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State/Territory Name: Michigan

State Plan Amendment (SPA) #: MI 23-0017

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

Financial Management Group

August 2, 2023

Kate Massey
Medicaid Director
State of Michigan, Department of Community Health
400 South Pine Street
Lansing, Michigan 48933

RE: Michigan State Plan Amendment (SPA) 23-0017

Dear Director Massey:

CMS is issuing this technical correction package to include the final submitted revision to Section IV Page 27. CMS included an earlier version that did not describe which cost report is used in the absence of the state plan defined cost report.

This technical correction maintains the original approval and effective date. We are enclosing the CMS-179 and the all previously approved pages including the update Page 27.

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

Sincerely,

Rory Howe

Rory Howe
Director

Enclosure

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTIONOR ATTACHMENT *(If Applicable)*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 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
June 28, 2023

17. DATE APPROVED
August 2, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
May 12, 2023

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

State requested a technical correction to the last page of the approved package on 9/21/2023.

FORM CMS-179 (09/24)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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.
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.

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.
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.