DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0017

2. STATE: MI

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
Effective May 12, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Section 1902(a) of the Social Security Act and 42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $48,800,000
b. FFY 2024 $0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-D Section IV Pages 9 and 9a
Attachment 4.19-D Section IV Page 13 and 13a
Attachment 4.19-D Section IV Page 20a and 20b
Attachment 4.19-D Section IV Page 22 and 22a
Attachment 4.19-D Section IV Page 27

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTIONOR ATTACHMENT *(If Applicable)*
Attachment 4.19-D Section IV Page 9 (TN 05-11)
Attachment 4.19-D Section IV Page 13 and 13a(TN05-11)
Attachment 4.19-D Section IV Page 20a (TN 17-0008)
Attachment 4.19-D Section IV Page 22 (TN 17-0008)
Attachment 4.19-D Section IV Page 27 (TN 09-06)

9. SUBJECT OF AMENDMENT
This SPA provides traditional state plan authority for the FY2022 and FY2023 rate setting methodology established in DR SPA 21-0015, DR SPA 22-0013, and DR SPA 23-0007. This is necessary to complete the final rate settlements for each fiscal year.

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10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
Meghan E Groen

11. TYPED NAME
Meghan Groen

12. TITLE
Senior Deputy Director

13. DATE SUBMITTED
June 28, 2023

15. RETURN TO

Behavioral and Physical Health and Aging Services Administration
Office of Strategic Partnerships & Medicaid Administrative Services – Federal Liaison
Capitol Commons Center – 7th 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

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

FORM CMS-179 (09/24)

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c. Change of Class: An existing provider becoming a Class I or Class II facility will be paid a plant cost component determined using the principles stated in Sections IV.A.1 through 4 above.

6. Grandfather Clause: Any provider who received a higher plant cost component under the reimbursement system in effect prior to April 1, 1985 may, at the option of the provider, be paid a plant cost component determined in accordance with Section IV.B below until facility fiscal years beginning on or after April 1, 1991. If a grandfathered facility is sold subsequent to April 1, 1985 and there is a change in licensure, then the grandfather clause will no longer be applicable and the new owner's rate will be determined utilizing the methods in Sections IV.A.1 through IV.A.5 above. If a grandfathered facility is sold subsequent to April 1, 1985, and there is no change in licensure, then the grandfather clause may continue to be applicable until facility fiscal years beginning on or after April 1, 1991.

7. Special Note on Recapture of Depreciation: In the event of a sale after March 31, 1985, there will be the application of 42 CFR 413.135(f) for any reimbursement received by the seller as depreciation expense from October 1, 1984 through the effective date of the sale and transfer of assets.

8. SPECIAL NOTE FOR OCTOBER 1, 2021 THROUGH SEPTEMBER 30, 2022: DUE TO THE COVID-19 PUBLIC HEALTH EMERGENCY, THE PLANT COST COMPONENT FOR CLASS I FACILITIES WILL BE CALCULATED BY APPLYING AN AVERAGE COST INCREASE TO THE FACILITY'S PLANT COST COMPONENT FROM THE MOST RECENT FISCAL YEAR THAT WAS NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY. THE COST INCREASE WILL BE CALCULATED USING THE AVERAGE CLASS-WIDE INCREASE OVER THE PREVIOUS 5 FISCAL YEARS THAT WERE NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY.

9. SPECIAL NOTE FOR OCTOBER 1, 2022 THROUGH DECEMBER 31, 2022: DUE TO THE COVID-19 PUBLIC HEALTH EMERGENCY, THE PLANT COST COMPONENT FOR CLASS I FACILITIES WILL BE CALCULATED BY APPLYING AN AVERAGE COST INCREASE TO THE FACILITY'S PLANT COST COMPONENT FROM THE MOST RECENT FISCAL YEAR THAT WAS NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY. THE COST INCREASE WILL BE CALCULATED USING THE AVERAGE CLASS-WIDE INCREASE OVER THE PREVIOUS 5 FISCAL YEARS THAT WERE NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY.

