST REPORT THAT IS NOT AUDITED WITHIN 21 MONTHS SHALL BE ACCEPTED AS FILED.

FOR DESK AUDITS OR ON SITE AUDITS, THE AUDIT SAMPLING METHODOLOGY WILL EMPLOY EITHER A STATISTICAL SAMPLING METHODOLOGY, A NON-STATISTICAL SAMPLING METHODOLOGY OR A COMBINATION OF METHODOLOGIES.

B. Each provider must allow access, during ~~on-site~~ audits ~~and/~~or reviews by the state agency AUDITORS OR THEIR DESIGNEES and representatives of the United State Department of Health and Human Services, to requisite ~~financial~~ records and statistical data specified in Section I of this plan. This access will include, BUT IS NOT LIMITED TO:

1. The complete records of related organizations

2. The record of lessors to determine underlying capital and operating costs of providers leasing facilities (per Section III.H).

3. Any records required by the Medicare Principles of Reimbursement ~~referenced in PRM-15, Chapter 24~~, FEDERAL LAWS OR REGULATIONS, STATE LAW, OR THE STATE AGENCY'S POLICIES.

4. Census records and numbers and types of leave days for each Medicaid beneficiary/resident (i.e. hospital, therapeutic).

DURING AN AUDIT OR REVIEW, PROVIDERS MUST SUBMIT RECORDS WITHIN THE TIME FRAMES DETERMINED BY THE STATE AGENCY.

C. If, upon audit or review, it is determined that a cost report contains incorrect data, the state agency shall use the corrected data to compute future rates and IF NECESSARY will retroactively change a previously applied rate ~~If audit adjustments to a filed cost report was used for setting an interim rate; the facility was approved for Plant Cost Certification due to capital cost changes, an approved non-available bed plan, or a plant rate affected by a DEFRA rate limitation for the cost report time period; audit adjustments that are required as a result of an appeal; Class I nursing facility was approved for Rate Relief for the rate year period~~. IF A STATISTICAL SAMPLING METHODOLOGY WAS USED FOR AN AUDIT, THEN THE AUDIT ADJUSTMENTS MAY BE DETERMINED USING EXTRAPOLATION METHODS. In cases of suspected fraud or failure to disclose required fiscal information, the state agency may retroactively adjust rates.

D. The audit process described under this section is not applicable to Class VII facilities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

F. The allowance for depreciation shall be determined in accordance with 42 CFR 413.134 through 413.149 (including section 413.134[f]) except that only the straight-line method (42 CFR 413.134[b][3]) shall be used and the useful life of the assets must be in compliance with subsection 104.17 of the Provider Reimbursement Manual (PRM) Part 1. Subsequent to sales, the depreciation basis will be held subject to the limitation on the revaluation of assets mandated by section 1861(v)(1)(O) of Title XVIII of the Social Security Act.

1. Consistent use of either component or composite asset depreciation schedules is required. Component depreciation is permitted in the case of a newly constructed facility and for recognized building improvements where the costs can be separated and acceptable useful lives determined. Composite depreciation must be used in the case of a newly purchased existing facility.

2. Depreciated replacement cost is defined as the current reproduction cost (42 CFR 413.134(b)(6)), adjusted for straight-line depreciation over the life of the asset to the time of the sale (per PRM, Part 1, subsection 104.14).

   The depreciated replacement cost shall be determined by an independent appraiser chosen and paid for by the provider in accordance with the "Appraisal Guidelines" in Part 1. subsection 134 et seq of the PRM. Prior to the appraisal, the sate agency must notify the appraiser of the "Appraisal Guidelines" to be utilized in the determination of his/her appraisal.

3. Class I and Class II facilities, paid in accordance with section IV.A., will not be paid based upon depreciation expense.

G. The allowance for interest expense shall be determined using EITHER principle 1 or 2 ~~below~~ IN CONCURRENCE WITH PRINCIPLE 3 BELOW:

1. For Class I and Class II facilities, reimbursement in accordance with the methods in section IV.A, interest expense will be determined in accordance with the Medicare Principles of Reimbursement at 42 CFR 413.153 in effect as of July 17, 1984 (prior to the regulatory changes associated with the mandates of the Deficit Reduction Act of 1984 and its limitations on the revaluation of assets).

