The Michigan Medicaid State Plan is an agreement between the State of Michigan and the federal government which identifies the general health care services, reimbursement of those services and the beneficiary and provider eligibility policies in effect under Michigan’s Medicaid program.

The Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services is the federal agency with oversight responsibility of the Medicaid Program. All parts, including updates or changes to the Plan, must be approved by CMS in order to become effective. Federal regulations detailing the State Plan purpose and maintenance procedures may be found at 42 CFR 430 Subpart B.

The State Plan posted here is available for information purposes only; it does not replace the official version and does not contain any pending amendment information or amendments approved since October 1, 2018.

Amendments pending approval or approved since October 1, 2018 may be found at:


http://www.michigan.gov/mdhhs/0,1607,7-132-2946_5080-108153--,00.html

Questions regarding the State Plan may be e-mailed to:

MSAPolicy@michigan.gov

The following table identifies the sections of the State Plan and a brief overview of each.

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<th>Section</th>
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<td>1</td>
<td>Single State Agency Organization</td>
<td>Provides information regarding the State’s designation of the Michigan Medicaid Single State Agency, the authority under which it operates and a description of the organization.</td>
</tr>
<tr>
<td>2</td>
<td>Coverage &amp; Eligibility</td>
<td>Outlines Michigan Medicaid’s eligibility conditions such as income, resources, assets and the various groups (i.e. aged, blind, disabled and family independence program)</td>
</tr>
<tr>
<td>3</td>
<td>Amount, Duration and Scope of Services Provided</td>
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</tr>
<tr>
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<td>provides assurances the State is in compliance with Federal Regulations regarding personnel administration standards and training.</td>
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<tr>
<td>6</td>
<td>Financial Administration</td>
<td>provides assurances the State is in compliance with Federal Regulations regarding fiscal policies and accountability, cost allocation and financial participation.</td>
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<tr>
<td>7</td>
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STATE PLAN UNDER TITLE XIX
OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

HCFA-AT-80-38 (BPP)
May 22, 1980
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*Forms Provided

TN No.: 03-13 Approval Date: 12/9/2003 Effective Date: 08/13/2003

Supersedes
TN No.: 92-01

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**2.6-A** Eligibility Conditions and Requirements *(Territories only)*

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: MICHIGAN

Citation
42 CFR 430.10

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
(Single State Agency)

submits the following State Plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

TN No. 96-0717 Approval Date 9-23-96 Effective Date 04/01/96
Supersedes
TN No. 92-01

HCFA ID: 7982E

Revision: HCFA-PM-91-4 OMB No. 0938-
August 1991
State: MICHIGAN

SECTION 1  SINGLE STATE AGENCY ORGANIZATION

Citation: 42 CFR 431.10
           AT-79-29

1.1  Designation and Authority

(a) The MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

TN No. 96-010  Approval Date 9-22-96  Effective Date 04/01/96

Supersedes

TN No. 74-48
Revision: HCFA-XT-30-38 (BPP)
May 22, 1980

State MICHIGAN

Citation Sec. 1302 (a) of the Act
1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

☐ Yes. The State agency so designated is

________________________________________

This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

☐X Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

74-48
Supersedes Approval Date 4/26/76 Effective Date 1/01/74
TN #
Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: MICHIGAN

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<th>1.1(c)</th>
<th>Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.</th>
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<td>Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.</td>
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<td></td>
<td></td>
<td>Not applicable. Waivers are no longer in effect.</td>
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<tr>
<td></td>
<td></td>
<td>Not applicable. No waivers have ever been granted.</td>
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| TN # 74-48 | Supervenes Approval Date 4/26/76 Effective Date 1/01/74 |

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan.

Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.
All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act. All other requirements of 42 CFR 431.10 are met.
1.2 Organization for Administration

(a) Attachment 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the Health Programs Administration has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) Attachment 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). Attachment 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.
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<th>1.3 Statewide Operation</th>
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<td>The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.</td>
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<tr>
<td>AT-79-29</td>
<td>☑️ The plan is State administered.</td>
</tr>
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<td></td>
<td>☐ The plan is administered by the political subdivisions of the State and is mandatory on them.</td>
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Supersedes Approval Date **3/27/75** Effective Date **10/01/74**

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STATE MEDICAL CARE ADVISORY COMMITTEE

There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

Tribal consultation requirements

Section 1902(a)(73) of the Social Security Act (the Act) requires a state in which one or more Indian health programs or urban Indian organizations furnish health care services to establish a process for the state Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), tribes or tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or urban Indian organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(i) of the Act was also amended to apply these requirements to the Children’s Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and urban Indian organizations.

The Tribal Liaison is to be informed of all proposed state plan amendments, proposals for demonstration projects, waiver requests, renewals, extensions or amendments that may have a direct impact on services provided for Native Americans, Indian health programs or urban Indian organizations. This would apply to any changes that are more restrictive for eligibility determinations, changes that reduce payment rates or changes in payment methodologies to providers, reimbursement to providers, or reductions in covered services.

The Tribal Chairperson, Tribal Health Directors, Urban Indian Health Director, and Indian Health Services Representative will receive written notification from the tribal liaison of all proposed state plan amendments, proposals for demonstration projects, waiver requests, renewals, extensions or amendments that may have a direct or adverse effect on Native Americans, Indian health programs or urban Indian organizations.

The notice will be sent sixty (60) days prior to the submission date and provide a brief synopsis of the proposal and impact on the Native American beneficiaries, tribal health clinics and urban Indian organizations. In situations where it is not possible to adhere to the sixty (60) days notification, the tribes will be notified as soon as possible. The procedures and timeline for submitting comments on the proposed changes will also be addressed in the notice. Additional information for a proposal will be provided by the liaison upon request. A cover letter is included in the correspondence encouraging input regarding the proposed changes through in person consultation or by telephone conference depending on the tribe’s preference. A consultation meeting is set up either as a group or individually, again according to the tribe’s preference. During the consultation, concerns are addressed and any suggestions, revisions, or objections voiced by the tribes are noted and relayed to the author of the proposal.
Occasionally, federal policy changes require immediate implementation. When this occurs, tribes are notified as soon as the tribal liaison is made aware of the proposed changes. Consultation is then held within twenty-one (21) days of notification.

Consultation with Tribal Chair representatives, Tribal Health Directors, and Indian Health Services representatives will be conducted at the quarterly Tribal Health Director meetings, or another venue at the request of the tribes. Consultation may be in person or by conference call.

The tribal liaison will acknowledge electronic mail or regular mail, all comments received during the consultation period.

All comments submitted by tribes will be forwarded by the tribal liaison to the Medicaid policy staff responsible for the proposed changes.

The tribal liaison will ensure that tribes commenting on proposed changes receive a response to their concerns arising from the proposed changes.

Tribes requesting changes to the proposed state plan amendment, waiver request, renewal, or amendment will receive confirmation from the tribal liaison regarding their request, and whether their comments have been included in the proposals submitted to cms. If the tribe’s comments are not included in the proposed changes when submitted to cms, it is the liaison’s responsibility to explain why their comments were not included.

Tribes will be informed by the liaison when CMS approves or denies state plan or waiver changes. The liaison will also be responsible for including the rationale for CMS denials.

The tribal liaison will be responsible for maintaining records of the notification process, consultation process, all written correspondence from tribes and tribal representatives, meeting notes, and all other discussions such as conference calls for all state plan or waiver changes that may impact the tribes. The tribal liaison will also document the outcome of the consultation process.

The SPA was sent to all of the tribes for review in March 2010. Consultation with the tribal health directors was held in April 2010 at the quarterly Tribal Health Directors meeting and discussed at length. The tribal health directors concurred that the proposed SPA language was acceptable with no objections or revisions.
Citation

1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.
Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

   ___ State Medicaid Agency
   X___ State Public Health Agency
SECTION 2 - COVERAGE AND ELIGIBILITY

Citation 2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.
Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.

For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.
The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.
2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

- Mandatory categorically needy and other required special groups only.
- Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.
- Mandatory categorically needy, other required special groups, and specified optional groups.
- Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(1)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.
2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.
2.4 Blindness

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.
All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.

We intend to make as allowed by Section 1902(v)(1) determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State Plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the SSA with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1614(a) of the SS Act.
## Citation(s)

42 CFR 435.10 and Subparts G & H 1902(a)(10)(A)(i)(III), (IV), (V), (VI), and (VII), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(C), 1902(f), 1902(l) and (m), 1905(p) and (s), 1902(r)(2), and 1920

## 2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.
Citation 2.7 Medicaid Furnished Out of State

431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.
3.1 Amount, Duration, and Scope of Services

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Not applicable. Nurse-midwives are not authorized to practice in this State.
19a

Revision: HCFA-PM-91-4 (BPD)  OMB No.: 0938-
AUGUST 1991

State/Territory: MICHIGAN

Citation 3.1(a)(l) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for; and received medical assistance on the day the pregnancy ends.

(iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10), clause (VII) of the matter following (E) of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(I)(IV) and 1902(a)(10)(A)(II)(IX) of the Act.

