

## **Table of Contents**

**State/Territory Name: MI**

**State Plan Amendment (SPA) #: 09-018**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

**Center for Medicaid and State Operations (CMSO)**

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Stephen Fitton, Director  
Medical Services Administration  
Department of Community Health  
400 South Pine  
Lansing, MI 48933

MAR 15 2010

RE: Michigan State Plan Amendment (SPA) 09-18

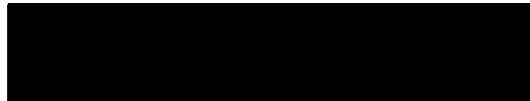
Dear Mr. Fitton:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-18. Effective for services on or after October 1, 2009, this amendment makes grammatical revisions to reimbursement methodology for special facilities for ventilator-dependent patients and facilities with specially placed patients transferred from an acute care hospital setting to an approved NF on a prior authorized basis.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-18 is approved effective October 1, 2009. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Todd McMillion at (608) 441-5344.

Sincerely,



*J* Cindy Mann  
Director  
Center for Medicaid and State Operations

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**  
FOR: HEALTH CARE FINANCING ADMINISTRATION

|  |                       |
|--|-----------------------|
| 1. TRANSMITTAL NUMBER:<br>09 - 18  | 2. STATE:<br>Michigan |
| 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) |                       |
| 4. PROPOSED EFFECTIVE DATE<br>October 1, 2009                              |                       |

TO: REGIONAL ADMINISTRATOR  
HEALTH FINANCING ADMINISTRATION  
DEPARTMENT OF HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

|   |  |
|---|--|
| 6. FEDERAL STATUTE/REGULATION CITATION:<br>42 CFR 447.253                                   | 7. FEDERAL BUDGET IMPACT:<br>a. FFY 10 _____ \$ -0-<br>b. FFY 11 _____ \$ -0-  |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>Attachment 4.19-D, Section IV, page 22 | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):<br>Attachment 4.19-D, Section IV, page 22 |

10. SUBJECT OF AMENDMENT:  
NF complex care - rate determination conditions

11. 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:  
Stephen Fitton, Director  
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:  
Stephen Fitton

14. TITLE:  
Director, Medical Services Administration

15. DATE SUBMITTED:  
December 23, 2009

16. RETURN TO:  
Medical Services Administration  
Program/Eligibility Policy Division - Federal Liaison Unit  
Capitol Commons Center - 7<sup>th</sup> Floor  
400 South Pine  
Lansing, Michigan 48933  
Attn: Nancy Bishop

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: \_\_\_\_\_

18. DATE APPROVED:  
3-15-10

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
OCT - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPE NAME:  
William Lasowski

22. TITLE:  
Deputy Director, CMSO

23. REMARKS:

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of MICHIGAN

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

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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. Beginning October 1, 2003, 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). 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. The QAS is equal to 21.76% of the Class I variable cost limit.

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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TN NO.: 09-18

Approval Date: **MAR 1 5 2010**

Effective Date: 10/01/2009

Supersedes  
TN No.: 05-11