   Exception: In cases where lessee/providers choose to forego increased reimbursement for interest expense as result of the requirements in section IV.A.5.b.2. below, the provider must report, as an allowable cost, the interest expense from the schedule of borrowings principal amortization and interest expense recognized for reimbursement by the Program prior to that sale.

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State of MICHIGAN

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

2. All other facilities will have interest expense determined in accordance with current Medicare Principles of Reimbursement, including the provisions at 42 CFR 413.153 and section 1861(v)(1)(O) of Title XVIII of the Social Security Act.
3. FOR LOANS ISSUED ON OR AFTER OCTOBER 1, 2019, INTEREST ON LOANS, TO BE ALLOWABLE, MUST REFLECT A PRINCIPAL BALANCE PAYMENT ON AT LEAST AN ANNUAL BASIS IF THE LOAN IS GREATER THAN FOUR YEARS OLD. FOR LOANS ISSUED PRIOR TO OCTOBER 1, 2019, INTEREST ON LOANS, TO BE ALLOWABLE, MUST REFLECT A PRINCIPAL BALANCE PAYMENT ON AT LEAST AN ANNUAL BASIS STARTING ON OCTOBER 1, 2023. REFINANCING OF A LOAN OR REFINANCING OF MULTIPLE LOANS IS NOT CONSIDERED A PRINCIPLE BALANCE PAYMENT, NOR IS A REFINANCED LOAN CONSIDERED A NEW LOAN FOR PURPOSES OF THIS SECTION.

H. Allowable lease costs are determined using principle 1 or 2 below:

1. A provider who entered into a bona fide, arms-length lease prior to September 1, 1973 where the lessor refused to open his books, will be allowed an actual lease cost up to a maximum of $2.50 per patient day. This limit was developed from the average lease rental cost for facilities leased prior to September 1, 1973, at which time the current method of calculation was effected. The pre-September 1, 1973 lessee has the right of appeal for bona fide, arms-length lease agreements which exceed the $2.50 limit.

2. Providers who enter into or amend a bona fide arms-length lease agreement after August 31, 1973 will be reimbursed a plant cost component determined in accordance with sections IV. A. or B. as applicable to an owner-provider, if the lessee discloses the allowable cost information required or rate setting as outlined in section IV.A.3. Without full disclosure lease expense will not be an allowable cost. The only exceptions to this disclosure rule shall be for lease expenses for pass through leases.

I. Bad debts, charity and courtesy allowances as defined in 42 CFR 413.80 are not recognized as allowable costs.

J. The cost of educational activities will be determined in accordance with 42 CFR 413.85, except the costs of educational activities outside the continental United States are not allowable.

K. The cost of research activities will be determined in accordance with 42 CFR 413.90.

L. The value of services of non-paid workers will be treated in accordance with 42 CFR 413.94.

M. Purchase discounts and allowances and refunds of expenses will be treated in accordance with 42 CFR 413.98.

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4. The return on current asset value component will be determined as the per patient day return on value, where the return on value will be a "tenure factor" times the lesser of "current asset value" or the "current asset value upper limitation." Current asset value will not be allowed to diminish below the "current asset value floor" (terms as defined below).

   a. The tenure factor is based upon a provider's number of years of continuous ~~licensure~~ MEDICAID CERTIFICATION UNDER THE CURRENT OWNERSHIP determined at the beginning of the provider's rate year and the number of calendar days in the provider's cost reporting period from which asset values and patient days are determined. Beginning with rate years starting on or after October 1, 1990, the tenure factor will be 2.5 percent for less than two years of ownership tenure and increase 0.25 percent per year of tenure up to 5.25 percent for 12 or more years of tenure. The tenure factor is the percentage determined above, times the ratio of days in the provider's cost reporting period to 365 days. ~~Licensure tenure will be based upon the number of full years that have elapsed from the effective date of a provider's license issued by the Michigan Department of Community health to the beginning of the provider's rate year. Exception: In the situation where licensure has changed, but there has been no effective change in operator/provider and there has been no transaction which would affect Medicaid reimbursement other than the tenure factor, the provider may petition the State agency to recognize the continuous tenure (i.e., the licensure tenure schedule would not revert to zero years at the time of licensure change if the petition is approved).~~

   b. The current asset value is determined by a formula using historical costs of capital assets times the difference between and inflationary index and an obsolescence factor. Assets purchased prior to 1960 will be treated as if they were brought into service in 1960.

