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State/Territory Name: Michigan

State Plan Amendment (SPA) #: MI 23-0026

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

November 17, 2023

Meghan Groen
Senior Deputy Director
State of Michigan, Department of Community Health
400 South Pine Street
Lansing, Michigan 48933

RE: Michigan State Plan Amendment (SPA) 23-0026

Dear Senior Deputy Director Groen:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 23-0026 effective for services on or after October 1, 2023. This SPA provides authority to increase reimbursement to level I and level II designated trauma facilities.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 23-0026 is approved effective October 1, 2023. We are enclosing the CMS-179 and the amended plan pages.

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 — 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTIONOR ATTACHMENT *(If Applicable)*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
October 23, 2023

17. DATE APPROVED
November 17, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

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 FACILITIES.
- 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$_n$)