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State/Territory Name: Michigan

State Plan Amendment (SPA) #: MI 14-0015

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

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

APR 27 2015

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

RE: Michigan State Plan Amendment (SPA) 14-0015

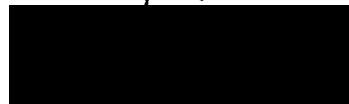
Dear Mr. Fitton:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 14-0015. Effective for services on or after November 1, 2014, this amendment adds a new criterion for Class I nursing facility rate relief eligibility that would allow nursing facilities with a variable rate base of less than or equal to 60% of the corresponding years variable cost limits to apply.

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 14-0015 is approved effective November 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,



Timothy Hill
Director

A handwritten signature in black ink, appearing to be "T. Hill", is written over the printed name and title.

Enclosure

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 14 - 015	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 November 1, 2014	

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 447.252	7. FEDERAL BUDGET IMPACT: a. FFY 2015 _____ \$ 1,842,967 b. FFY 2016 _____ \$ 1,884,430
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, Section IV, Pages 18, 19 and 20	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D, Section IV, Pages 18, 19 and 20
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10. SUBJECT OF AMENDMENT:

This amendment adds a new criterion for Class I Nursing Facility rate relief eligibility that would allow Nursing Facilities with a Variable Rate Base of less than or equal to 60% of the corresponding year's Variable Cost Limit to apply.

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT
 OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 Stephen Fitton, Director
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
 Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:


13. TYPE NAME:
Stephen Fitton

14. TITLE:
Director, Medical Services Administration


15. DATE SUBMITTED:
October 22, 2014

16. RETURN TO:

Medical Services Administration
Actuarial Division
Capitol Commons Center - 7th Floor
400 South Pine Street
Lansing, Michigan 48933

Attn: Loni Hackney

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED:	18. DATE APPROVED: APR 27 2015

PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: NOV 11 2014	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPE NAME: Kristen FAN	22. TITLE: Deputy Director, FMG

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- 4) The provider must also meet at least one of the following five SIX criteria:
- a) The sum of the provider's Variable Rate Base, Economic Inflation Update and other associated rate add-ons (excluding Nurse Aide Training and Testing reimbursement), plus the net Quality Assurance Supplement, must be less than the provider's audited Medicaid variable cost per resident day for the provider's two fiscal cost reporting periods of not less than seven months immediately prior to the first period of rate relief. Costs for Nurse Aide Training and Testing are not included in the Medicaid variable costs. To demonstrate this difference, the provider must submit an analysis comparing their variable costs incurred and variable costs reimbursed for the two years previous to the year for which rate relief is requested.
 - b) The provider is required, as a result of a survey by the State Survey Agency (SSA), or federal regulatory agency, to correct one or more substandard quality of care deficiencies to attain or sustain compliance with Medicaid certification requirements. The survey must have occurred within six months prior to the provider's request for rate relief. The provider must submit a copy of the citation and an approved Plan of Correction outlining the action being taken by the provider to address the deficiencies. A copy of facility staffing levels before and after the survey citation must be provided to demonstrate the staffing increase is sustained and is not for short term training purposes only; or
 - c) The facility has a significant change in the level of care needed for current Medicaid residents. A significant charge is defined as an increase of at least 10 minutes of nursing care per patient resident per day as demonstrated by Minimum Data Set (MDS) data, which results in a corresponding increase in direct care staffing equal to or greater than the increase in patient minutes per day. The provider must submit an analysis comparing resident acuity levels from the rate base year to current resident acuity levels. The Minimum Data Set (MDS) data must be used for this comparison. This data will be subject to a clinical review by DCH clinical staff. The analysis must also include a comparison of the previous and current nursing staffing levels required based on actual residential census or actual patient days and other nursing related costs or requirements likely to increase the operational costs. This does not include nursing administration staff; or
 - d) The provider is new in a Medicaid Enrolled facility and the facility's most recent cost report submitted to DCH was incomplete, undocumented or had unsubstantiated cost data by the previous provider. Inadequate cost reporting would include non-payment of accrued liabilities due to the previous provider's bankruptcy as determined by Medicaid auditors in accord with Medicaid allowable costs, or inadequate records to support the filed cost report. Proof of the change of ownership must be submitted along with an explanation of why the cost report data is inadequate to calculate the provider's reimbursement rate; or