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10. SPECIAL NOTE FOR JANUARY 1, 2023 TO SEPTEMBER 30, 2023, MDHHS WILL TEMPORARILY INCREASE THE NURSING FACILITY INTERIM PLANT COST COMPONENT BY 4.55%. THIS COMPONENT IS CALCULATED BY TAKING THE NURSING FACILITY'S PREVIOUSLY CALCULATED FY 2022 INTERIM PLANT COST COMPONENT AND INCREASING IT BY 4.55%.

B. Plant Cost Component (for Class III facilities)

The prospectively established plant cost component for county medical care facilities and hospital long term care units and facilities grandfathered in Section IV.A.6. above is the lesser of allowable per patient day plant cost or the per patient day plant cost limit, as described below:

1. The allowable per patient day plant cost is the sum of depreciation expense, interest expense, property taxes, and recognized lease costs (as defined in Section III.H) divided by total patient days, as derived from the most recent audited cost report.

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B. Plant Cost Component (CLASS II AND Class III facilities)
4. Special Provisions (continued)

f. Change of Class: An existing provider becoming a Class III facility will be paid a plant cost component determined using the principles stated in Section IV.B.2. of this plan.

5. SPECIAL NOTE FOR OCTOBER 1, 2021 THROUGH SEPTEMBER 30, 2022: DUE TO THE COVID-19 PUBLIC HEALTH EMERGENCY, THE PLANT COST COMPONENT FOR CLASS III FACILITIES WILL BE CALCULATED BY APPLYING AN AVERAGE COST INCREASE TO THE FACILITY'S PLANT COST COMPONENT FROM THE MOST RECENT FISCAL YEAR THAT WAS NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY. THE COST INCREASE WILL BE CALCULATED USING THE AVERAGE CLASS-WIDE INCREASE OVER THE PREVIOUS 5 FISCAL YEARS THAT WERE NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY.

6. SPECIAL NOTE FOR OCTOBER 1, 2022 THROUGH DECEMBER 31, 2022: DUE TO THE COVID-19 PUBLIC HEALTH EMERGENCY, THE PLANT COST COMPONENT FOR CLASS III FACILITIES WILL BE CALCULATED BY APPLYING AN AVERAGE COST INCREASE TO THE FACILITY'S PLANT COST COMPONENT FROM THE MOST RECENT FISCAL YEAR THAT WAS NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY. THE COST INCREASE WILL BE CALCULATED USING THE AVERAGE CLASS-WIDE INCREASE OVER THE PREVIOUS 5 FISCAL YEARS THAT WERE NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY.

7. SPECIAL NOTE FOR JANUARY 1, 2023 TO SEPTEMBER 30, 2023, MDHHS WILL TEMPORARILY INCREASE THE NURSING FACILITY INTERIM PLANT COST COMPONENT BY 4.55%. THIS COMPONENT IS CALCULATED BY TAKING THE NURSING FACILITY'S PREVIOUSLY CALCULATED FY 2022 INTERIM PLANT COST COMPONENT AND INCREASING IT BY 4.55%.

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C. Variable Cost Component

For Class II provider cost reporting periods, beginning on or after January 1, 1989, the variable cost component of the prospective rate will be based on a submitted cost report. Cost will be settled retrospectively against a fixed ceiling using allowable cost principles, as defined in Section III of this attachment. Fixed variable component ceilings will be determined for each facility based on the submitted budget.

For provider cost reporting periods beginning on or after April 1, 1986, the variable cost component for long term care facilities in Classes I and III will be determined in accordance with the following sections. Rate setting for prior periods will be made in accordance with the State plan in effect at the beginning of the provider's rate setting period.