Supersedes Approval Date 4-11-92 Effective Date 10/01/91

TN No. 22-C, 90-11

HCFA ID: 7982E
**State/Territory:** MICHIGAN

<table>
<thead>
<tr>
<th>Citation</th>
<th>Amount, Duration, and Scope of Services: Categorically Needy (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1(a)(1)</td>
<td>(vi) Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.</td>
</tr>
<tr>
<td>1902(e)(7) of the Act</td>
<td>(vii) Inpatient services that are being furnished to infants and children described in section 1902(1)(L)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.</td>
</tr>
<tr>
<td>1902(e)(9) of the Act</td>
<td>(viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.</td>
</tr>
<tr>
<td>1902(a)(52) and 1925 of the Act</td>
<td>(ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.</td>
</tr>
<tr>
<td>1905(a)(23) and 1929</td>
<td>(x) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.</td>
</tr>
</tbody>
</table>

**ATTACHMENT 3.1-A** identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.
State of Michigan
PACE State Plan Amendment Pre-Print

Citation 3.1(a)(1) Amount, Duration and Scope of Services: Categorically Needy (continued)

1905(a)(26) and (xi) X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 2 to Attachment 3.1-A

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)
This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

(i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905 (a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

(ii) Prenatal care and delivery services for pregnant women.

Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.
Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

(iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, 440.160 Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act

(vii) Services in an institution for mental diseases for individuals over age 65.

(viii) Services in an intermediate care facility for the mentally retarded.

(ix) Inpatient psychiatric services for individuals under age 21.
Citation

1902(e)(9) of Act

1905(a)(23) and 1929 of the Act

3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

X (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

(xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.
Citation 3.1(a)(2)  

**Amount, Duration and Scope of Services: Medically Needy**  
(continued)

1905(a)(26) and 1934  

(xii) X  
Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 2 to Attachment 3.1-A

ATTACHMENT 3.1-B identifies services provided to the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)
3.1 Amount, Duration, and Scope of Services (continued)

(a)(3) Other Required Special Groups: Qualified Medicare Beneficiaries

Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.

(a)(4)(i) Other Required Special Groups: Qualified Disabled and Working Individuals

Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.

(ii) Other Required Special Groups: Specified Low-Income Medicare Beneficiaries

Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.

(iii) Other Required Special Groups: Qualifying Individuals - I

Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv) (I) and subject to 1953 of the Act are provided as indicated in item 3.2 of this plan.
Other Required Special Groups: Qualifying Individuals - I

The portion of the amount of increase to the Medicare Part B premium attributable to the Zone Health provisions for qualifying individuals described in 1972(A)(13)(B)(iv) (II) and subject to 1973 of the Act are provided as indicated in Item 3.1 of this plan.

1923 of the Act

Other Required special Groups: Families Receiving Expanded Medicaid Benefits

Expanded Medicaid benefits for families described in section 1925 of the Act are provided as indicated in Item 3.1 of this plan.

TV No. 92-01
Supersedes Approval Date 5/22/98 Effective Date 02/01/99
Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they—

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 505(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Revision: HCFA-PM-98-1 (CMSO)
APRIL 1998

State: Michigan

Citation
Sec 245A(h) or the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

Approval Date 5/22/98 Effective Date 4/1/98
Limited Coverage for Certain Aliens (continued)

(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.

Homeless Individuals

Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.

Presumptively Eligible Pregnant Women

Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.

EPSDT Services

The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic and treatment (EPSDT) services.
Citation 3.1(a)(9)  

Amount, Duration, and Scope of Services: EPSDT Services (continued)

The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

A monthly list is generated for managed care organizations listing their enrollees due or overdue for EPSDT (well child) visits during the subsequent month. At the same time, the Medicaid agency receives the same listings.

On a monthly basis managed care organizations and Clinic Plans report EPSDT visits provided, giving the children's Medicaid ID numbers and the date(s) of service.

The Medicaid agency can compare the number of children due or overdue for EPSDT visits with the number of such visits provided.

42 CFR 440.240 and 440.250

(a)(10) Comparability of Services

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

(iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.
Citation 3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

☐ Yes

☐ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

☐ Yes, to all

☐ Yes, to individuals age 21 or over; SNF services are provided

☐ Yes, to individuals under age 21; SNF services are provided

☐ No; SNF services are not provided

☐ Not applicable; the medically needy are not included under this plan

# 77-1
Supersedes Approval Date 3/03/77 Effective Date 3/31/77
Citation 3.1  Amount, Duration, and Scope of Services (continued)

42 CFR 431.53  (c)(1)  Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10  (c)(2)  Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).
State MICHIGAN

Citation
42 CFR 440.260
AT-78-90

3.1(d) Methods and Standards to assure Quality of Services

The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

TN # 74-44
Approval Date 3/27/75 Effective Date 10/01/74

Supercedes

Revision:  HCFA-AT-80-38 (BPP)
May 22, 1980

State: MICHIGAN

Citation  3.1(e) Family Planning Services
42 CFR 441.20
AT-78-90

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

TN #: 74-44
Supersedes
TN #________________________

Approval Date  3/27/75
Effective Date  10/01/74

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **MICHIGAN**

### Optometric Services

**Citation**
- 3.1(f)(1)
- 42 CFR 441.30
- AT-78-90

**Optometric Services**

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

- **YES**.

**10/01/74 (TN74-44)**

- **☐** No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.
- **☐** Not applicable. The conditions in the first sentence do not apply.

### Organ Transplant Procedures

**Citation**
- 1903(i)(1) of the Act, P.L. 99-272 (Section 9507)

**Organ Transplant Procedures**

- **☐** No.
- **☒** Yes. Similarly situated individuals are treated alike and any restrictions on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.
Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who—

1. Are medically dependent on a ventilator for life support at least six hours per day;

2. Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of—

   - 30 consecutive days;
   - ___ days (the maximum number of inpatient days allowed under the State plan);

3. Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

4. Have adequate social support services to be cared for at home; and

5. Wish to be cared for at home.

Yes. The requirements of section 1902(e)(9) of the Act are met.

Not applicable. These services are not included in the plan.
Community supported living arrangements services provided to developmentally disabled individuals in accordance with section 1930 of the Act.

_Yes._

_X_ No.

Attachment 3.1-F identifies the community supported living arrangements services provided.
3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

X Part A X Part B

The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.
Enclosure 3 continued

Revision: HCFA-PM-97-3 (CMSO)
December 1997
State: MICHIGAN

Citation

1902(a)(10)(E)(ii) and 1905(s) of the Act (ii) Qualified Disabled and Working Individual (QDWI)

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act (iii) Specified Low-Income Medicare Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act (iv) Qualifying Individual-1 (QI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.

1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(ii), and 1933 of the Act (v) Qualifying Individual-2 (QI-2)

The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.
Enclosure 3 continued

29a-1

Revision: HCFA-PM-97-2 (CMSO)
December 1997

State: Michigan

Citation

1902(a)(10)(B)(iii) and 1905(p)(3)(A)(iii) (iii) Specified Low-Income Medicare Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.

1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(i), and 1933 of the Act (iv) Qualifying Individual-1 (QI-1)

The Medicaid agency pays Medicare part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.

1902(a)(10)(E)(iv)(II), 1935(p)(3)(A)(ii), and 1933 of the Act (v) Qualifying Individual-2 (QI-2)

The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.

TN No. 93-01 Approval Date 6/22/98 Effective Date 02/07/98

Supersedes
TN No. 32-01
Enclosure 3 continued

Revision: HCFA-PM-97-3 (CMSO)
December 1997
State: MICHIGAN

Citation
1843(b) and 1905(a) of the Act and
42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

X All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) within a group listed at 42 CFR 431.625(d)(2).

Individuals receiving title II or Railroad Retirement benefits.

X Medically needy individuals (FFP is not available for this group).

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

X The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

TN No. 98-01
Supersedes Approval Date 5/29/98 Effective Date 02/01/98
TN No. 93-27

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
(b) Deductibles/Coinsurance

(1) Medicare Part A and B

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a)(10), 1902(n), 1905(a), and 1916 of the Act

(i) Qualified Medicare Beneficiaries (QMBs)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

Sections 1902 (a)(10), 1902(a)(30), and 1905(p) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

X For the entire range of services available under Medicare Part B.

Only for the amount, duration, and scope of services otherwise available under this plan.

Sections 1902 (a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1906 of the Act</td>
<td>(c) <strong>Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations</strong></td>
</tr>
<tr>
<td></td>
<td>The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans.</td>
</tr>
<tr>
<td></td>
<td>When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).</td>
</tr>
<tr>
<td>1902(a)(10)(F) of the Act</td>
<td>(d) /X/ The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.</td>
</tr>
</tbody>
</table>
S

State MICHIGAN

Citation 42 CFR 441.101, 42 CFR 431.620(c) and (d) AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.
State: MICHIGAN

<table>
<thead>
<tr>
<th>Citation</th>
<th>3.4 Special Requirements Applicable to Sterilization Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 441.252</td>
<td>All requirements of 42 CFR Part 441, Subpart F are met.</td>
</tr>
<tr>
<td>AT-78-99</td>
<td></td>
</tr>
</tbody>
</table>

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

Supersedes Approval Date 6/20/79  Effective Date 2/06/79

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are—

Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

- Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- Medical or remedial care provided by licensed practitioners.
- Home health services.
Citation 3.5  

Families Receiving Extended Medicaid Benefits  
(Continued)

- Private duty nursing services.  
- Physical therapy and related services.  
- Other diagnostic, screening, preventive, and rehabilitation services.  
- Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.  
- Intermediate care facility services for the mentally retarded.  
- Inpatient psychiatric services for individuals under age 21.  
- Hospice services.  
- Respiratory care services.  
- Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.
(c) The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--
   - 1st 6 months
   - 2nd 6 months

We The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.
   - 1st 6 mos.
   - 2nd 6 mos.