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5. Special Provisions: The plan cost component will be determined using special methods for Class I and Class II providers with either newly purchased facilities or newly participating facilities or existing providers with either a change of class or major additions, renovations, or new construction.

   Special methods are required because there is no, or there is an inadequate, historical plan cost basis upon which to determine rates or rates are determined by different methods.

   a. Plant Cost Certifications: Such providers are ~~requested~~ REQUIRED to certify and submit to the single State agency their expected allowable costs (in accordance with Medicare Principles of Reimbursement as modified by Section III) for interest expense, property taxes, leases, and historical asset acquisition costs PRIOR TO THE COST REPORTING PERIOD FILING DEADLINE AND MEET THE QUALIFICATIONS IN ORDER TO RECEIVE AN INTERIM REIMBURSEMENT RATE. If approved, the agency will determine the provider's initial period plant cost component based upon the certified amounts using the principles described in Sections IV.A.1. through 4 above and IV.A.5.b. and c below. This rate will be retrospectively adjusted to reflect the facility's actual audited allowable plant costs for each fiscal year until the facility's rate is prospectively established from a cost reporting period which reflects a full cost reporting period of costs related to the original purpose of the plant cost certification. If, as a result of audit, the State agency finds a significant discrepancy between certified information and actual costs, all excess funds paid by the State agency to the facility as a result of that request will be recovered with a penalty factor (equal to the then current Medicare rate on net equity) applied to the discrepancy.

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4. Special Provisions: The plant cost component will be determined using special methods for Class III providers with newly purchased facilities or newly participating facilities or a change of class. Special methods are also required for Class III and grandfathered Class I and Class II providers with major additions, renovations or new construction. Special methods are required because there is an inadequate historical plant cost basis upon which to determine rates or rates are determined utilizing different methods.

   a. Plant Cost Certification: Such providers are ~~requested~~ REQUIRED to certify and submit to the State agency their expected plant costs PRIOR TO THE COST REPORTING PERIOD FILING DEADLINE AND MEET THE QUALIFICATIONS IN ORDER TO RECEIVE AN INTERIM REIMBURSEMENT RATE. The State agency will use the certified expected dollar value or plant costs, when approved, in calculating the prospective rate, pending audit. This rate will be retrospectively adjusted to reflect the facility's actual audited allowable plant costs for each fiscal year until the facility's rate is prospectively established from a cost reporting period which reflects a full cost reporting period of costs related to the original purpose of the plant cost certification. If, as a result of audit, the State agency finds a significant discrepancy between certified information and actual costs, all excess funds paid by the State agency to the facility as a result of that request will be recovered with a penalty factor applied to the discrepancy. The penalty will be 10 percent of the aggregate dollar amount difference between the overpayment and the plant cost settlement reimbursement. The penalty is waived if the aggregate dollar amount difference is equal to or less than 10 percent.

   b. The plant cost limit (PCL) for these facilities will be calculated based on one or both of the following principles:

      1) The per patient day plant cost limit will be updated to reflect changes in costs of construction and changes in standards and regulation which have a direct impact upon plant costs. Costs of construction will be updated using the Department of Commerce Composite Index Federal Housing Finance Board for Newly Built Homes.
      2) The per patient day plant cost limit will be updated to reflect changes in interest rates. The interest rate used to calculate the PCL will be updated by applying an index of change in interest rates for home mortgage loans (as reflected in conventional new home mortgage rates) Federal Housing Finance Board for Newly Built Homes to the interest rate used to calculate the original PCL (Section IV.B.3. above).

