

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

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| 1. TRANSMITTAL NUMBER<br><u>23</u> — <u>0007</u> | 2. STATE<br><u>MI</u> |
|--|-----------------------|

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

TO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

3. PROPOSED EFFECTIVE DATE  
January 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION  
Sections 201 and 301 of the National Emergencies Act (50 U.S.C.1601 et seq.)  
Section 1135 of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)  
a. FFY 2023 \$12,430,000  
b. FFY 2024 \$0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  
  
Section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT  
  
This SPA provides authority to address the National Emergency by allowing for a temporary change to the nursing facility rate setting methodology.

10. GOVERNOR'S REVIEW (Check One)

|  |  |
|--|--|
| <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT         | <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: |
| <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED        |  |
| <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL |  |

11. SIGNATURE OF STATE AGENCY OFFICIAL  
*Farah Hanley*

11. TYPED NAME  
Farah Hanley

12. TITLE  
Chief Deputy for Health

13. DATE SUBMITTED  
March 16, 2023

15. RETURN TO  
Behavioral and Physical Health and Aging Services Administration  
Office of Strategic Partnerships & Medicaid Administrative Services – Federal Liaison  
Capitol Commons Center – 7<sup>th</sup> Floor  
400 South Pine  
Lansing, Michigan 48933  
Attn: Erin Black

**FOR CMS USE ONLY**

|                   |                   |
|-------------------|-------------------|
| 16. DATE RECEIVED | 17. DATE APPROVED |
|-------------------|-------------------|

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL

20. TYPED NAME OF APPROVING OFFICIAL

19. SIGNATURE OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

## Section 7 – General Provisions

### 7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

*Michigan reserves the right to terminate any of the emergency provisions in this amendment prior to the end of the emergency period through submission of a disaster relief SPA rescission to CMS. Michigan Medicaid policy will provide detail on which requirements are amended.*

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

#### Request for Waivers under Section 1135

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a.  SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b.  Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

State/Territory: Michigan

- c.  Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Michigan Medicaid state plan, as described below:

Michigan plans to conduct Tribal consultation after the State Plan Amendment submission to CMS. The State will send a written notice.

**Section A – Eligibility**

- 1. \_\_\_\_\_ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

*Include name of the optional eligibility group and applicable income and resource standard.*

- 2. \_\_\_\_\_ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. \_\_\_\_\_ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- b. \_\_\_\_\_ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: \_\_\_\_\_

- 3. \_\_\_\_\_ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

State/Territory: Michigan

Less restrictive resource methodologies:

4. \_\_\_\_ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. \_\_\_\_ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. \_\_\_\_ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

**Section B – Enrollment**

1. \_\_\_\_ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

*Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.*

2. \_\_\_\_ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

*Please describe any limitations related to the populations included or the number of allowable PE periods.*

State/Territory: Michigan

3. \_\_\_\_ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

*Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.*

4. \_\_\_\_ The agency adopts a total of \_\_\_\_ months (not to exceed 12 months) continuous eligibility for children under age enter age \_\_\_\_ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. \_\_\_\_ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every \_\_\_\_ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. \_\_\_\_ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a. \_\_\_\_ The agency uses a simplified paper application.
  - b. \_\_\_\_ The agency uses a simplified online application.
  - c. \_\_\_\_ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

### Section C – Premiums and Cost Sharing

1. \_\_\_\_ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

\_\_\_\_\_

2. \_\_\_\_ The agency suspends enrollment fees, premiums and similar charges for:
- a. \_\_\_\_ All beneficiaries
  - b. \_\_\_\_ The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

State/Territory: Michigan

3. \_\_\_\_ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

*Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.*

#### Section D – Benefits

##### Benefits:

1. \_\_\_\_ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. \_\_\_\_ The agency makes the following adjustments to benefits currently covered in the state plan:

3. \_\_\_\_ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. \_\_\_\_ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a. \_\_\_\_ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. \_\_\_\_ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

*Please describe.*

State/Territory: Michigan

*Telehealth:*

5. \_\_\_\_ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

*Please describe.*

*Drug Benefit:*

6. \_\_\_\_ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

*Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.*

7. \_\_\_\_ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. \_\_\_\_ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

*Please describe the manner in which professional dispensing fees are adjusted.*

9. \_\_\_\_ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

**Section E – Payments**

*Optional benefits described in Section D:*

1. \_\_\_\_ Newly added benefits described in Section D are paid using the following methodology:

- a. \_\_\_\_ Published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

TN: 23-0007

Supersedes TN: 22-0013

Approval Date: \_\_\_\_\_

Effective Date: 1/01/2023

State/Territory: Michigan

b. \_\_\_ Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

2. \_\_\_ The agency increases payment rates for the following services:

*Please describe criteria.*

a. \_\_\_ Payment increases are targeted based on the following criteria:

*Please describe criteria.*

b. Payments are increased through:

i. \_\_\_ A supplemental payment or add-on within applicable upper payment limits:

*Please describe.*

ii. \_\_\_ An increase to rates as described below.