1. Variable costs are defined as total allowable costs allocated to base and support costs in the routine service centers. Allowable costs and expenses are determined allowable in accordance with Medicare Principles of Reimbursement as modified by Section III of this attachment. The agency's cost reporting forms specifically allocate routine service center costs into base, support, and plant costs. Costs of other services are also allocated on the cost reporting forms into ancillary service centers (retrospectively cost settled or paid fee-for-service), home for the aged service centers and other non-reimbursable service centers.

2. The variable cost component consists of two subcomponents - the base cost component and the support cost component. Base costs are generally defined as those costs which cover activities associated with direct patient care. Special add-ons to provide cash flow for anticipated costs that are not included in the cost base period may also be included in the rate. Special add-ons are calculated based on the same underlying methodology as the prospective payment rate, which is cost, and special add-ons are retrospectively settled. special add-ons apply to Class I and Class III providers to cover costs related to Nurse Aide Training and Testing (NAT&T) and to Class I providers for Special Dietary costs. Special add-ons provide reimbursement for costs that are not previously included in the variable cost component. Effective for cost reporting periods beginning on or after October 1, 1990, base costs include: 1) labor costs and related benefits and payroll taxes except medical records, medical director, general and administration, housekeeping and operation of plant cost categories; 2) raw and processed food costs; 3) the cost of all utilities; 4) consultant costs for base cost categories from a related organization; 5) the cost of contracted agency nursing personnel; 6) linen; 7) all worker compensation costs; and, 8) all other costs incurred in base cost categories except as specifically defined as support costs.

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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. Effective August 1, 2017, Class I, and Class III nursing facilities receive a monthly payment as part of the 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) percentage. 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 twelve month period beginning in June of the previous calendar year. The hospice reimbursement for nursing facility bed days where Medicaid pays room and board for hospice residents in nursing facilities include the QAS amount. Hospice is responsible for reimbursing nursing facilities for room and board consistent with their contract. Between August 1, 2017 and September 30, 2017, the QAS percentage is equal to 21.51% of the lesser of the facility's variable rate base or the class variable rate limit except for publicly owned facilities, in which the QAS percentage is applied to the lesser of the public Class III variable cost component or the Class I variable rate 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. Effective October 1, 2017 forward, the QAS percentage will be 21.76%.

7. SPECIAL NOTE FOR OCTOBER 1, 2021 THROUGH SEPTEMBER 30, 2022: DUE TO THE COVID-19 PUBLIC HEALTH EMERGENCY, THE VARIABLE COST COMPONENT FOR CLASS I AND CLASS III FACILITIES WILL BE CALCULATED BY APPLYING AN AVERAGE COST INCREASE TO THE FACILITY'S VARIABLE COST COMPONENT FROM THE MOST RECENT FISCAL YEAR THAT WAS NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY. THE COST INCREASE WILL BE CALCULATED USING THE AVERAGE CLASS-WIDE INCREASE OVER THE PREVIOUS 5 FISCAL YEARS THAT WERE NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY.

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8. SPECIAL NOTE FOR OCTOBER 1, 2022 THROUGH DECEMBER 31, 2022: DUE TO THE COVID-19 PUBLIC HEALTH EMERGENCY, THE VARIABLE COST COMPONENT FOR CLASS I AND CLASS III FACILITIES WILL BE CALCULATED BY APPLYING AN AVERAGE COST INCREASE TO THE FACILITY'S VARIABLE COST COMPONENT FROM THE MOST RECENT FISCAL YEAR THAT WAS NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY. THE COST INCREASE WILL BE CALCULATED USING THE AVERAGE CLASS-WIDE INCREASE OVER THE PREVIOUS 5 FISCAL YEARS THAT WERE NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY.

9. SPECIAL NOTE FOR JANUARY 1, 2023 TO SEPTEMBER 30, 2023, MDHHS WILL TEMPORARILY INCREASE THE NURSING FACILITY INTERIM VARIABLE COST COMPONENT BY 4.55%. THIS COMPONENT IS CALCULATED BY TAKING THE NURSING FACILITY'S PREVIOUSLY CALCULATED FY 2022 INTERIM VARIABLE COST COMPONENT AND INCREASING IT BY 4.55%.