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- e) Rate relief is needed because the facility will be closed due to a regulatory action by the State Survey Agency (SSA) or federal regulatory agency where the facility's closure will result in severe hardship for its residents and their families due to the distance to other nursing facilities, and no new provider will operate the facility at its current reimbursement rate. A facility would meet this hardship criteria only if a new owner has agreed to take over its operation and if it is either the only nursing facility in the county or, the closing facility has at least sixty-five percent of the Medicaid nursing facility (Class I, III and V) certified beds in that county; OR,
- F) THE PROVIDER'S CURRENT VARIABLE RATE BASE IS LESS THAN OR EQUAL TO 60 PERCENT OF THE CORRESPONDING RATE YEAR'S VARIABLE COST LIMIT. A FACILITY IS NOT ELIGIBLE UNDER THIS CRITERION IF AN OWNER OR ADMINISTRATOR'S COMPENSATION IS ABOVE THE CURRENT COMPENSATION LIMIT. A PROVIDER WITH NON-ALLOWABLE RELATED PARTY TRANSACTION COSTS OR NON-ALLOWABLE RELATED PARTY LEASE COSTS CANNOT BE ELIGIBLE UNDER THIS CRITERION.

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C. Variable Cost Component

4. Nursing Facility Class 1 Rate Relief

- b. Levels of Rate Relief – New providers who meet the criteria above and have a Variable Rate base less than or equal to 80% of the Class Average Variable Cost may apply for NF Class 1 Rate Relief. A new rate will be calculated using the Class I average variable cost for the appropriate year as the variable rate base for the calculation of the facility variable cost component. This variable rate base will be in effect through the current State fiscal year rate period ending September 30.

Current providers and new providers with a variable rate base between 80 – 100% of the class average variable costs and who meet the criteria outlined above may request accelerated rebasing, which is the use of the Medicaid cost report data from the period ending in the current calendar year in the rate setting process, rather than using cost report data from the period ending in the previous calendar year under the standard reimbursement methodology. The nursing facility's allowable variable cost will be indexed to October 1 of the year that is one year prior to the rate year being calculated, by applying the appropriate Cost Index.

CURRENT PROVIDERS WITH A VARIABLE RATE BASE LESS THAN OR EQUAL TO 60% OF THE CLASS I VARIABLE COST LIMIT AND WHO MEET THE CRITERIA OUTLINED ABOVE MAY APPLY FOR NF CLASS I RATE RELIEF. A NEW RATE WILL BE CALCULATED USING UP TO 50% OF THE DIFFERENCE BETWEEN THE CLASS I AVERAGE VARIABLE COST AND THE FACILITY'S VARIABLE RATE BASE FOR THE APPROPRIATE YEAR. THE NEW RATE WILL SERVE AS THE VARIABLE RATE BASE FOR THE CALCULATION OF THE FACILITY VARIABLE COST COMPONENT. THIS VARIABLE RATE BASE WILL BE IN EFFECT THROUGH THE CURRENT STATE FISCAL YEAR RATE PERIOD ENDING SEPTEMBER 30. EFFECTIVE OCTOBER 1 OF THE FOLLOWING STATE FISCAL YEAR RATE PERIOD, THE VARIABLE RATE BASE IS DETERMINED USING ACCELERATED REBASING. THE ACCELERATED REBASING UTILIZES THE MEDICAID COST REPORT DATA FROM THE PERIOD ENDING IN THE CURRENT CALENDAR YEAR IN THE RATE SETTING PROCESS. THE NURSING FACILITY ALLOWABLE VARIABLE COST IS INDEXED TO OCTOBER 1 OF THE YEAR THAT IS ONE YEAR PRIOR TO THE NEW RATE YEAR BEING CALCULATED BY APPLYING THE APPROPRIATE COST INDEX.

No retroactive rate relief will be approved. Providers may apply and receive rate relief under this policy once every 7 years (84 months). This seven-year period begins on the effective date of rate relief. The rate relief period will be based on the facility, and not the owner or licensee.

The NF Class I Rate Relief agreement may be withdrawn by the State if the facility is cited by the state or federal regulatory agency for serious certification violations while

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receiving rate relief. Such citations would be for serious and immediate threat or substandard quality of care.

5. Special Provisions: The variable cost component will be determined using special methods for providers that are "new facilities" or have changed class. Special methods are required because there is no (or an inadequate) cost basis upon which to determine rates. Providers with newly purchased facilities or with major additions, renovations or new construction are not granted any special methods because there are historical variable costs upon which to base rates.
 - a. New Facility: A "new facility" which is defined as a long term care provider in a

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