(d) (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:
   - Enrollment in the family option of an employer's health plan.
   - Enrollment in the family option of a State employee health plan.
   - Enrollment in the State health plan for the uninsured.
   - Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).
Citation 3.5  Families Receiving Extended Medicaid Benefits

(Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

(ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).
SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.
4.2 Hearings for Applicants and Recipients

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.
Revision: HCFA-AT-87-9  (BERC)  OMB No.: 0938-0193
AUGUST 1987

State/Territory:          MICHIGAN

Citation
42 CFR 431.301
AT-79-29

4.3 Safeguarding Information on Applicants and Recipients

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

All other requirements of 42 CFR Part 431, Subpart F are met.

Supersedes
TN No. 74-2

Approval Date 01-14-88  Effective Date 01-15-74

HCFA ID: 1010P/0012P
Citation 4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

\[\checkmark\] Yes.

\[\checkmark\] Not applicable. The State has an approved Medicaid Management Information System (MMIS).

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TN No. 87-11
Supersedes
TN No. 85-19

Approval Date 08/26/87 Effective Date 04/01/87

HCFA ID: 1010P/0012P
The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.
Citation

4.5(a)(1) Medicaid Recovery Audit Contractor Program

Section 1902(a)(42)(B)(i) of the Social Security Act

☐ The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.

☒ The State is seeking an exception to establishing such program for the following reasons:

Due to program integrity policies and procedures now in place on the front end and the fact that the Michigan Medicaid population is predominately managed care, the existing Recovery Audit Contractor (RAC) indicated it was not interested in continuing. The State Of Michigan was unable to secure a new RAC who is interested and meets the minimum standards despite posting a request for proposal (RFP) multiple times in 2017.

The State of Michigan has entered into a Joint Operating Agreement (JOA) with the CMS Unified Program Integrity Contractor to conduct audits on Michigan Medicaid providers. The state requests that it be granted an exception to the RAC requirements to allow the State to expand utilization of this JOA to include RAC audits.

Section 1902(a)(42)(B)(ii)(I) of the Act

The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.

Place a check mark to provide assurance of the following:

☐ The State will make payments to the RAC(s) only from amounts recovered.

☐ The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

Section 1902(a)(42)(B)(ii)(II)(aa) of the Act

☐ The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

☐ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

☐ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

☐ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.

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TN NO.: 17-0013 Approval Date: MARCH 14, 2018 Effective Date: 4/1/2017 to 4/1/2019

Supersedes
TN No.: 13-06
Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act

The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):

Contingency fee.

Section 1902 (a)(42)(B)(ii)(III) of the Act

The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).

Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act

The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.

Section 1902 (a)(42)(B)(ii)(IV)(bb) of the Act

The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.

Section 1902 (a)(42)(B)(ii)(IV)(cc) of the Act

Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.
Revised: HCFA-AT-80-38 (BPP)
May 22, 1980

State: MICHIGAN

Citation
42 CFR 431.16
AT-79-29

4.6 Reports
The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Supersedes
Approval Date 7/05/74 Effective Date 1/15/74
4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.
Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.
State: MICHIGAN

Citation: 42 CFR 433.37
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

TN # 74-2
Supersedes

Approval Date 7/05/74  Effective Date 1/15/74
4.10 Free Choice of Provider

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis. Providers who elect not to provide services based on a history of bad debt, including unpaid co-payments, shall give beneficiaries appropriate verbal notice and a reasonable opportunity for payment. Beneficiaries retain the ability to seek services from other enrolled providers.

(b) Paragraph (a) does not apply to services furnished to an individual —

(1) Under an exception allowed under 42 CFR 413.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,

Section 1902(a)(23) of the Social Security Act
P.L. 105-33

Section 1932(a)(1)
Section 1905(t)

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services. or

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).
Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ___________ MICHIGAN

Citation 4.11 Relations with Standard-Setting and Survey Agencies
42 CFR 431.610
AT-78-90
AT-80-34

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is the Michigan Department of Consumer and Industry Services.

(b) The State authority (ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are) the: Michigan Department of State Police, Fire Marshal Division.

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Supersedes

TN No. _96-04_ Approval Date _9-23-96_ Effective Date _4-1-96_

TN No. _74-35_
4.11(d) The Michigan Department of Consumer and Industry Services (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.
Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

\checkmark Yes, as listed below:
- Institutions for Mental Diseases

\xmark Not applicable. Similar services are not provided to other types of medical facilities.
With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

(a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

(b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are met.

(c) For providers of ICF/MR services, the requirements of participation in 42 CFR 483, Subpart D are also met.

(d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920 (b)(2) and (c) are met.

Not applicable. Ambulatory pre-natal care is not provided to pregnant women during a presumptive eligibility period.
For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual’s medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether
statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

Not applicable. No State law or court decision exist regarding advance directives.

Effective Date: 08/13/2003
**State: Michigan**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Utilization/Quality Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 431.60</td>
<td>(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:</td>
</tr>
<tr>
<td>42 CFR 456.2</td>
<td>Directly</td>
</tr>
<tr>
<td>50 FR 15312</td>
<td>X</td>
</tr>
<tr>
<td>1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)</td>
<td>By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO —</td>
</tr>
<tr>
<td>1932(c)(2) and 1902(d) of the Act, P.L. 99-509 (section 9431)</td>
<td>A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organization under contract, except where exempted by the regulation.</td>
</tr>
</tbody>
</table>

**TN No.: 03-13**

**Approval Date: 12/9/2003**

**Effective Date: 08/13/2003**

Supersedes

**TN No.: 92-10**

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Citation 4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

- All hospitals (other than mental hospitals).
- Those specified in the waiver.
- No waivers have been granted.
(c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

- All mental hospitals.
- Those specified in the waiver.

No waivers have been granted.

Not applicable. Inpatient services in mental hospitals are not provided under this plan.
4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

All skilled nursing facilities.

Those specified in the waiver.

No waivers have been granted.
The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

- Facility-based review.
- Direct review by personnel of the medical assistance unit of the State agency.
- Personnel under contract to the medical assistance unit of the State agency.
- Utilization and Quality Control Peer Review Organizations.
- Another method as described in ATTACHMENT 4.14-A.
- Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

Not applicable. Intermediate care facility services are not provided under this plan.
For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.

Not applicable
State/Territory: **MICHIGAN**

<table>
<thead>
<tr>
<th>Citation</th>
<th>4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act</td>
<td>The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:</td>
</tr>
<tr>
<td></td>
<td>ICFs/MR;</td>
</tr>
<tr>
<td></td>
<td>Inpatient psychiatric facilities for recipients under age 21; and</td>
</tr>
<tr>
<td></td>
<td>Mental Hospitals.</td>
</tr>
<tr>
<td>42 CFR Part 456 Subpart A and 1902(a)(30) of the Act</td>
<td>All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.</td>
</tr>
<tr>
<td></td>
<td>Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.</td>
</tr>
<tr>
<td></td>
<td>Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.</td>
</tr>
<tr>
<td></td>
<td>Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.</td>
</tr>
</tbody>
</table>

**TN No.92-25**  
Supersedes **TN No.76-17**  
Approval Date **10-28-92**  
Effective Date **07-01-92**  
HCFA ID: _______
4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.
Citation(s)

42 CFR 433.36 4.17 Liens and Adjustments or Recoveries

(a) Liens

☐ The State imposes liens against an individual’s real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36 (c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

☐ The State imposes liens on real property on account of benefits incorrectly paid.

☐ The State imposes TEFRA liens 1917 (a) (1) (B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State Plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

☒ The State imposes liens on both real and personal property of an individual after the individual’s death.
(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

1. For permanently institutionalized individuals, adjustments or recoveries are made from the individual’s estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

2. The State determines “permanent institutional status” of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1) (B) (even if it does not impose those liens).

3. For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual’s estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:

All services covered by the Michigan Medicaid program for individuals age 55 and over except Medicare cost sharing identified at 4.17(b)(3) (continued).
4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.
The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

☐ The State adjusts or recovers from the individual’s estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset and resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the state plan as listed below:

All services covered by the Michigan Medicaid program for individuals age 55 and over except Medicare cost-sharing identified at 4.17(b)(3).

☐ The State does not adjust or recover from the individual’s estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

☐ The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

All assets and resources not otherwise excluded under this provision of the Michigan Medicaid Program.

☒ If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual’s estate for the amount of assets or resources disregarded.