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inpatient hospital rate for currently placed acute care Medicaid patients who are ventilator dependent. The prospective rate shall be periodically re-evaluated (no more than annually) to ensure the reasonableness of the rate and the appropriate balance of supply and demand for special care is met.

3. The cost basis shall be determined in accordance with Section 1 through III of this plan, excluding Sections III.B., III.C. and III.D. Providers are required to maintain distinct part accounting records for all costs associated with the beds to ensure those costs are not included as a reimbursement basis in the other distinct parts of the facility.

4. Effective August 1, 2017, non-publicly owned ventilator-dependent care units licensed as 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) percentage. A facility's Medicaid utilization will be 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. Between August 1, 2017 and September 30, 2017, the QAS percentage is equal to 21.51% of the Class I variable cost limit. Effective October 1, 2017 forward, the QAS percentage will be 21.76%.

5. SPECIAL NOTE FOR OCTOBER 1, 2021 THROUGH SEPTEMBER 30, 2022: DUE TO THE COVID-19 PUBLIC HEALTH EMERGENCY, THE VARIABLE COST COMPONENT FOR NON-PUBLICLY OWNED VENTILATOR-DEPENDENT CARE UNITS LICENSED AS NURSING FACILITIES WILL BE CALCULATED BY APPLYING AN AVERAGE COST INCREASE TO THE FACILITY'S VARIABLE COST COMPONENT FROM THE MOST RECENT FISCAL YEAR THAT WAS NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY. THE COST INCREASE WILL BE CALCULATED USING THE AVERAGE CLASS-WIDE INCREASE FOR CLASS V FACILITIES OVER THE PREVIOUS 5 FISCAL YEARS THAT WERE NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY.

6. SPECIAL NOTE FOR OCTOBER 1, 2022 THROUGH DECEMBER 31, 2022: DUE TO THE COVID-19 PUBLIC HEALTH EMERGENCY, THE VARIABLE COST COMPONENT FOR NON-PUBLICLY OWNED VENTILATOR-DEPENDENT CARE UNITS LICENSED AS NURSING FACILITIES WILL BE CALCULATED BY APPLYING AN AVERAGE COST INCREASE TO THE FACILITY'S VARIABLE COST COMPONENT FROM THE MOST RECENT FISCAL YEAR THAT WAS NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY. THE COST INCREASE WILL BE CALCULATED USING THE AVERAGE CLASS-WIDE INCREASE FOR CLASS V FACILITIES OVER THE PREVIOUS 5 FISCAL YEARS THAT WERE NON-AFFECTED BY THE COVID-19 PUBLIC HEALTH EMERGENCY.

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7. SPECIAL NOTE FOR JANUARY 1, 2023 TO SEPTEMBER 30, 2023, MDHHS WILL TEMPORARILY INCREASE THE NURSING FACILITY INTERIM VARIABLE COST COMPONENT BY 4.55%. THIS COMPONENT IS CALCULATED BY TAKING THE NURSING FACILITY'S PREVIOUSLY CALCULATED FY 2022 INTERIM VARIABLE COST COMPONENT AND INCREASING IT BY 4.55%.

G. Payment Determination for Specially Placed Patients

The payment rates for all specially placed patients shall be an individually negotiated per patient day prospective rate determined by the single state agency. The rate for these patients shall not be subject to the provisions in Sections IV.A. through IV.F. above, but the provisions within this section shall be used for payment determination.

1. Payment shall be made for specially placed patients transferred from an acute-care hospital setting to an approved nursing facility on a prior authorized basis. The purpose of the negotiated rate is to provide reimbursement adequate to meet the unusual needs of this type of patient in a less costly and more appropriate environment than an inpatient hospital setting. The goal of this policy is the most cost effective provision of services needed by the special care patient.

