

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

1. TRANSMITTAL NUMBER <u>22</u> — <u>0013</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
October 1, 2021

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 \$0
b. FFY 2023 \$42,230,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

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

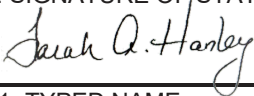
10. GOVERNOR'S REVIEW (Check One)

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
Farah Hanley

12. TITLE
Chief Deputy for Health

13. DATE SUBMITTED
October 6, 2022

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
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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

Section 7 – General Provisions

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

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

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

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

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

Request for Waivers under Section 1135

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

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

State/Territory: Michigan

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

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

Section A – Eligibility

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

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

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

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

Income standard: _____

-or-

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

Income standard: _____

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

Less restrictive income methodologies:

State/Territory: Michigan

Less restrictive resource methodologies:

4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).
5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

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

Section B – Enrollment

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

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

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

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

State/Territory: Michigan

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

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

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

Section C – Premiums and Cost Sharing

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

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

Please list the applicable eligibility groups or populations.

State/Territory: Michigan

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

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

Section D – Benefits

Benefits:

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

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

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

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

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

Please describe.

State/Territory: Michigan

Telehealth:

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

Please describe.

Drug Benefit:

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

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

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

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

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

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

Section E – Payments

Optional benefits described in Section D:

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

- a. ____ Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

TN: 22-0013

Supersedes TN: 21-0015

Approval Date: _____

Effective Date: 10/01/2021

State/Territory: Michigan

b. ___ Other:

Describe methodology here.

Increases to state plan payment methodologies:

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

Please describe criteria.

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

Please describe criteria.

b. Payments are increased through:

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

Please describe.

ii. ___ An increase to rates as described below.

Rates are increased:

___ Uniformly by the following percentage: _____

___ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

___ Up to the Medicare payments for equivalent services.

___ By the following factors:

Please describe.

TN: 22-0013

Supersedes TN: 21-0015

Approval Date: _____

Effective Date: 10/01/2021

State/Territory: Michigan

Payment for services delivered via telehealth:

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

Describe telehealth payment variation.

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

Other:

4. Other payment changes:

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

Interim Prospective Rate

MDHHS will calculate the FY22 interim Variable Cost Component by taking the Nursing Facility's previously calculated FY21 Variable Cost Component and increasing it by 2.5%. MDHHS will calculate the FY23 interim Variable Cost Component by taking the Nursing Facility's previously calculated FY22 interim Variable Cost Component and increasing it by 2.5%

MDHHS will calculate the FY22 interim Plant Cost Component by taking the Nursing Facility's previously calculated FY21 Plant Cost Component and increasing it by 2.5%. MDHHS will calculate the FY23 interim Plant Cost Component by taking the Nursing Facility's previously calculated FY22 interim Plant Cost Component and increasing it by 2.5%.

Final Audited Rate

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

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

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

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

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

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

Section F – Post-Eligibility Treatment of Income

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

- a. ___ The individual’s total income
- b. ___ 300 percent of the SSI federal benefit rate
- c. ___ Other reasonable amount: _____

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

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

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

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

State/Territory: Michigan

PRA Disclosure Statement

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

TN: 22-0013
Supersedes TN: 21-0015

Approval Date: _____
Effective Date: 10/01/2021

Michigan Medicaid Nursing Facility Upper Payment Limit Non-Federal Funding Questions – 10/1/2021

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 \$1,839.6 million for fiscal year 2020. The non-federal share for these payments is approximately \$577.5 million and is financed with state funding of \$391.3 million, local funding of \$6.1 million, and \$180.1 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 \$337 million for fiscal year 2020. The non-federal share for these payments is \$105.8 million and is funded with nursing facility provider tax.

CPE Payments – Approximately \$4.4 million was funded through certified public expenditures (CPEs) in FY20. 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 \$337 million for fiscal year 2020. The non-federal share for these payments is \$105.8 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 \$14 million was made to County Medical Care Facilities in FY20. The non-federal share of \$4.4 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.*