TN NO.: 16-0005 Approval Date: MAY 24, 2016 Effective Date: 1/01/2016

Supersedes
TN No.: 13-015
(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

(1) Adjustments or recovery of medical assistance correctly paid will be made only after the death of the individual’s surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustments or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual’s home:

(a) a sibling of the individual (who was residing in the individual’s home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual’s home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(c) a survivor who resides in the medical assistance beneficiary’s home for a period of at least 2 years immediately before the date of the medical assistance beneficiary’s admission to a medical institution and who establishes that he or she provided care that permitted the medical assistance beneficiary to reside at home rather than in an institution.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.
(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangements).

- individual’s home,

- equity interest in the home.

- residing in the home for at least 1 or 2 years,

- on a continuous basis,

- discharge from the medical institution and return home, and

- lawfully residing.

- survivor
(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

TN NO.:  13-16 Approval Date:  AUG 11, 2016 Effective Date:  01/01/2014

Supersedes
TN No.:  03-13

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

TN NO.: 13-16 Approval Date: AUG 11, 2016 Effective Date: 01/01/14

Supersedes
TN No.: 92-01

HCFA ID: 7982E

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.

For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.

A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

TN NO.:  13-16  Approval Date:  AUG 11, 2016  Effective Date:  01/01/16
Supersedes
TN No.:  92-01

HCFA ID: 7982E

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

TN NO.: 13-16  Approval Date: AUG 11, 2016  Effective Date: 01/01/14

Supersedes  TN No.: 92-01

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

TN NO.: 13-16  Approval Date: AUG 11, 2016  Effective Date: 01/01/14

Supersedes
TN No.: 92-01

HCFA ID: 7982E

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Citation 4.19 Payment for Services

42 CFR 447.252 (a) The Medicaid agency meets the requirements of 1902(a)(13) of 42 CFR Part 447, Subpart C, and sections 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

\( \checkmark \) Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

\( \checkmark \) Inappropriate level of care days are not covered.
4.19(b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:

(1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).

(2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902(a)(10) and 1902(a)(30) of the Act

SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.
Revisim: HCFA-AT-80-38 (BPP)
May 22, 1980

State: MICHIGAN

Citation
42 CFR 447.40
AT-78-90

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☑ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☐ No.

TN # 77-34
Supersedes
Approval Date 1/20/78 Effective Date 10/01/77
4.19 (d)

(1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

At the average rate per patient day paid to SWFs for routine services furnished during the previous calendar year.

At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for SWF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

(4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

Supersedes TW No. 91-32

Approval Date 3-29-93 Effective Date 10-02-91

HCPA ID: 1010P/0012P
The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.
The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.
The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.
Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State: MICHIGAN

Citation: 4.19(h) The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Supersedes

TN # 79-14
Approval Date 11/28/79
Effective Date 8/06/79
The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

<table>
<thead>
<tr>
<th>Citation</th>
<th>4.19(i)</th>
<th>Description</th>
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<tbody>
<tr>
<td>42 CFR 447.201</td>
<td></td>
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<tr>
<td>42 CFR 447.204</td>
<td></td>
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<tr>
<td>AT-78-90</td>
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</tbody>
</table>
The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.

The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.
The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.
Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

The State:

- sets a payment rate at the level of the regional maximum established by the DHHS Secretary.
- is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.
- sets a payment rate below the level of the regional maximum established by the DHHS Secretary.
- is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

$7 for injectable; $3 for oral

Medicaid beneficiary access to immunizations is assured through the following methodology:

Other
Citation
42 CFR 447, 434, 438 and
1902(a)(4), 1902(a)(6) and
1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A

- Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-B

- Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services
☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.
Citation 4.21  Prohibition Against Reassignment of Provider Claims
42 CFR 447.10(c)
AT-78-90
7/1/81 | 46 FR 42699

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.
State of MICHIGAN

Citation
42 CFR 433.137 4.22 Third Party Liability

(a) The Medicaid agency meets all requirements of:

1) 42 CFR 433.138 and 433.139
2) 42 CFR 433.145 through 433.148
3) 42 CFR 433.151 through 433.154
4) Section 1902(a)(25)(H) and (I) of the Act
5) Section 6035 of the Deficit Reduction Act of 2005

(b) Attachment 4.22-A:

1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

2) Describes the methods the agency uses for meeting the follow up requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources; and

4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources. The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(l) of the Social Security Act.

TN NO.: 07-05 Approval DateSEP 1 1 2007 Effective Date: 01/03/2007

Supersedes
TN No.: 97-01

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

ATTACHMENT 4.22-B specifies the following:

1. The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).

2. The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

3. The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.
42 CFR 433.151(a) (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

- X State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.
- Other appropriate State agency(s)--
- Other appropriate agency(s) of another State--
- Courts and law enforcement officials.

1902(a)(60) of the Act (g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

- X The Secretary's method as provided in the State Medicaid Manual, Section 3910.
- The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.
### Use of Contracts

<table>
<thead>
<tr>
<th>Citation</th>
<th>4.23 Use of Contracts</th>
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<tbody>
<tr>
<td>42 CFR 434.4</td>
<td>The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.</td>
</tr>
<tr>
<td>48 FR 54013</td>
<td></td>
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</table>

- Not applicable. The State has no such contracts.

<table>
<thead>
<tr>
<th>42 CFR Part 438</th>
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<tr>
<td></td>
<td>The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through a procurement process that is consistent with 45 CFR Part 74. The risk contract is with:</td>
</tr>
</tbody>
</table>

- a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2.

- a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2.

- Not applicable.

- a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.

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TN No.: 03-13  
Approval Date: 12/9/2003  
Effective Date: 08/13/2003

Supersedes  
TN No.: 84-9

*October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.*
State/Territory: MICHIGAN

Citation

42 CFR 442.10 and 442.100
AT-78-90
AT-79-18
AT-80-25
AT-80-34
52 FR 32544
P.L 100-203 (Sec. 4211)
54 FR 5316
56 FR 48826

4.24 Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services

With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.

Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.
The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.
4.26 Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

2. The DUR program assures that prescriptions for outpatient drugs are:
   - Appropriate
   - Medically necessary
   - Are not likely to result in adverse medical results

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:
   - Potential and actual adverse drug reactions
   - Therapeutic appropriateness
   - Overutilization and underutilization
   - Appropriate use of generic products
   - Therapeutic duplication
   - Drug disease contraindications
   - Drug-drug interactions
   - Incorrect drug dosage or duration of drug treatment
   - Drug-allergy interactions
   - Clinical abuse/misuse

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:
   - American Hospital Formulary Service Drug Information
   - United States Pharmacopeia-Drug Information
   - American Medical Association Drug Evaluations
DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has nevertheless chosen to include nursing home drugs in:

- Prospective DUR
- Retrospective DUR.

The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

The DUR program includes retrospective DUR through its mechanized drug claims process and information retrieval system or others, which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary
- Among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.
F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatment
- Clinical abuse/misuse

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

G.1. The DUR program has established a State DUR Board either:

- [X] Directly, or
- Under contract with a private organization

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

3. The activities of the DUR Board include:

- Retrospective DUR,
- Application of standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.
The interventions include in appropriate instances:
- Information dissemination
- Written, oral, and electronic reminders
- Face-to-Face discussions
- Intensified monitoring/review of prescribers/dispensers

The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.

The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:
- real time eligibility verification
- claims data capture
- adjudication of claims
- assistance to pharmacists, etc. applying for and receiving payment.

Prospective DUR is performed using an electronic point of sale drug claims processing system.

Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.
Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State MICHIGAN

Citation 42 CFR 431.115 (c)
AT-78-90
AT-79-74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

TN # 80-3
Supersedes Approval Date 5/14/80 Effective Date 10/15/79
State/Territory: MICHIGAN

Citation 4.28 Appeals Process

(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.

(b) The State provides an appeals system that meets the requirements of 42 CFR 483 Subpart E, 42 CFR 431 Subpart B, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.
State: Michigan

Citation

1902(a)(4)(C) of the Social Security Act P.L. 105-33

4.29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58

The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).
Revision: HCFA-PM-87-14 (BERC)  
OCTOBER 1987  
OMB No.: 0938-0193

State/Territory: MICHIGAN

Citation 4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals
42 CFR 1002.203 AT-79-54 48 FR 3742 51 FR 34772

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

The agency, under the authority of State law, imposes broader sanctions.

TN No. 87-22 Supersedes TN No. 87-11

Approval Date 01-14-88 Effective Date 11-01-87

HCFA ID: 1010P/0012P

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Citation (b) The Medicaid agency meets the requirements of—

1902(p) of the Act

(1) Section 1902(p) of the Act by excluding from participation—

(A) At the State’s discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

42 CFR 438.808

(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that—

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

1932(d)(1)

42 CFR 438.610

(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c).

Supersedes

TN No.: 87-22

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of--

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.
Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal of the Act agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (SECTION 1137 OF THE ACT AND 42 CFR 435.940 through 435.960)

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

(C) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other states. The information that is requested will be exchanged with states and other entities legally entitled to verify Title XIX applicants and individuals eligible for covered Title XIX services consistent with applicable PARIS agreements.
4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.
4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation

(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.