Rates are increased:

\_\_\_ Uniformly by the following percentage: \_\_\_\_\_

\_\_\_ Through a modification to published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

\_\_\_ Up to the Medicare payments for equivalent services.

\_\_\_ By the following factors:

*Please describe.*



State/Territory: Michigan

Payment for services delivered via telehealth:

3. \_\_\_ For the duration of the emergency, the state authorizes payments for telehealth services that:
- a. \_\_\_ Are not otherwise paid under the Medicaid state plan;
  - b. \_\_\_ Differ from payments for the same services when provided face to face;
  - c. \_\_\_ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

- d. \_\_\_ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - i. \_\_\_ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - ii. \_\_\_ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4.  Other payment changes:

*Except as otherwise noted in the state plan, Michigan's Medicaid payment rates are uniform for both private and governmental providers. Reimbursement is made in accordance with Medicaid's fee screens or the usual and customary charge for these services, whichever amount is less. All rates are published at [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders). Effective October 1, 2021, through the Public Health Emergency, Michigan Department of Health and Human Services (MDHHS) will not use the filed 2020 Cost Reports to calculate the Nursing Facility per diem rate for Class I, Class III, and Class V facilities. Instead, the rates will be calculated using the following methodology:*

**Interim Prospective Rate**

*MDHHS will calculate the FY22 interim Variable Cost Component by taking the Nursing Facility's previously calculated FY21 Variable Cost Component and increasing it by 2.5%. MDHHS will calculate from October 1, 2022 to December 31, 2022 the interim Variable Cost Component by taking the Nursing Facility's previously calculated FY22 interim Variable Cost Component and increasing it by 2.5%. For the time period of January 1, 2023 to May 11, 2023, MDHHS will temporarily increase the Nursing Facility interim Variable Cost Component by taking the Nursing Facility's previously-calculated FY2022 interim Variable Cost Component and increasing it by 4.55%.*

MDHHS will calculate the FY22 interim Plant Cost Component by taking the Nursing Facility's previously calculated FY21 Plant Cost Component and increasing it by 2.5%. MDHHS will calculate from October 1, 2022 to December 31, 2022 the interim Plant Cost Component by taking the Nursing Facility's previously calculated FY22 interim Plant Cost Component and increasing it by 2.5%. For the time period of January 1, 2023 to May 11, 2023 MDHHS will temporarily increase the Nursing Facility interim Plant Cost Component by taking the Nursing Facility's previously-calculated FY2022 interim Plant Cost Component and increasing it by 4.55%.

Final Audited Rate

MDHHS will use the providers audited 2020 cost report to determine the Plant Cost and Long-Term Asset Review information that will flow forward into 2021.

MDHHS will use the providers audited 2021 cost report to determine the Plant Cost and Long-Term Asset Review information that will flow forward into 2022.

MDHHS will use the providers audited 2022 cost report to determine the Variable Cost and Plant Cost components that will be applied to the final normal FY22 rate formula.

MDHHS will use the providers audited 2021 cost report to determine the Plant Cost and Long-Term Asset Review information that will flow forward into 2022.

MDHHS will use the providers audited 2022 cost report to determine the Plant Cost and Long-Term Asset Review information that will flow forward into 2023.

MDHHS will use the providers audited 2023 cost report to determine the Variable Cost and Plant Cost components that will be applied to the final normal FY23 rate formula.

**Section F – Post-Eligibility Treatment of Income**

1. \_\_\_ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

- a. \_\_\_ The individual's total income
- b. \_\_\_ 300 percent of the SSI federal benefit rate
- c. \_\_\_ Other reasonable amount: \_\_\_\_\_

2. \_\_\_ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

*Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.*

State/Territory: Michigan

**Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information**

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*CMS Disclosure\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.