2. Factors used by the single state agency in the determination of the per patient day prospective rate include, but are not limited to:" complexity, type of equipment and supplies required, the patient's condition and the market place

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Final Settlement Calculation:

For each facility, final settlement calculations will be conducted upon completion of the final audit of the facility's cost report.

The Medicaid loss will be calculated using the methodology described above but utilizing each audited expenditure period cost report, actual patient days from the cost report, actual Medicaid days for the period, and actual Medicaid rate payments and other applicable payments. The Medicaid loss calculated at final settlement is reconciled with the initial settlement Medicaid loss payments made for the cost reporting period.

All adjustments to the initial payment will be done via gross adjustment and processed through Michigan's claims processing system. The Federal share of any overpayment is credited to the Federal government.

1. FINAL AUDITED RATE FOR OCTOBER 1, 2021 THROUGH SEPTEMBER 30, 2022

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.

2. FINAL AUDITED RATE FOR OCTOBER 1, 2022 THROUGH SEPTEMBER 30, 2023

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.

Public Notice

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration
State Plan Amendment Request to Update Nursing Facility Rate Setting Methodology for FY2022 and FY2023

The Michigan Department of Health and Human Services (MDHHS) plans to submit a State Plan Amendment (SPA) request to the Centers for Medicare & Medicaid Services (CMS).

The purpose of this SPA is to provide traditional state plan authority for the FY2022 and FY2023 rate setting methodology established in DR SPA 21-0015, DR SPA 22-0013 and DR SPA 23-007. These DR SPAs were necessary to complete the final rate settlements described below for each fiscal year.

Rate Setting Methodology for FY2022

For FY2022, MDHHS has temporarily increased the Nursing Facility interim Variable Cost and Plant Cost Components by 2.5 percent. These components are calculated by taking the Nursing Facility's previously calculated FY 2021 Variable Cost and Plant Cost Components and increasing them by 2.5 percent.

To determine the final rates for FY2022, 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 FY2022 rate formula. For FY2022, if a change of ownership occurs which causes there to not be a completed and audited cost report covering at least 7 months of 2022 for the previous owner, MDHHS will use the most recent completed annual audited cost report for that owner.

Rate Setting Methodology for FY2023

- From October 1, 2022 to December 31, 2022 MDHHS will temporarily increase the Nursing Facility interim Variable Cost Component by 2.5 percent. This component is calculated by taking the Nursing Facility's previously calculated FY2022 interim Variable Cost Component and increasing it by 2.5 percent.
- From October 1, 2022 to December 31, 2022 MDHHS will temporarily increase the FY2023 Nursing Facility interim Plant Cost Component by 2.5 percent. This

component is calculated by taking the Nursing Facility's previously calculated FY2022 interim Plant Cost Component and increasing it by 2.5 percent.

- From January 1, 2023 to September 30, 2023 MDHHS will temporarily increase the Nursing Facility interim Variable Cost Component by 4.55 percent. This component is calculated by taking the Nursing Facility's previously calculated FY2022 interim Variable Cost Component and increasing it by 4.55 percent.
- From January 1, 2023 to September 30, 2023 MDHHS will temporarily increase the FY2023 Nursing Facility interim Plant Cost Component by 4.55 percent. This component is calculated by taking the Nursing Facility's previously calculated FY2022 interim Plant Cost Component and increasing it by 4.55 percent.

To determine the final rates for FY2023, 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 FY2023 rate formula. For FY2023, if a change of ownership occurs which causes there to not be a completed and audited cost report covering at least 7 months of 2023 for the previous owner, MDHHS will use the most recent completed annual audited cost report for that owner.

The approval by CMS for this rate methodology will be effective the day after the end of the Public Health Emergency (PHE), May 12, 2023.

The estimated annual gross cost to the State of Michigan for the SPA is $76 million.