(b) The agency uses the following remedy(ies):

(1) Denial of payment for new admissions.
(2) Civil money penalty.
(3) Appointment of temporary management.
(4) In emergency cases, closure of the facility and/or transfer of residents.

(c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.

(d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:

(1) Public recognition.
(2) Incentive payments.
4.35 Enforcement of Compliance for Nursing Facilities

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

1. nature of noncompliance,
2. which remedy is imposed,
3. effective date of the remedy, and
4. right to appeal the determination leading to the remedy.

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

The State considers additional factors. Attachment 4.35-A describes the State's other factors.
c) Application of Remedies

42 CFR §488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR §488.417(b) §1919(h)(2)(C) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.


(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.


(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).

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Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.
The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR §488.406(b).

- (1) Temporary Management
- (2) Denial of Payment for New Admissions
- (3) Civil Money Penalties
- (4) Transfer of Residents; Transfer of Residents with Closure of Facility
- (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

- (e) **State Incentive Programs**
  - (1) Public Recognition
  - (2) Incentive Payments
The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.
Nurse Aide Training and Competency Evaluation for Nursing Facilities

(a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.

(b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).

(c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.

(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.

(e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.

(f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

TN No. 92-10
Approval Date 04-08-92
Effective Date 01-01-92

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

For program reviews other than the initial review, the State visits the entity providing the program.

The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).
The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.

The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.

The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).

The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).

The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.

The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.
When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.

The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.

The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.

The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.

Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.

The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).

The State has a standard for successful completion of competency evaluation programs.
The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.

The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).

The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.

The State includes home health aides on the registry.

The State contracts the operation of the registry to a non State entity.

ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(i)(iii) and (iv).

ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).
Citation
Secs.
1902(a)(28)(D)(1) and 1919(e)(7) of the Act;
P.L. 100-203 (Sec. 4211(c));
P.L. 101-508 (Sec. 4801(b)).

State/Territory: MICHIGAN

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

(e) ATTACHMENT 4.39 specifies the State's definition of specialized services.
4.40 Survey & Certification Process

(a) The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.

(b) The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.

(c) The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.

(d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?

(e) The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.

(f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.
The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.

The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.

The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.

The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.

The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.
1919(g)(2) (D) of the Act

(m) The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.

1919(g)(2) (E)(i) of the Act

(n) The State uses a multidisciplinary team of professionals including a registered professional nurse.

1919(g)(2) (E)(ii) of the Act

(o) The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.

1919(g)(2) (E)(iii) of the Act

(p) The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.

1919(g)(4) of the Act

(q) The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures.

1919(g)(5) (A) of the Act

(r) The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.

1919(g)(5) (B) of the Act

(s) The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.

1919(g)(5) (C) of the Act

(t) If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.

1919(g)(5) (D) of the Act

(u) The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.
Revision: HCFA-PM-92-2  
MARCH 1992

State/Territory: MICHIGAN

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<tr>
<th>Citation</th>
<th>4.41 Resident Assessment for Nursing Facilities</th>
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<tr>
<td>Sections 1919(b)(3) and 1919(e)(5) of the Act</td>
<td>The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.</td>
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<td>1919(e)(5)(A) of the Act</td>
<td>The State is using: X the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or</td>
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<tr>
<td>1919(e)(5)(B) of the Act</td>
<td>a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].</td>
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Employee Education About False Claims Recoveries

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

1) Definitions

A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made.
State of MICHIGAN

under the State Plan during the preceding Federal fiscal year.

B) An "employee" includes any officer or employee of the entity

C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

5) The State will implement this State Plan amendment on January 1, 2007.

(b) Attachment 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.
SECTION 5 PERSONNEL ADMINISTRATION

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☐ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.
State: MICHIGAN

5.2 [Reserved]
5.3 Training Programs; Subprofessional and Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.
SECTION 6  FINANCIAL ADMINISTRATION

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.
6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

Revised: HCFA-AT-81- (BPP)

State: MICHIGAN

Citation
42 CFR 433.34
47 FR 17490

Approval Date: 8/20/82
Effective Date: 7/16/82
6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

☐ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

☑ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.
SECTION 7 - GENERAL PROVISIONS

Plan Amendments

Citation 7.1

42 CFR 430.12(c) The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.
In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.
Citation 7.4 State Governor’s Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

☐ Not applicable. The Governor --

☐ Does not wish to review any plan material.

☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of the:

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
(Designated Single State Agency)

Date: ___ September 16, 1996 ___

Signature: ____________________________
James K. Haveman, Jr.
Title: Director

TN No. 96-0/10 Approval Date 9-23-96 Effective Date 4-1-96

Supersedes

TN No. 92-01 HCFA ID: 7982E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of  Michigan

ATTORNEY GENERAL’S CERTIFICATION

I certify that:

The Michigan Department of Community Health is the single State agency responsible for:

[ ] administering the plan.

The legal authority under which the agency administers the plan on a statewide basis is contained in


(statutory citation)

[ ] supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a statewide basis is contained in

(statutory citation)

The agency’s legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is

(statutory citation)

June 13, 1996

DATE

Frank J. Kelley
Attorney General

TN No. 96-010 Approval Date 9-23-96 Effective Date 4/1/96
Supercedes
TN No. N/A

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

TN # 02-08
Supersedes TN # 96-10
Approved date 6/19/02
Effective date 02/01/2002
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

ORGANIZATION FOR ADMINISTRATION

The Michigan Department of Community Health is designated as the single state agency responsible for the Medical Assistance Program. A general description of the principal organizational components of the Department follows:

1. The Policy and Legal Affairs Administration has responsibility for the development and coordination of all health policy for the programs under the Department's purview, including Medicaid. In addition, the administration handles the Department's legal affairs and legislative activities.

2. The Health Programs Administration is Michigan's designated Medicaid unit with prior authorization and operational responsibility for the Medical Assistance program. This administration is supported by The Policy and Legal Affairs Administration for Medicaid policy and legal issues and The Budget and Finance Administration for fiscal issues. The Health Programs Administration also has operational responsibility for a number of other programs: Mental Health and Substance Abuse; MiChild; Children's Special Health Care Services (CSHCS); Women, Infants and Children; Long Term Care and Pharmacy. In addition, managed care contract administration, pharmacy contract administration and prior authorization services for CSHCS beneficiaries are responsibilities of this Administration.

3. The Executive Operations Administration includes an Office of Special Projects, the Office of Recipient Rights, and the Division for Vital Records and Health Statistics.

4. The Health Administration has responsibility for public health agency programs in disease and injury prevention as well as all laboratory functions. In addition, the department's medical consultant staff are in this administration.

5. The Budget and Finance Administration has responsibility for all fiscal activities within the department, including Medicaid claims processing, institutional audit and rate setting and actuarial services.

6. The Office of Quality Assurance and Customer Services has responsibility for assuring that the department's various health care programs maintain an appropriate level of quality. In addition, this area has responsibility for customer service activities and managed care enrollment.

Attachments 1.2-A
Page 2
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Michigan

ORGANIZATION FOR ADMINISTRATION

Skilled Professional Medical Personnel

The Department employs 21 skilled professional medical personnel (physicians, dentists, nurses, and other specialized personnel who have professional education and training in the field of medical care or appropriate medical practice) and 3 supporting staff (secretarial, clerical, and others whose activities are directly necessary to the carrying out of the functions which are the responsibility of the skilled professional medical personnel) to administer the state’s Medicaid program.

TN # 02-08
Approval Date: 6/19/02
Effective: 02/01/2002

Supersedes
TN # 74-2 // 1/15/73
Through interagency agreement, staff in the Family Independence Agency perform the eligibility determination function for the Medical Assistance Program.

Staff in the Family Independence Agency’s central office provide coordination, administration, review and support of county-based operations. They prepare and distribute instructional materials to the county-based staff, conduct training as is necessary and perform other supportive services. They also monitor the activities of county-based staff to assure compliance with applicable policy and procedure.

The county-based operations are responsible for the determination of client eligibility for Medicaid and performance of other supportive services to assure client access to and receipt of medically necessary care. Staff facilitate client appeals of negative actions and assure compliance with any decisions affecting eligibility issued as a result.
SECTION 2: Coverage & Eligibility
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDSS</td>
<td>42 CFR 435.110</td>
<td>The following groups are covered under this plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Recipients of AFDC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The approved State AFDC plan includes:</td>
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<tr>
<td></td>
<td></td>
<td>- Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Pregnant women with no other eligible children.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>MDSS</td>
<td>42 CFR 435.115</td>
<td>2. Deemed Recipients of AFDC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.</td>
</tr>
</tbody>
</table>

*Agency that determines eligibility for coverage.

TIN No. 22-02 Approval Date 03-1-92 Effective Date 10-01-91
Supersedes
TIN No. 86-12 HCFA ID: 7983E

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

ATTACHMENT 2.2-A
Page 1
OMB NO.: 0938-
### A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

#### 2. Deemed Recipients of AFDC.

<table>
<thead>
<tr>
<th>Agency*</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1902(a)(10)(A)(1)(I) of the Act</td>
<td>b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.</td>
</tr>
<tr>
<td></td>
<td>402(a)(22)(A) of the Act</td>
<td>c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.</td>
</tr>
<tr>
<td></td>
<td>406(h) and 1902(a)(10)(A)(1)(I) of the Act</td>
<td>d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.</td>
</tr>
<tr>
<td></td>
<td>1902(a) of the Act</td>
<td>e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.</td>
</tr>
</tbody>
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*Agency that determines eligibility for coverage.