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e) Rate relief is needed because the facility will be closed due to a regulatory action by the State Survey Agency (SSA) or federal regulatory agency where the facility's closure will result in severe hardship for its residents and their families due to the distance to other nursing facilities, and no new provider will operate the facility at it's current reimbursement rate. A facility would meet this hardship criteria only if a new owner has agreed to take over its operation and if it is either the only nursing facility in the county or, the closing facility has at least sixty-five percent of the Medicaid nursing facility (Class I, III and V) certified beds in that county; or,

f) The provider's current ~~Variable Rate Base is~~ ACTUAL VARIABLE COSTS ARE less than or equal to 60 percent of the corresponding rate year's Variable Cost Limit. A facility is not eligible under this criterion if an owner or administrator's compensation is above the current compensation limit. A provider with non-allowable related party transaction costs or non-allowable related party lease costs cannot be eligible under this criterion.

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VIII. Appeals Procedure

The appeals procedure can be initiated by a provider upon receipt of a notice of adverse action, AND ALLOWS THE PROVIDER AN OPPORTUNITY TO SUBMIT ADDITIONAL EVIDENCE AND RECEIVE PROMPT ADMINISTRATIVE REVIEW WITH RESPECT TO SUCH ISSUES THE STATE AGENCY DETERMINES APPROPRIATE~~, for an informal or formal review or hearing. Procedure I contains provisions for the informal review of an adverse action that is contained in the final summary of audit findings issued by the State agency. This procedure is available to Class I, II and III providers and is effective for cost reporting periods ending on or after September 30, 2000. Procedure II contains provisions for: 1) all classes of providers for formal hearings; 2) all classes of providers for informal reviews which pertain to such adverse action issues as cost settlement determinations, rate determinations, and incentives; and 3) Class IV and V providers for informal reviews of audit findings, if applicable.~~

~~A. Procedure I – Informal Review of the Final Summary of Audit Findings~~

~~A Class I or Class III provider can request an area office conference for the purpose of review of an adverse action that is contained in the preliminary summary of audit findings issued by the State agency. The election to participate in an area office conference does not result in the waiver of the provider's right to any further administrative processes contained in these provisions and in administrative hearing rules R400.3405 through R400.3424. The following provisions will apply:~~

~~1. Provision 1. As used in these provisions:~~

~~a. Adverse action means the audit adjustments contained in the final summary of audit findings that is issued by the appropriate audit representative(s) of the department~~

~~b. Administration means the Medical Services Administration of the Michigan Department of Community Health~~

~~c. Appropriate audit representative(s) means that individual(s) employed or contracted by the Michigan Department of Community Health to conduct audits of provider cost reports.~~

~~d. Days, as used herein, refer exclusively to calendar days unless otherwise specified.~~

~~e. Department means the Michigan Department of Community Health, its officials or agents.~~

~~f. Final determination notice means a notice of an adverse action which includes the action to be taken; the date of the proposed action; the reason for the action; the statute, rule or guideline under which the action is taken; and the right to a hearing.~~

~~g. Provider means an individual, firm corporation, association, agency, institution or other legal entity which is providing, has formerly provided, or has been approved to provide, medical assistance to a recipient pursuant to the medical assistance program.~~

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h. ~~Receipt of as used herein is either on the day of personal delivery or will be presumed on the third day subsequent to the postmark date if the article of mail containing the referenced document is: deposited in Michigan in the United State mail; mailed first class; and properly addressed with postage pre-paid.~~

2. ~~Provision 2. Audit Review and Area Office Conference:~~

   a. ~~The appropriate audit representative(s), after completion of the field (desk) audit, will issue a preliminary summary of audit findings to the provider.~~

   b. ~~If the provider or its representative desires to contest the findings required by Provision 2.a), the provider or its representative must respond to the appropriate audit representative(s) within 10 business days of the date of the preliminary summary of audit findings, and indicate which findings it contests.~~

   c. ~~If no timely request for an area office conference is made by a provider or its representative, the provider will receive a final summary of audit adjustments notice. The notice advises the provider of subsequent appeal rights, up to and including an administrative hearing. The provider or its representative has 30 calendar days from the date of the final summary of audit adjustments notice to request a formal hearing in accordance with MDCH rules for hearings.~~

   d. ~~The appropriate audit representative(s) must schedule and conduct a conference to discuss the preliminary summary of audit findings. This conference will be called the area office conference. The provider or its representative must present the appropriate audit representative(s) with the documents and arguments it feels support its position relative to the issue(s) it is contesting. Likewise, the appropriate audit representative(s) shall explain to the provider his/her basis for the findings which the provider is contesting.~~

