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 — 0026

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
October 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $42,277,600
b. FFY 2025 $42,277,600

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19--A Page 5
Attachment 4.19--A Page 6

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTIONOR ATTACHMENT *(If Applicable)*
Attachment 4.19--A Page 5 (TN# 15-0014)
Attachment 4.19--A Page 6 (TN# 15-0014)

9. SUBJECT OF AMENDMENT
This SPA provides authority to increase reimbursement to level I and level II designated trauma facilities.

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
October 23, 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)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates
Inpatient Hospital

2. Statewide DRG Rates

Two statewide medical/surgical hospital DRG rates are developed by the state using the Episode File. For hospital DRG rate setting purposes, the medical/surgical Episode File is limited to those hospitals enrolled with the state as of October 1 of the applicable rate year. Two separate statewide rates are developed: one rate is developed for prospective payment system (PPS) hospitals and another rate is developed for hospitals designated as critical access by CMS as of October 1 of the applicable rate year. In the event a hospital status changes from PPS to critical access hospital (CAH), the state recognizes the hospital under CAH status as of the CMS effective date. The reverse is also true. If a hospital status changes from CAH to PPS, the state recognizes the hospital under PPS status as of the CMS effective date. Statewide rates are updated annually on October 1.

A budget neutrality factor is included in the hospital price calculation. Hospital prices are reduced by the percentage necessary so that total aggregate hospital payments using the new hospital prices and DRG relative weights do not exceed the total aggregate hospital payments made using the prior hospital base period data and DRG Grouper relative weights. The estimate is based on one year's paid claims, including MHP encounter data with FFS rates applied. The calculated DRG prices are deflated by the percentage necessary for the total payments to equate to the amount paid prior to the change. Budget neutrality for CAHs is determined as a group, independent of PPS.

Hospitals' final DRG rates are calculated as follows:

- The case mix is calculated using the sum of all relative weights assigned to each hospital's claims during the base period, divided by the total number of episodes for the hospital during the same period.
- The case mix index adjusted cost for each hospital is summed.
- A hospital-specific standardized cost per discharge is computed.
    - Divide total adjusted costs by the total number of episodes.
    - Divide average costs by the case mix.
    - Multiply the result by the applicable inflation factor to bring costs to a common point in time. Costs are inflated through the rate period. For example, for FY 2015 rates, costs are inflated through September 30, 2016. Inflation factors are obtained from IHS Global Insight.
- The statewide rate per discharge is the weighted mean of all hospital-specific standardized cost.
- A RATE ADJUSTMENT IS APPLIED TO DESIGNATED LEVEL I AND II TRAUMA FACITILIES.
- The statewide rate is adjusted by an Area Wage Index and Budget Neutrality Factor to determine the hospital's final DRG rate.

In developing the statewide DRG rate, the following data and calculations are used for each hospital:

1) Hospital's adjusted charges;
2) Inpatient cost-to-charge ratio;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates – Inpatient Hospital

3) Hospital's adjusted costs (line 1 x line 2);
4) Hospital's episodes;
5) Cost per discharge (line 3/line 4);
6) Hospital's case mix;
7) Standardized cost per discharge (line 5/line 6);
8) Establish statewide rate as weighted standardized cost per discharge ((∑line 7 x line 4)/∑ line 4);
9) APPLY RATE ADJUSTMENT TO DESIGNATED LEVEL I AND II TRAUMA FACILITIES;
10) Hospital's Area Wage Index;
11) Apply budget neutrality factor; and
12) Hospital's final DRG rate (line 8 x line 9 x line 10). The DRG rate is rounded to the nearest whole dollar amount.

The statewide rates are listed on the state Inpatient Hospital website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Inpatient Hospitals.

3. Relative Weights

Michigan-specific relative weights are developed utilizing the adjusted costs from the Episode File. The average cost for episodes within each DRG is calculated by dividing the sum of the costs for the episodes by the number of episodes within the DRG. The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes. A table showing the relative weights, average lengths of stay, and low day outlier threshold for each DRG is available on the state Inpatient Hospital website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Inpatient Hospitals. Relative weights are updated annually on October 1.

The state establishes alternate weights for neonatal services from episodes that are assigned to one of the DRGs in the following range: 580x-640x. These weights are utilized for services rendered in a neonatal intensive care unit (NICU). The remaining claims assigned to these DRGs are used for the base weights (non alternate weights). No other alternate weights are assigned.

To ensure each relative weight adequately reflects resource utilization for a particular DRG in the state, the state requires that each DRG have a minimum of 10 episodes. If a DRG does not have at least 10 episodes, an alternative solution is applied as follows:

State-Specific Relative Weight Methodology:

- If the episode count for a DRG is 10 or more, use the relative weight setting methodology outlined. Otherwise:
  - For severity levels 1 through 3 where the targeted severity level is equal to *n:*
    - If the episode count for the next greater severity level is 10 or more, the following calculation is completed: (MI DRG Severity$_{n+1}$ Relative Weight) x (National DRG Severity$_n$ Relative Weight) / (National DRG Severity$_{n+1}$ Relative Weight) = (MI Relative Weight Factor$_n$)
    - Otherwise, (National DRG Severity$_n$ Relative Weight) x (MI Case Mix Factor$_n$)

Medicaid Hospital Upper Payment Limit Non-Federal Funding Questions

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

   ***Response 4.19-B**: 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 4.19-A*: Funding for all hospital payments detailed below must be appropriated by the state legislature before expenditures can be incurred. The funding sources supporting appropriations for specific payments are itemized below.*

DRG Payments – Hospital DRG payments made under section 4.19-A are estimated to be $326.4 million for fiscal year 2021. State funding for these payments is estimated at $61.6 million for this time period.