<table>
<thead>
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<th>TN No.</th>
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<th>Effective Date</th>
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<td>ZK-32</td>
<td>03-19-92</td>
<td>10-01-91</td>
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**HCFA ID: 7983E**

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

3. Qualified Family Members

Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.

Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:

a. Families denied AFDC solely because of income and resources deemed to be available from--

(1) Step父母 who are not legally liable for support of stepchildren under a State law of general applicability;

(2) Grandparents;

(3) Legal guardians; and

(4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);

b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

*Agency that determines eligibility for coverage.

Supersedes

TN No. 86-12 Approval Date 06-29-88 Effective Date 10-01-91

HCFA ID: 7983E
### A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

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<tr>
<td>MDSS</td>
<td>42 CFR 435.114</td>
<td>6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).</td>
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<tr>
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<td></td>
<td>- Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Not applicable with respect to intermediate care facilities; State did or does not cover this service.</td>
</tr>
<tr>
<td>MDSS</td>
<td>(A)(10) and 1905(n) of the Act</td>
<td>7. Qualified Pregnant Women and Children.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. A pregnant woman whose pregnancy has been medically verified who--</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;</td>
</tr>
</tbody>
</table>

*Agency that determines eligibility for coverage.*

<table>
<thead>
<tr>
<th>TN No.</th>
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<td>92-03</td>
<td>08-13-72</td>
<td>10-01-72</td>
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Supersedes: N/A

HCFA ID: 7983E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

COVERAGE AND CONDITIONS OF ELIGIBILITY

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Groups Covered</th>
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</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (i)(III) and 1905(n) of the Act</td>
<td></td>
</tr>
</tbody>
</table>

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or

(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State’s approved AFDC plan.

b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State’s approved AFDC plan.

Children under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State’s approved AFDC plan.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

COVERAGE AND CONDITIONS OF ELIGIBILITY

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</tbody>
</table>

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in Section 1902(a)(10)(A)(I)(IV) and 1902(I)(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.

The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.

9. Children:

a. who have attained 1 year of age but have not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.

b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels. (See Supplement 8a to Attachment 2.6-A)

TN No. 98-05
Supersedes
TN No. 92-14

Approval Date 7-17-94
Effective Date 05/01/98

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

COVERAGE AND CONDITIONS OF ELIGIBILITY

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Groups Covered

Children born after ___________________.
(specify optional earlier date) who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for these groups are specified in Supplement 1 to Attachment 2.6-A.

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TN No. 98-05
Supersedes
TN No. N/A

Approval Date 2-17-98
Effective Date 05/01/98

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10) (A)(i)(V) and 1905(m) of the Act

10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.

1902(e)(5) of the Act

11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

1902(e)(6) of the Act

b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

Approval Date 04/16/92 Effective Date 01/01/92

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (continued)

<table>
<thead>
<tr>
<th>1902(e)(4) of the Act</th>
<th>12. Deemed Newborns – A child born in the United States to a woman who is eligible for and receiving Medicaid (including coverage of an alien for labor and delivery as emergency medical services) for the date of the child’s birth, including retroactively. The child is deemed eligible for one year from birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.120</td>
<td>13. Aged, Blind and Disabled Individuals Receiving Cash Assistance</td>
</tr>
<tr>
<td></td>
<td>a. Individuals receiving SSI. This includes beneficiaries’ eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981, persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.</td>
</tr>
<tr>
<td></td>
<td>X  Aged</td>
</tr>
<tr>
<td></td>
<td>X  Blind</td>
</tr>
<tr>
<td></td>
<td>X  Disabled</td>
</tr>
</tbody>
</table>
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

13. b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

Aged  
Blind  
Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

<table>
<thead>
<tr>
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<tr>
<td>87-02</td>
<td>08-27-72</td>
<td>10-01-71</td>
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<tr>
<td>87-11</td>
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<td></td>
</tr>
</tbody>
</table>

HCFA ID: 7983E
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

14. Qualified severely impaired blind and disabled individuals under age 65, who--

a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or

b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--

(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;

(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;

(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.
A. **Mandatory Coverage - Categorically Needy and Other Required Special Groups** (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

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*Agency that determines eligibility for coverage.*

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Approval Date</th>
<th>Effective Date</th>
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<td>02-15-92</td>
<td>10-01-</td>
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<tbody>
<tr>
<td>87-11</td>
<td>7983E</td>
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</table>
A. **Mandatory Coverage - Categorically Needy and Other Required Special Groups** (Continued)

<table>
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<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1619(b)(3) of the Act</td>
<td>The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.</td>
</tr>
</tbody>
</table>

*Agency that determines eligibility for coverage.*

<table>
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<tr>
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<td>10-01-91</td>
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</table>

*HCFA ID: 7983E*
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--

a. Are at least 18 years of age;

b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.

16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.

*Agency that determines eligibility for coverage.
Agency Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131 18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

- Aged  
- Blind  
- Disabled

Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

TN No. 02-22  Approval Date 03-13-92  Effective Date 10-01-91
Supersedes
TN No. N/A  HCFA ID: 7983E
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they—

a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and

b. Remain institutionalized; and

c. Continue to need institutional care.

20. Blind and disabled individuals who—

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and

b. Were eligible for Medicaid in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.
### A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

<table>
<thead>
<tr>
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<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDSS</td>
<td>42 CFR 435.134</td>
<td>21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*<em>/*</em> Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>\ Text\ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).</td>
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</tbody>
</table>
|         |                   | /\ Text\ Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.*

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</tbody>
</table>

HCFA ID: 7983E
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

MDSS 42 CFR 435.135 22. Individuals who --
   a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and
   b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

- Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.
- Not applicable because the State applies more restrictive eligibility requirements than those under SSI.
- The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

<table>
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<td>7983E</td>
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</tbody>
</table>
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634 of the Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

TN No. 92-22 Approval Date 03-12-92 Effective Date 10-01-91
Supersedes
TN No. 86-12

HCFA ID: 7983E
**State/Territory: MICHIGAN**

### Agency* Citation(s) Groups Covered

<table>
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<tr>
<th>1634(d) of the Act</th>
<th>A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</th>
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<tbody>
<tr>
<td>24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.</td>
<td></td>
</tr>
</tbody>
</table>

---

The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

---

In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

---

In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.

---

In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual.

---

*Agency that determines eligibility for coverage.

<table>
<thead>
<tr>
<th>TN No. 42-10</th>
<th>Approval Date 04-08-92</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supersedes</td>
<td></td>
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<tr>
<td>TN No. 92-02</td>
<td>Effective Date 01-01-92</td>
</tr>
</tbody>
</table>
### Mandatory Coverage - Categorically Needy and Other Required Special Groups (continued)

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>1902(a)(10)(E)(i) and 1905(p) and 1860D-14 (a)(3)(D) of the Act</td>
<td>25. Qualified Medicare beneficiaries - -</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Whose income does not exceed 100 percent of the Federal poverty level; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Whose resources do not exceed three times the SSI resources limit, adjusted annually by the increase in the Consumer Price Index.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Who are entitled to hospital insurance benefits under Medicare Part A, under section 1818A of the Act;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Whose income does not exceed 200 percent of the Federal poverty level; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Whose resources do not exceed two times the SSI resource limit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act).</td>
</tr>
</tbody>
</table>

*Agency that determines eligibility for coverage.

**TN NO.: 10-20**  
**Approval Date:** FEB 01 2011  
**Effective Date:** 10-1-2010  
**Supersedes**  
**TN No.: 99-01**  
**HCFA ID:** 7983E  

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
**Mandatory Coverage - Categorically Needy and Other Required Special Groups (continued)**

27. Specified Low-Income Medicare Beneficiaries --

   a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);

   b. Whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and

   c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index.

   (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

28. Qualifying Individuals --

   a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);

   b. Whose income is at least 120 percent but less than 135 percent of the Federal poverty level;

   c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index.

29. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) of (v) of Section 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.

*Agency that determines eligibility for coverage.*
Agency: Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy

42 CFR 435.210

1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

☐ The plan covers all individuals as described above.

☐ The plan covers only the following group or groups of individuals:

☐ Aged
☐ Blind
☐ Disabled
☐ Caretaker relatives
☐ Pregnant women

42 CFR 435.211

2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determines eligibility for coverage.

TN No. 96-20 Approval Date 11/3/97 Effective Date 10-01-96

Supersedes

TN No. 92-02 HCFA ID: 7983E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Groups Covered and Agencies Responsible for Eligibility Determination

Agency: FIA
Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

[ ] 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

The State elects not to guarantee eligibility

The State elects to guarantee eligibility. The minimum enrollment period is ___ months (not to exceed six).