   e. ~~The appropriate audit representative(s) will issue a final summary of audit findings to the provider. The Final Summary of Audit Findings advises the provider of subsequent appeal rights, up to and including an administrative hearing. The provider or its representative has 30 calendar days from the date of the final summary of audit adjustments notice to request a formal hearing in accordance with MDCH rules for hearings. This is the final step in the audit review process.~~

   f. ~~If no timely request for an administration conference is made by a provider or its representative, the audited data as outlined in the final summary of audit findings will be submitted for the rate determination process. The provider will be deemed to have waived its right to any further administrative processes contained in these provisions and in administrative hearing rules R400.3405 through R400.3424. The findings as outlined in the final summary of audit findings will be implemented.~~

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~~3. Provision 3 – In computing any period of time prescribed or allowed, the day of the act, event or default after which the designated period of time begins to run is not included. The last day of the period so computed is included, unless it is a Saturday, Sunday or legal holiday in which event the period runs until 5 pm of the next business day which is not a Saturday, Sunday or legal holiday.~~

~~B.~~ A. Procedure ~~II~~

1. Once a notice of adverse action is issued, a provider may ~~invoke Procedure II~~ REQUEST AN APPEAL by submitting its application in writing to the State agency. The written request shall include an identification of the issue(s) for which resolution is being sought and a description of why the provider believes the determination on these matters is incorrect.

2. Appeals which are allowable under this plan through this procedure will be conducted in accordance with the procedures outlined in the MICHIGAN ADMINISTRATIVE CODE ~~rules, filed on March 4, 1978, as amended, and adopted into Administrative Rules, R400.3401 through R400.3424~~.

~~3. A written application for a formal hearing (that is, a hearing conducted by an administrative law judge) must be received within 30 calendar days of the date of notice of an adverse action or a final determination notice. Exceptions: 1) A written request for a formal hearing pertaining to a notification of intent to terminate shall be made in accordance with sub rule 6(4) of Administrative Rule R400.3406. 2) A written application for a formal hearing following an administration conference conducted under Provision 4(c) of Procedure II shall be made in accordance with Provision 4(e) of Procedure II and 3) as otherwise provided in Section VIII.A.1 above.~~

~~C. Specific Situation Provisions for Procedure I~~

~~1. If the State agency is responsible for a delay in the procedures and either an area office conference or administration conference is in progress, or the potential for an area office conference or an administration conference is still open, at the beginning of the rate year that begins the start of the state fiscal year the following calendar year, the provider will be given a provisional rate for the new rate year. For this purpose, "delay in the procedures" means, if applicable: 1) the State agency failed to issue the preliminary summary of audit adjustments timely (that is, in accordance with Provision 2(a) or as amended in accordance with specific situation 1); 2) the State agency failed to conduct the area office conference timely (that is, in accordance with Provision 2(d) or as amended pursuant to specific situation 1); 3) the State agency failed to issue the final summary of audit findings timely (that is, in accordance with Provision 2(e) or as amended pursuant to specific situation 1); and/or 4) the State agency failed to issue a final determination notice timely (that is, in accordance with Provision 4(c) or as amended pursuant to specific situation 1). The provisional rate will be established by updating the payment rate for the immediately preceding state fiscal rate year using the provider's filed cost data. Upon the completion of the audit appeal process, an adjustment, retroactive to the beginning of the new rate year, will be made.~~

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~~D.~~ B. Non-appealable Elements

Elements of the reimbursement program for which an administrative remedy, if permitted for a single provider, would imply or necessitate a change in the program for all providers or for all providers in a class may not be appealed through administrative rules or provisions but may be appealed to a court of appropriate jurisdiction. These elements include, but are not limited to: 1) the determination of the selection and use of inflationary adjustors (Section IV.C.3.); 2) the principles of reimbursement and guidelines which define allowable costs (Section III.); 3) non- Medical Assistance Program issues; 4) the cost limits, unless otherwise specifically provided (Sections JV.B.2., and the appropriate subsections of IV.C.3. and IV.B.4.); and 5) the State agency determination of the allowability of items certified under this plan (until such time as an audit is completed).

~~E.~~ C. Adjustments

If the results of an appeal require a change in a provider's rate, the change will be effected through an aggregate adjustment.