

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER <u>25</u> — <u>0016</u>	2. STATE <u>MI</u>
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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
December 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 \$174,000
b. FFY 2027 \$174,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A, Page 36
Attachment 4.19-B, Page 23

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
Attachment 4.19-A, Page 36 (TN# 20-0001)
Attachment 4.19-B, Page 23 (TN# 20-0001)

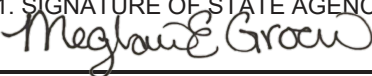
9. SUBJECT OF AMENDMENT

The purpose of this SPA is to update the eligibility criteria of the Rural Access Pool.

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


11. TYPED NAME
Meghan Groen

12. TITLE
Chief Deputy Director

13. DATE SUBMITTED
November 25, 2025

15. RETURN TO
Health Services Administration— 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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)***

Rural Access Pool

The State will establish a Rural Access Pool beginning in State FY 2013 for hospitals that provide Medicaid services to low income rural residents. Effective State FY 2021, eligibility for the rural access pool is limited to non-critical access hospitals. To be eligible for this pool, hospitals must be categorized by the Centers for Medicare & Medicaid Services as a sole community hospital, or meet both of the following criteria.

1. A hospital must have 50 or fewer staffed beds. The State will calculate staffed beds by dividing the total hospital days reported by the hospital on its Medicaid cost report with a fiscal year ending between October 1, 2010 and September 30, 2011, by the number of days covered in the cost report; and
2. A hospital must be located in a county with a population of not more than ~~165,000~~ 195,000 and within a city, village, or township with a population of not more than ~~12,000~~ 15,000. The population threshold will be measured against population counts from the ~~2000~~ 2020 federal decennial census.

Each hospital's allocation from this pool will be calculated as the unreimbursed cost the hospital incurred providing inpatient services to Michigan Medicaid beneficiaries during its cost period that ended during the second previous fiscal year. For example, to calculate the 2013 pool, hospital cost reports with fiscal years ending between October 1, 2010 and September 30, 2011 will be used.

Provider costs will be determined using data reported on the following lines of the CMS 2552-96 or their equivalent lines on the CMS 2552-10. Inpatient costs are obtained from Worksheet D-1, Part II, Title XIX, Line 49. The following gross Medicaid payments from this cost report period will be applied against cost to determine unreimbursed cost: operating, capital, graduate medical education, executive order reductions, and Medicaid access to care initiative, or any other supplemental payment.

Payments will be made within 45 days of the beginning of each quarter. The quarterly payments will be made in four equal installments based on the total annual amount the hospital is eligible to receive.

The total amount of the rural access pool payments is the sum of each hospital's allocation from this pool described above.

In the aggregate, the State reimburses hospitals up to maximum allowable under the Federal upper payment limits for inpatient services provided to Medicaid beneficiaries. To keep total Medicaid fee-for-service payments to hospitals within the Federal upper payment limits, the State will reduce the size of the applicable year's MACI Pool payments by the size of the Rural Access Pool.

TN NO.: 25-0016

Approval Date: _____

Effective Date: 12/01/2025

Supersedes
TN No.: 20-0001

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates (Other than Inpatient Hospital and Long Term Care Facilities)

Rural Access Pool

The State will establish a Rural Access Pool beginning in State FY 2013 for hospitals that provide Medicaid services to low income rural residents. Effective State FY 2021, eligibility for the rural access pool is limited to non-critical access hospitals. To be eligible for this pool, hospitals must be categorized by the Centers for Medicare & Medicaid Services as a sole community hospital, or meet both of the following criteria.

1. A hospital must have 50 or fewer staffed beds. The State will calculate staffed beds by dividing the total hospital days reported by the hospital on its Medicaid cost report with a fiscal year ending between October 1, 2010 and September 30, 2011, by the number of days covered in the cost report; and
2. A hospital must be located in a county with a population of not more than ~~165,000~~ 195,000 and within a city, village, or township with a population of not more than ~~12,000~~ 15,000. The population threshold will be measured against population counts from the ~~2000~~ 2020 federal decennial census.

Each hospital's allocation from this pool will be calculated as the unreimbursed cost the hospital incurred providing outpatient services to Michigan Medicaid beneficiaries during its cost period that ended during the second previous fiscal year. For example, to calculate the 2013 pool, hospital cost reports with fiscal years ending between October 1, 2010 and September 30, 2011 will be used.

Provider costs will be determined using data reported on the following lines of the CMS 2552-96 or their equivalent lines on the CMS 2552-10: GME costs are determined. First, Total Medicaid Outpatient Program Charges (reported on Worksheet D, Part V, Column 5, Lines 37.00 through 65.99, excluding Lines 63.50 through 63.99 of the CMS 2552-96) are divided by Total Hospital Charges Net of Hospital Based Physicians, for all provider types (reported on Worksheet G2, Column 1, Lines 1, 2, 10-14, 17, and 18 of the CMS 2552-96). This ratio is then multiplied by the Intern and Resident Cost (reported on the Worksheet B, Part 1, Columns 22 and 23, Line 95 of the CMS 2552-96) to determine GME costs. Non-GME costs are obtained from Worksheet D, Part V, Column 9, Lines 37.00 through 65.99, excluding lines 63.50 through 63.99. GME and Non-GME costs are combined to determine total costs. The following gross Medicaid payments from this cost report period will be applied against cost to determine unreimbursed cost: operating, capital, graduate medical education, and Medicaid Access to Care Initiative, or any other supplemental payment.

Payments will be made within 45 days of the beginning of each quarter. The quarterly payments will be made in four equal installments based on the total annual amount the hospital is eligible to receive.

The total amount of the rural access pool payments is the sum of each hospital's allocation from this pool described above.