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

TN NO.: 03-13 Approval Date: 12/9/2005 Effective Date: 08/13/2003

Supersedes
TN No.: 92-10

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Groups Covered and Agencies Responsible for Eligibility Determination

<table>
<thead>
<tr>
<th>Agency: FIA</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1932 (a)(4) of the Act</td>
<td>1903(m)(2)(H), 1902(a)(52) of the Act, P.L. 101-508, 42 CFR 438.56(g)</td>
<td>Optional Groups Other Than Medically Needy (continued)</td>
</tr>
</tbody>
</table>

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity’s service area or becomes ineligible.

- Disenrollment rights are restricted for a period of 12 months.

  During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

- No restrictions upon disenrollment rights.

- In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

  - The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

  - The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

TN NO.: 03-13

Approval Date: 08/13/2003

Effective Date: 08/13/2003

Supersedes

TN No.: 99-13

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
### B. Optional Groups Other Than the Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.217</td>
<td>X 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.</td>
</tr>
</tbody>
</table>

*Agency that determines eligibility for coverage.*

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Approval Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>92-02</td>
<td>02-28-92</td>
<td>01-01-92</td>
</tr>
</tbody>
</table>

HCFA ID: 7983E
B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(10) 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

☐ The State covers all individuals as described above.

☐ The State covers only the following group or groups of individuals:

☐ Aged
☐ Blind
☐ Disabled
☐ Individuals under the age of--
  21
  20
  19
  18
☐ Caretaker relatives
☐ Pregnant women

*Agency that determines eligibility for coverage.

TN No. O208  Approval Date 08-14-72  Effective Date 10-01-91
Supersedes
TN No. N/A  HCFA ID: 7983E
B. Optional Groups Other Than the Medically Needy
(Continued)

6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

- Individuals under the age of—
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

7. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21 as indicated below.

- 20
- 19
- 18
B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.222

b. Reasonable classifications of individuals described in (a) above, as follows:

(1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

   (a) In foster homes (and are under the age of ____).

   (b) In private institutions (and are under the age of ____).

   (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ____).

(2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ____).

(3) Individuals in NFS (who are under the age of ____). NFS services are provided under this plan.

(4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ____).
### B. Optional Groups Other Than the Medically Needy

(Continued)

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TM No.</th>
<th>Supersedes</th>
<th>Approval Date</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>42-12</td>
<td>N/A</td>
<td>09-13-92</td>
<td>10-01-91</td>
</tr>
</tbody>
</table>

HCFA ID: 7983E

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Groups Covered

Citation 1902(a)(10)(A)(ii)(VIII) of the Act

B. Optional Groups other than the Medically Needy (continued)

8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical rehabilitative care, and who before execution of the agreement --

a. Was eligible for Medicaid under the State’s approved Medicaid plan; or
b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of --

X 21

20

19

18

The State does not consider income or resources for this population.

TN NO.: 08-13

Approval Date: MAR 18 2009 Effective Date: 10/1/2008

Supersedes
TN No.: 99-12

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
B. Optional Groups Other Than the Medically Needy (Continued)

9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:

1902(a)(10) and 1905(a) of the Act

- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women
### Groups Covered

**B. Optional Groups Other Than the Medically Needy**

(Continued)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSA</td>
<td>42 CFR 435.230</td>
<td>States using SSI criteria with agreements under sections 1616 and 1634 of the Act.</td>
</tr>
</tbody>
</table>

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- **a.** Based on need and paid in cash on a regular basis.
- **b.** Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- **c.** Available to all individuals in the State.
- **d.** Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>All aged individuals.</td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>All blind individuals.</td>
<td></td>
</tr>
<tr>
<td>(3)</td>
<td>All disabled individuals.</td>
<td></td>
</tr>
</tbody>
</table>
State: **MICHIGAN**

<table>
<thead>
<tr>
<th>Agency* Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.230</td>
<td>(Continued)</td>
</tr>
<tr>
<td></td>
<td>(4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td></td>
<td>(5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td></td>
<td>(6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td></td>
<td>(7) Individuals receiving a Federally Administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
</tr>
<tr>
<td></td>
<td>(8) Individuals receiving a State administered Optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
</tr>
<tr>
<td></td>
<td>(9) Individuals in additional classifications approved by the Secretary as follows:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approval Date</th>
<th>08/20/98</th>
</tr>
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<tr>
<td>Effective Date</td>
<td>01/01/98</td>
</tr>
</tbody>
</table>

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
B. Optional Groups Other Than the Medically Needy  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

☐ Yes.  
☒ No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.
11. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.*

The State covers all individuals as described above.

The State covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

12. Certain disabled children age 18 or under who are living at home, who would be eligible, if in a medical institution, for SSI or a State supplemental payment under title XVI of the Act, and therefore for Medicaid under the plan, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act.

* The income standard is $1,266.
Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

(4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

(8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

(9) Individuals in additional classifications approved by the Secretary as follows:
B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes

No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.
### B. Optional Groups Other Than the Medically Needied

(Continued)

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(BPD) 42 CFR 435.231</td>
<td>12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A. *</td>
</tr>
<tr>
<td></td>
<td>1902(a)(10) (A)(ii)(V) of the Act</td>
<td>The State covers all individuals as described above.</td>
</tr>
<tr>
<td></td>
<td>1902(a)(10)(A) (ii) and 1905(a) of the Act</td>
<td>The State covers only the following group or groups of individuals:</td>
</tr>
<tr>
<td></td>
<td>X</td>
<td>Aged</td>
</tr>
<tr>
<td></td>
<td>X</td>
<td>Blind</td>
</tr>
<tr>
<td></td>
<td>X</td>
<td>Disabled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individuals under the age of--</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21</td>
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<td>20</td>
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<td>19</td>
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<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Caretaker relatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pregnant women</td>
</tr>
</tbody>
</table>

* The income standard is $1,452.
B. Optional Groups Other Than the Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDSS</td>
<td>1902(e)(3)</td>
<td>Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.</td>
</tr>
<tr>
<td></td>
<td>1902(a)(10) (A)(ii)(IX) and 1902(1) of the Act</td>
<td>The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Infants under one year of age.</td>
</tr>
</tbody>
</table>
B. Optional Groups Other Than the Medically Needy

(Continued)

1902(a) (10)(A) (11)(IX) and 1902(1)(1) (D) of the Act

15. The following individuals who are not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 of ATTACHMENT 2.6-A for a family of the same size.

Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained--

☐ 7 years of age; or
☐ 8 years of age.
B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a). \(\text{(ii)}(X)\) and 1902(m) (1) and (3) of the Act

16. Individuals--

a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.

b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.
## Groups Covered and Agencies Responsible for Eligibility Determination

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(47) and 920 of the Act</td>
<td>X 17. Pregnant women who are determined by a &quot;qualified provider&quot; (as defined in 1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under Attachment 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with section 1920 of the Act.</td>
</tr>
</tbody>
</table>

**Approval Date:** 4/25/95  
**Effective Date:** 01/01/2005  
**Supersedes TN No.: 92-14**
B. Optional Groups Other Than the Medically Needy (Continued)

1906 of the Act

18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of 1 months.

1902(a)(10)(F) and 1902(u)(1) of the Act

19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid extenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### STATE: MICHIGAN

### GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATIONS

<table>
<thead>
<tr>
<th>AGENCY*</th>
<th>CITATION(s)</th>
<th>GROUPS COVERED</th>
</tr>
</thead>
</table>

1902(a)(10)(A)(ii)(XIV) of the Act

- **20. Optional Targeted Low Income Children who:**
  - a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability);
  - b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on April 15, 1997 (other than because of the §1902(l)(2)(D));
  - c. are not covered under a group health plan or other group health insurance (as such terms are defined in §2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no Federal funds for the program;
  - d. have family income at or below:
    - 200 percent of the Federal poverty level for the size family involved, as revised annually in the Federal Register; or
    - A percentage of the Federal poverty level, which is in excess of the "Medicaid applicable income level" (as defined in §2110(b)(4) of the Act) but by no more than 50 percentage points.

The state covers:
- All children described above who are under age _____ (18, 19) with family income at or below _____ percent of the poverty level.
- The following reasonable classifications of children described above who are under age _____ (18, 19) with family income at or below the percent of the Federal poverty level specified for the classification:
  (ADD NARRATIVE DESCRIPTION(S) OF THE REASONABLE CLASSIFICATION(S) AND THE PERCENT OF THE FEDERAL POVERTY LEVEL USED TO ESTABLISH ELIGIBILITY FOR EACH CLASSIFICATION.)

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**Attachment 2.2-A**

**Page 23a.1**

Supersedes

TN No. **n/a - new page**

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Groups Covered and Agencies Responsible for Eligibility Determinations

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(e)(12) of the Act</td>
<td>✕ 21. A child under age 19 (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of 12 (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.</td>
<td></td>
</tr>
<tr>
<td>1920A of the Act</td>
<td>✕ 22. Children under age 19 who are determined by a “qualified entity” (as defined in 1920A(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan.</td>
<td>The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman’s eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.</td>
</tr>
</tbody>
</table>

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Approval Date: 4/25/05  
Effective Date: 01/01/2005  
Supersedes  
TN No.: 02-17

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Citation(s)  
B. Optional Coverage Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(XVIII) of the Act  
X 24. Women who:
   a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;
   b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;
   c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and
   d. have not attained age 65.