There is no public meeting scheduled regarding this notice. Any interested party wishing to request a written copy of the SPA or wishing to submit comments may do so by sending an e-mail to MSADraftPolicy@michigan.gov or submitting a request in writing to: MDHHS/ Behavioral and Physical Health and Aging Services Administration, Program Policy Division, PO Box 30479, Lansing MI 48909-7979 by June 17, 2023. A copy of the proposed State Plan Amendment will also be available for review at : https://www.michigan.gov/mdhhs/inside-mdhhs/budgetfinance/264/state-plan-amendments.

RELEASED: May 18, 2023

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

April 11, 2023

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Notice of Intent to Submit a Disaster Relief State Plan Amendment (DR SPA) Impacting Nursing Facility Interim Rates for January 1, 2023 to May 11, 2023 and a State Plan Amendment (SPA) to Provide Traditional State Plan Authority for Previously Approved Changes to Rate Setting Methodologies for Fiscal Years 2022 and 2023 and to Continue the Supplemental Payment for Nursing Facility Direct Care Workers

This letter, in compliance with Section 1902(a)(73) and Section 2107(e)(1)(C) of the Social Security Act, serves as notice to all Tribal Chairs and Health Directors of the intent by the Michigan Department of Health and Human Services (MDHHS) to submit both a DR SPA request and a State Plan Amendment (SPA) request to the Centers for Medicare & Medicaid Services (CMS).

DR SPA Regarding Rate Setting Methodology for January 1, 2023 to May 11, 2023

The purpose of the DR SPA is to adjust the nursing facility rate setting methodology used for FY2023 for the time period of January 1, 2023 to May 11, 2023. For this time period, MDHHS will temporarily increase the Nursing Facility interim Variable Cost Component by taking the Nursing Facility's previously-calculated FY2022 Variable Cost Component and increasing it by 4.55 percent. MDHHS will also temporarily increase the Nursing Facility interim Plant Cost Component by by taking the Nursing Facility's previously-calculated FY2022 Plant Cost Component and increasing it by 4.55 percent.

The final rate calculations for these components will be consistent with the approach stated in the "Rate Setting Methodology for FY2023" section below.

SPA Regarding Rate Setting Methodology for FY2022 and FY2023

The purpose of the SPA is to provide traditional state plan authority for the FY2022 and FY2023 rate setting methodology established in DR SPA 21-0015, DR SPA 22-0013,

and the proposed DR SPA referenced above. This is necessary to complete the final rate settlements described below for each fiscal year.

Rate Setting Methodology for FY2022

For FY2022, MDHHS has temporarily increased the Nursing Facility interim Variable Cost Component by 2.5 percent. This component is calculated by taking the Nursing Facility's previously-calculated FY2021 Variable Cost Component and increasing it by 2.5 percent. MDHHS temporarily increased the Nursing Facility interim Plant Cost Component by 2.5 percent. This component is calculated by taking the Nursing Facility's previously calculated FY2021 Plant Cost Component and increasing it by 2.5 percent.

To determine the final rates for FY2022, 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 FY2022 rate formula. For FY2022, if a change of ownership occurs which causes there to not be a completed and audited cost report covering at least 7 months of 2022 for the previous owner, MDHHS will use the most recent completed annual audited cost report for that owner.

Rate Setting Methodology for FY2023

- From October 1, 2022, to December 31, 2022, MDHHS will temporarily increase the Nursing Facility interim Variable Cost Component by 2.5 percent. This component is calculated by taking the Nursing Facility's previously-calculated FY2022 interim Variable Cost Component and increasing it by 2.5 percent.
- From October 1, 2022, to December 31, 2022, MDHHS will temporarily increase the FY2023 Nursing Facility interim Plant Cost Component by 2.5 percent. This component is calculated by taking the Nursing Facility's previously-calculated FY2022 interim Plant Cost Component and increasing it by 2.5 percent.
- From January 1, 2023, to September 30, 2023, MDHHS will temporarily increase the Nursing Facility interim Variable Cost Component by 4.55 percent. This component is calculated by taking the Nursing Facility's previously-calculated FY2022 interim Variable Cost Component and increasing it by 4.55 percent.
- From January 1, 2023, to September 30, 2023, MDHHS will temporarily increase the FY2023 Nursing Facility interim Plant Cost Component by 4.55 percent. This component is calculated by taking the Nursing Facility's previously-calculated FY2022 interim Plant Cost Component and increasing it by 4.55 percent.