Per Diem Payments – Hospital per diem payments made under section 4.19-A are estimated to be $7.7 million for fiscal year 2021. State funding for these payments is estimated at $1.1 million for this time period.

TEFRA Payments – Hospital TEFRA payments made under section 4.19-A are estimated to be $48.2 million for fiscal year 2021. State funding for these payments is estimated at $14.3 million for this time period.

Capital Payments – Hospital capital payments made under section 4.19-A are included in the DRG and Per Diem payments listed above for fiscal year 2021. State funding for these payments is listed above for this time period.

GME Payments – Hospital GME payments made under section 4.19-A are estimated to be $52.2 million for fiscal year 2021. State funding for these payments is estimated at $19.8 million for this time period.

GME payments consisted of $31.2 million in GME Funds Pool and Primary Care Pool payments and $20.9 million in Innovations Pool payments. The latter were made to Pine Rest Christian Hospital, Hurley Medical Center, and Detroit Receiving Hospital under arrangements with Michigan State University and Wayne State University, respectively, whereby the universities provided the state share of approximately $10.5 million.

DSH Payments – Hospital DSH payments under 4.19-A are estimated to be $489.3 million for fiscal year 2021. The total non-federal share of hospital DSH payments was approximately $145.4 million for this time period. There are four components to the non-federal share of the payments:
1. Approximately $61.3 million was funded through state general fund tax dollars.
2. Approximately $1.0 million was funded through intergovernmental transfers (IGTs) from public entities. The state received the state share from public entities prior to issuing the DSH payment to the hospitals. Attachment A provides additional information related to these IGTs.
3. Approximately $28.1 million was funded through certified public expenditures (CPEs). The methodology for these payments is described on pages 24b and 24c of Section 4.19-A of Michigan's Medicaid State Plan. Attachment B provides additional information related to these CPEs.

4. Approximately $55.0 million was funded through a hospital provider tax to support the Outpatient Uncompensated Care DSH Pool.

<u>Supplemental/Enhanced Payments</u> – Hospital supplemental payments made under section 4.19-A are estimated to be $399.9 million for fiscal year 2021. These payments consist of $398.8 million in Medicaid Access to Care Initiative (MACI) payments and $1.1 million in Rural Access Pool (RAP) payments. MACI payments are supported by a hospital provider tax. RAP payments are supported by the state general fund. The non-federal share of supplemental/enhanced payments is estimated at $87.1 million.

***<u>Response 4.19-B</u>**: Funding for all hospital payments detailed below must be appropriated by the state legislature before expenditures can be incurred. The funding sources supporting appropriations for specific payments are broken out below.*

Regular Outpatient Hospital Payments- Regular outpatient hospital payments made under section 4.19-B are estimated to be $104.8 million for fiscal year 2021. These payments are supported by state general fund. State funding for these payments is estimated at $12.4 million for this time period.

Supplemental/Enhanced Payments- Hospital supplemental payments made under section 4.19-B for fiscal year 2021 are estimated to be $131.3 million. These payments consist of $130.8 million in Medicaid Access to Care Initiative (MACI) payments and $0.5 million in Rural Access Pool (RAP) payments. MACI payments are supported by a hospital provider tax. RAP payments are supported by the state general fund. The non-federal share of supplemental/enhanced payments is estimated at $27.6 million.

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.

   ***<u>Response 4.19-A</u>**: The Medicaid Access to Care Initiative (MACI) and Rural Access Pool (RAP) payments detailed in section 4.19-A are considered to be supplemental payments. Total supplemental inpatient payments made under section 4.19-A for fiscal year 2021 are approximately $398.8 million for MACI payments and $1.1 million for the RAP payments.*

   ***<u>Response 4.19-B</u>**: Medicaid Access to Care (MACI) and Rural Access Pool (RAP) hospital payments detailed in Attachment 4.19-B are considered to be supplemental payments. Total supplemental payments made under Attachment 4.19-B for fiscal year 2021 are approximately $130.8 million for MACI payments and $0.5 million for the RAP payments.*

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: The answer to this question is provided in the State's response to the CMS formal UPL reporting requirements. The State's UPL packet includes a final copy of its fiscal year 2023 upper payment limit demonstration and the accompanying completed fillable documents.

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 hospital providers' 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.

Public Notice

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration

Trauma Facility Rate Increase State Plan Amendment Request

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) to increase reimbursement to level I and level II designated trauma facilities in accordance with Public Act 119 of 2023. The anticipated effective date for the Trauma Facility Rate Increase SPA is October 1, 2023. The estimated gross cost to the State of Michigan for the SPA is $56.76 million per year.

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 September 30, 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: September 13, 2023

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

September 28, 2023

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Trauma Facility Rate Increase

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 a State Plan Amendment (SPA) request to the Centers for Medicare & Medicaid Services (CMS).

Upon CMS approval, MDHHS will increase reimbursement to level I and level II designated trauma facilities in accordance with Public Act 119 of 2023. MDHHS expects this change to positively impact Native American beneficiaries by maintaining access to trauma facilities. The anticipated effective date of this SPA is October 1, 2023.

There is no public hearing scheduled for this SPA. Input regarding this SPA 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 November 13, 2023.**

In addition, MDHHS is offering to set up group or individual consultation meetings to discuss the SPA, 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,

Meghan E. Groen, Director
Behavioral and Physical Health and Aging Services Administration

CC: Keri Toback, 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 23-53
September 28, 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. Phyllis Davis, Tribal Council Member, Match-E-Be-Nash-She-Wish Potawatomi
Ms. Mariah Austin, Tribal Council Member, 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: Keri Toback, 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