In the aggregate, the State reimburses hospitals up to maximum allowable under the Federal upper payment limits for outpatient services provided to Medicaid beneficiaries. To keep total Medicaid fee-for-service payments to hospitals within the Federal upper payment limits, the State will reduce the size of the applicable year's MACI Pool payments by the size of the Rural Access Pool.

TN NO.: 25-0016

Approval Date: _____

Effective Date: 12/01/2025

Supersedes

TN No.: 20-0001

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 \$294.6 million for fiscal year 2023. State funding for these payments is estimated at \$62.3 million for this time period.*

Per Diem Payments – *Hospital per diem payments made under section 4.19-A are estimated to be \$5.0 million for fiscal year 2023. State funding for these payments is estimated at \$0.6 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 2023. State funding for these payments is estimated at \$15.5 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 2023. 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 \$52.1 million for fiscal year 2023. State funding for these payments is estimated at \$20.5 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 \$490.5 million for fiscal year 2023. The total non-federal share of hospital DSH payments was approximately \$142.6 million for this time period. There are four components to the non-federal share of the payments:*

- 1. Approximately \$60.3 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 \$27.5 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 \$53.8 million was funded through a hospital provider tax to support the Outpatient Uncompensated Care DSH Pool.

Supplemental/Enhanced Payments – Hospital supplemental payments made under section 4.19-A are estimated to be \$398.6 million for fiscal year 2023. These payments consist of \$397.9 million in Medicaid Access to Care Initiative (MACI) payments and \$.7 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 \$89.8 million.

Response 4.19-B: 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 \$100.9 million for fiscal year 2023. These payments are supported by state general fund. State funding for these payments is estimated at \$22.7 million for this time period.

Supplemental/Enhanced Payments- Hospital supplemental payments made under section 4.19-B for fiscal year 2023 are estimated to be \$109.0 million. These payments consist of \$108.2 million in Medicaid Access to Care Initiative (MACI) payments and \$0.8 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 \$24.6 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.

Response 4.19-A: 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 2023 are approximately \$397.9 million for MACI payments and \$0.7 million for the RAP payments.

Response 4.19-B: 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 2023 are approximately \$108.2 million for MACI payments and \$0.8 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 2025 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 Health Services

Rural Access Pool Eligibility 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 update the eligibility criteria of the Rural Access Pool. The effective date for the Rural Access Pool SPA is on or after December 1, 2025. The estimated gross cost to the State of Michigan for the SPA is budget neutral.

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/ Health Services Administration, Program Policy Division, PO Box 30479, Lansing MI 48909-7979 by November 26, 2025. A copy of the proposed SPA will also be available for review at:

<https://www.michigan.gov/mdhhs/inside-mdhhs/budgetfinance/264/state-plan-amendments>.

RELEASED: October 27, 2025



STATE OF MICHIGAN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

November 3, 2025

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Rural Access Pool Eligibility

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).

Pending CMS approval, MDHHS will update the eligibility criteria of the Rural Access Pool. MDHHS expects that tribal members will benefit by the support for rural hospitals as a result of this change. The effective date of this SPA is on or after December 1, 2025.

Due to the timing of the guidance received, it is not possible to adhere to the sixty (60) days notification. Therefore, notification is being provided as soon as possible. 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 December 18, 2025.**

In addition, MDHHS is offering to set up group or individual consultation meetings to discuss the SPA, according to the tribe's 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.

L 25-63
November 3, 2025
Page 2

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

Sincerely,

A handwritten signature in black ink that reads "Meghan E. Groen". The signature is written in a cursive style with a large initial "M" and "G".

Meghan E. Groen, Chief Deputy Director
Health Services

CC: Keri Toback, CMS
Nancy Grano, CMS
Chasity Dial, CEO, American Indian Health and Family Services of Southeastern
Michigan
Chris Poole, Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS

**Distribution List for L 25-63
November 3, 2025**

Ms. Whitney Gravelle, President, Bay Mills Indian Community
Ms. Lucy DeWildt, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Ms. Sandra Witherspoon, Chairperson, Grand Traverse Band Ottawa & Chippewa Indians
Ms. Sonya Zotigh, Health Director, Grand Traverse Band Ottawa/Chippewa
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Mr. RD Curtis, 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
Dr. Daryl Wever, Health Director, Little River Band of Ottawa Indians
Ms. Winnay Wemigwase, Tribal Chairperson, Little Traverse Bay Band of Odawa Indians
Ms. Jodi Werner, Health Director, Little Traverse Bay Band of Odawa Indians
Dr. Frank Animikwam, Medical Director, Little Traverse Bay Band of Odawa Indians
Mr. Bob Peters, Chairman, Match-E-Be-Nash-She-Wish Potawatomi Indians (Gun Lake Band)
Ms. Mallory Horwath, Interim Tribal Council Member, Match-E-Be-Nash-She-Wish Potawatomi
Ms. Dorie Rios, Tribal Chairperson, Nottawaseppi Huron Band of Potawatomi Indians
Ms. Daun Bieda, Interim Health Director, Nottawaseppi Band of Potawatomi Indians
Ms. Nichol Bremer, Nottawaseppi Huron Band of Potawatomi Indians - Tribal Health Department
Mr. Andrew Straatsma, Nottawaseppi Huron Band of Potawatomi Indians – Tribal Health Department
Mr. Matthew Wesaw, Tribal Chairman, Pokagon Band of Potawatomi Indians
Ms. Priscilla Gatties, Interim Health Director, Pokagon Potawatomi Health Services
Mr. Tim Davis, 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. James Benko, 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
Chris Poole, Director, Indian Health Service - Bemidji Area Office
Lorna Elliott-Egan, MDHHS