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State/Territory Name: MI

State Plan Amendment (SPA) #: 10-017

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-13-15
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification (CMCS)

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

DEC 17 2010

RE: Michigan State Plan Amendment (SPA) 10-17

Dear Mr. Fitton:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 10-17. Effective for services on or after September 24, 2010, this amendment revises the methodology for making supplemental payments to nursing facilities under the Quality Assurance Assessment Program (QAAP).

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 hereby inform you that Medicaid State plan amendment 10-17 is approved effective September 24, 2010. 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,

[redacted]

Cindy Mann,
Director (CMCS)

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 10 - 17

2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 24, 2010

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:
42 CFR 447, Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 10 $ (613,253.59)
b. FFY 11 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Section IV, Page 20a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Section IV, Page 20a

10. SUBJECT OF AMENDMENT:
Quality Assurance Supplement payment reconciliation

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. SIGNATUE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Stephen Fitton

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
September 28, 2010

16. RETURN TO:

Medical Services Administration
Program/Eligibility Policy Division - Federal Liaison Unit
Capitol Commons Center - 7th Floor
400 South Pine
Lansing, Michigan 48933

Attn: Nancy Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18 DATE APPROVED:
12-17-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
SEP 24 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPE NAME:
William Lasowski

22. TITLE:
Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179(07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

C. Variable Cost Component

5. Special Provisions:

a. New Facility (continued):

facility that does not have a Medicaid historical cost basis, will be paid in accordance with Section c. below.

b. Change of Class: An existing enrolled nursing facility which becomes a Class I or III facility, will be paid in accordance with Section c. below.

c. Payment Determination:

1) During the first two cost reporting periods, rates for providers defined in Sections a. and b. above will be calculated using a variable rate base equal to the class average of variable costs.
2) In subsequent periods the provider's variable rate base will be determined using methods in Section IV.C.1. through IV.C.3. above.

6. Effective September ~~15, 2008~~, **24, 2010**, Class I, and Class III nursing facilities receive a monthly payment as part of the 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) percentage. A facility's Medicaid utilization is the sum of all routine nursing care and therapeutic leave days billed to Medicaid by that facility during a twelve month period beginning in June of the previous calendar year. The hospice reimbursement for nursing facility bed days where Medicaid pays room and board for hospice residents in nursing facilities include the QAS amount. Hospice is responsible for reimbursing nursing facilities for room and board consistent with their contract. Between September ~~15~~ **24, ~~2008~~ 2010** and September 30, ~~2008~~ **2010** the QAS is equal to ~~19.86~~ **21.11**% of the lesser of the facility's variable rate base or the class variable cost limit except for publicly owned facilities, in which the QAS percentage is applied to the lesser of the public Class III variable cost component or the Class I variable cost limit. The nursing facility's current fiscal year rate is based on the facility's cost report for the second fiscal year prior to the current fiscal year. After October 1, ~~2008~~ **2010** and from that date onward, the QAS percentage will be 21.76%.