To determine the final rates for FY2023, 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 FY2023 rate formula. For FY2023, if a change of ownership occurs which causes there to not be a completed and audited cost report covering at least 7 months of 2023 for the previous owner, MDHHS will use the most recent completed annual audited cost report for that owner.

Direct Care Worker Wage Increase

The SPA also includes a supplemental wage increase for all Direct Care Workers employed by Medicaid-certified nursing facilities. Current authority for this change is provided in DR-SPA 21-0016 and is effective October 1, 2021, through May 11, 2023. Effective the day after the PHE ends, May 12, 2023, a supplemental payment of $2.35 per hour will continue to be applied to base wages for in-person care provided by registered nurses, licensed practical nurses, competency-evaluated nursing assistants and respiratory therapists employed by Medicaid-certified nursing facilities. The supplemental payment for these providers will also include any associated share of the employer Federal Insurance Contributions Act (FICA) payroll taxes.

MDHHS expects the above updates to increase access to services for Native American beneficiaries.

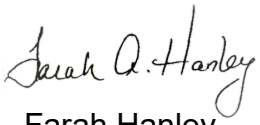
There is no public hearing scheduled for these amendments. Input regarding these SPAs is highly encouraged, and comments regarding this notice of intent may be submitted to Lorna Elliott-Egan, MDHHS Liaison to the Michigan tribes. Lorna can be reached at 517-512-4146, or via email at Elliott-EganL@michigan.gov. **Please provide all input by May 26, 2023.**

In addition, MDHHS is offering to set up group or individual consultation meetings to discuss the SPAs, according to the tribes' preference. Consultation meetings allow tribes the opportunity to address any concerns and voice any suggestions, revisions, or objections to be relayed to the author of the proposal. If you would like additional information or wish to schedule a consultation meeting, please contact Lorna Elliott-Egan at the telephone number or email address provided above.

MDHHS appreciates the continued opportunity to work collaboratively with you to care for the residents of our state.

An electronic copy of this letter is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Sincerely,



Farah Hanley
Senior Chief Deputy Director for Health

CC: Christine J. Davidson, CMS
Nancy Grano, CMS
Chasity Dial, CEO, American Indian Health and Family Services of Southeastern Michigan
Daniel Frye, Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Distribution List for L 23-24
April 11, 2023

Ms. Whitney Gravelle, President, Bay Mills Indian Community
Ms. Audrey Breakie, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Mr. David M. Arroyo, Chairman, Grand Traverse Band Ottawa & Chippewa Indians
Ms. Doris Winslow, Health Director, Grand Traverse Band Ottawa/Chippewa
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Ms. Doreen G. Blaker, Tribal President, Keweenaw Bay Indian Community
Ms. Deanna Foucault, Health Director, Keweenaw Bay Indian Community - Donald Lapointe Health/Educ Facility
Mr. James Williams, Jr., Tribal Chairman, Lac Vieux Desert Band of Lake Superior Chippewa Indians
Ms. Sadie Valliere, Health & Human Services Director, Lac Vieux Desert Band
Mr. Larry Romanelli, Ogema, Little River Band of Ottawa Indians
Mr. Daryl Wever, Health Director, Little River Band of Ottawa Indians
Ms. Regina Gasco-Bentley, Tribal Chairman, Little Traverse Bay Band of Odawa Indians
Ms. Jodi Werner, Health Director, Little Traverse Bay Band of Odawa
Mr. Bob Peters, Chairman, Match-E-Be-Nash-She-Wish Potawatomi Indians (Gun Lake Band)
Ms. Kelly Wesaw, Health Director, Match-E-Be-Nash-She-Wish Potawatomi
Mr. Jamie Stuck, Tribal Chairman, Nottawaseppi Huron Band of Potawatomi Indians
Ms. Rosalind Johnston, Health Director, Huron Potawatomi Inc.- Tribal Health Department
Ms. Rebecca Richards, Tribal Chairwoman, Pokagon Band of Potawatomi Indians
Ms. Priscilla Gatties, Interim Health Director, Pokagon Potawatomi Health Services
Ms. Theresa Peters-Jackson, Tribal Chief, Saginaw Chippewa Indian Tribe
Mrs. Karmen Fox, Executive Health Director, Nimkee Memorial Wellness Center
Mr. Austin Lowes, Tribal Chairperson, Sault Ste. Marie Tribe of Chippewa Indians
Mr. Leonid Chugunov, Health Director, Sault Ste. Marie Tribe of Chippewa Indians - Health Center

CC: Christine J. Davidson, CMS
Nancy Grano, CMS
Chasity Dial, CEO, American Indian Health and Family Services of Southeastern Michigan
Daniel Frye, Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

Michigan Medicaid Nursing Facility Upper Payment Limit Non-Federal Funding Questions – 10/1/2022

The following questions should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology for each of the applicable services that are submitted pursuant to SMDL #13-003.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

   ***Response**: Providers will not return any portion of any Medicaid-related payments they receive.*

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   i. a complete list of the names of entities transferring or certifying funds;
   ii. the operational nature of the entity (state, county, city, other);
   iii. the total amounts transferred or certified by each entity;
   iv. clarify whether the certifying or transferring entity has general taxing authority: and,
   v. whether the certifying or transferring entity received appropriations (identify level of appropriations).

***Response**: Funding for all nursing facility payments must be appropriated by the state legislature before expenditures can be incurred. The funding sources supporting appropriations for specific payments are broken out below.*

Per Diem Payments – Nursing facility per diem payments made under Attachment 4.19-D of the Michigan State Plan are estimated to be $1,672.8 million for fiscal year 2021. The non-federal share for these payments is approximately $497.2 million and is financed with state funding of $335.7 million, local funding of $5.5 million, and $155.9 million in nursing home provider tax.

Supplemental/Enhanced Payments - The Quality Assurance Supplement (QAS) payments made under Attachment 4.19-D Section IV page 20a of the Michigan State Plan are supplemental payments. QAS payments are estimated to be $308 million for fiscal year 2021. The non-federal share for these payments is $91.4 million and is funded with nursing facility provider tax.

CPE Payments – Approximately $2.5 million was funded through certified public expenditures (CPEs) in FY21. The methodology for these payments is described on pages 24-27 of Attachment 4.19-D Section IV of the Michigan State Plan. Attachment A provides additional information related to these CPEs.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

   ***Response:** The following supplemental payments are made to nursing facilities under Attachment 4.19-D Section IV of the Michigan State Plan.*

   Quality Assurance Assessment (QAS) - QAS payments are estimated to be $307.5 million for fiscal year 2021. The non-federal share for these payments is $91.4 million for this time period. Payments are funded with a nursing facility provider tax. The methodology for these payments is described in Attachment 4.19-D Section IV page 20a of the Michigan State Plan.

   CPE Payments – A supplemental payment of $8.5 million was made to County Medical Care Facilities in FY21. The non-federal share of $2.5 million was funded through certified public expenditures. The methodology for these payments is described on pages 24-27 of Attachment 4.19-D Section IV of the Michigan State Plan. Attachment A provides additional information related to these CPEs.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and

privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Response: *N/A*

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

   Response: *In the aggregate, the payments are under the Medicare upper payment limit. They therefore do not exceed the nursing facilities' reasonable costs of providing services. A mechanism has been implemented to recoup and return the federal share of overpayments in the event that overpayment occurs.*