1920B of the Act  
25. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902(aa) the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

*This group may be subject to managed care enrollment

Supersedes
TN No. new page
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Groups Covered and Agencies Responsible for Eligibility Determination

Agency: FIA

Citation

Groups Covered

B. Optional Groups Other than the Medically Needy, (continued)

1902(a)(10)(A) (ii)(XII) of the Act

23. BBA Work Incentives Eligibility Group – Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A

1902(a)(10)(A) (ii)(XV) of the Act

24. TWWIIA Basic Coverage Group – Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A

1902(a)(10)(A) (ii)(XVI) of the Act

25. TWWIIA Medical Improvement Group – Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Groups Covered

B. Optional Coverage Other than the Medically Needy (continued)

1902(a)(10)(A) X 26. All “independent foster care adolescents” (as defined in §1905(w)(1) of the Social Security Act). Individuals 18 to 21 years of age who, on their 18th birthday were in foster care under the jurisdiction of the State, without consideration of income, assets or resources.

a) Reasonable classifications of individuals described in 26 above as follows:

  X 1) Individuals under the age of
      _ 19
      _ 20
      X 21

  _ 2) Individuals to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of title IV before the date the individuals attained 18 years of age.

  _ 3) Other

b) Financial requirements:

  _ 1) Income test
     X There is no income test for this group
     _ The income test for this group is:

  _ 2) X There is no resource test for this group
     _ The resource test for this group is:


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Approval Date: FEB 21 2008
Effective Date: 10/01/2007

Supersedes
TN No.: N/A new page

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### C. Optional Coverage of the Medically Needy

<table>
<thead>
<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDSS</td>
<td>42 CFR 435.301</td>
<td>This plan includes the medically needy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>![Yes] Yes: This plan covers:</td>
</tr>
<tr>
<td>MDSS</td>
<td>1902(e) of the Act</td>
<td>1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.</td>
</tr>
<tr>
<td>DSS</td>
<td>1902(a)(10) (C)(ii)(I) of the Act</td>
<td>2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Supersedes Approval Date</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>93-08</td>
<td>03-12-92</td>
<td>10/01/91</td>
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<tr>
<td>N/A</td>
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</tbody>
</table>

HCFA ID: 7983E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Coverage and Conditions of Eligibility

C. Optional Coverage of Medically Needy (continued)

4. Reserved

5. X a. Financially eligible individuals who are not described in section C.3. above and who are under the age of:

   X 21
   _ 20
   _ 19
   _ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

   b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19 or 18 as specified below:

   1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

      a) In foster homes (and are under the age of ___).
      b) In private institutions (and are under the age of ___).
### C. Optional Coverage of Medically Needy (Continued)

- **(c)** In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of __ _).

- **(2)** Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ______).

- **(3)** Individuals in NFs (who are under the age of ______). NF services are provided under this plan.

- **(4)** In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ______).

- **(5)** Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ______). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

- **(6)** Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.
C. Optional Coverage for the Medically Needy (Continued)

- MDCH 42CFR 435.310  X  6. Caretaker Relatives

42CFR 435.326  10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42CFR 435.212 and the same rules apply to medically needy individuals.

42CFR 435.340  11. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;

b. Were eligible as medically needy in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

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TN NO 03-09 Approval Date: Effective Date _04-01-03

Supersedes

TN No. 02-22
C. Optional Coverage of Medically Needy
(Continued)

1906 of the Act

12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Requirements Relating to Determining Eligibility for Medicare
Prescription Drug Low-income Subsidies

1935(a) and 1902(a)(66) 42 CFR 423.774 and 42 CFR 423.904

The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.

1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;

2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;

3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER THE AGE OF 21, 20, 19, AND 18

NOT APPLICABLE
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MICHIGAN

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

Statewide average DRG outlier per diem payment is determined for the child's diagnosis. This becomes the cap for Title XIX covered home care. Care plan is developed and all medically necessary services are provided. At the end of the fiscal year, expenditures for services are compared to DRG allowable cap. If expenditures exceed cap, amount is "cost settled" against Title V, using state dollars. No Title XIX claims will be made exceeding cap.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **MICHIGAN**

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. General Conditions of Eligibility</strong></td>
<td></td>
</tr>
<tr>
<td>42 CFR Part 435, Subpart G</td>
<td>1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.</td>
</tr>
<tr>
<td>a. For the categorically needy:</td>
<td></td>
</tr>
<tr>
<td>(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.</td>
<td></td>
</tr>
<tr>
<td>(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.</td>
<td></td>
</tr>
<tr>
<td>(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.</td>
<td></td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>b. 1905(p) of the Act</td>
<td>For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.</td>
</tr>
<tr>
<td>c. 1905(s) of the Act</td>
<td>For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.</td>
</tr>
<tr>
<td>42 CFR 435.402</td>
<td>3. Is residing in the United States and—</td>
</tr>
<tr>
<td>a.</td>
<td>Is a citizen;</td>
</tr>
<tr>
<td>b.</td>
<td>Is a qualified alien, as defined in section 431(b) of P.L. 104-193, whose coverage is mandatory under sections 402 and 403 of P.L. 104-193, including those who entered the U.S. prior to August 22, 1996 and those who entered on or after August 22, 1996.</td>
</tr>
<tr>
<td>c.</td>
<td>Is a qualified alien, as defined in sections 431(b) of P.L. 104-193, whose coverage is optional under sections 402 and 403 of P.L. 104-193, including those who entered the U.S. prior to August 22, 1996, and those who entered on or after August 22, 1996.</td>
</tr>
<tr>
<td>c.</td>
<td>Is an alien who is not a qualified alien, as defined in section 431(b) of P.L. 104-193, or who is a qualified alien but is not eligible under the provisions of (b) above. (Coverage is restricted to certain emergency services.)</td>
</tr>
</tbody>
</table>

**TN No. 96-20 Supersedes TN No. 92-01**

**Approval Date 2/15/97 Effective Date 1/1/97**
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>d.</td>
<td>Is an alien granted lawful temporary resident status under section 210 of the Immigration and Nationality Act not within the scope of c. above (coverage must be restricted to certain emergency services during the five-year period beginning on the date the alien was granted such status); or</td>
</tr>
<tr>
<td>e.</td>
<td>Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (coverage must be restricted to certain emergency services).</td>
</tr>
<tr>
<td>42 CFR 435.403</td>
<td>4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.</td>
</tr>
<tr>
<td>1902(b) of the Act</td>
<td></td>
</tr>
</tbody>
</table>

- State has interstate residency agreement with the following States:
- State has open agreement(s).
- Not applicable; no residency requirement.

<table>
<thead>
<tr>
<th>TN No.</th>
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<th>Effective Date</th>
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<tr>
<td>87-11</td>
<td>88-03</td>
<td>08-19-92</td>
<td>10/01/91</td>
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HCFA ID: 7985E
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<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.1008</td>
<td>5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.</td>
</tr>
<tr>
<td>42 CFR 435.1008 1905(a) of the Act</td>
<td>b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.</td>
</tr>
<tr>
<td>42 CFR 433.145 1912 of the Act</td>
<td>6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)</td>
</tr>
</tbody>
</table>
An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

Assignment of rights is automatic because of State law.

42 CFR 435.910 7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.910</td>
<td>Assignment of rights is automatic because of State law.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>TN No.</th>
<th>91-30</th>
<th>Approval Date</th>
<th>07-06-92</th>
<th>Effective Date</th>
<th>10-01-91</th>
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<td>Supersedes</td>
<td>N/A</td>
<td>HCFA ID:</td>
<td>7985E</td>
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<td></td>
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<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
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</tr>
<tr>
<td>1902(c)(2)</td>
<td>6. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1902(e)(10)(A) and (B) of the Act</td>
<td>9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)</td>
<td></td>
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<td></td>
<td></td>
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</tbody>
</table>

**Supersedes**: 03-19-92

**Approval Date**: 03-19-92

**Effective Date**: 10/01/91

**HCFA ID**: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Condition or Requirement

10. Is required to apply for enrollment in an employer based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

New York State Department of Social Services v. Dublino, 413 U.S. (1973)

11. Is required to apply for coverage under Medicare Parts A, B and/or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state agrees to pay any applicable premiums and cost sharing (except those applicable under Part D) for individuals required to apply for Medicare. Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

TN NO.: 06-03

Approval Date: JUN 28, 2006

Effective Date: 01/01/2006

Supersedes
TN No.: 91-30

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B. Post-Eligibility Treatment of Institutionalized Individuals

The following amounts are deducted from gross income when computing the application of an individual’s or couple’s income to the cost of institutional care:

1. Personal Needs Allowance
   a. Aged, blind, disabled—
      Individuals $30 plus *
      Couples $60 plus *

   For the following individuals with greater need—
   b. AFDC related—
      Children $30 plus *
      Adults $30 plus *
   c. Individuals under age 21 covered in this plan as specified in Item B.7. of Attachment 2.2-A $_________

2. For maintenance of the non-institutionalized spouse only. The amount must be based on a reasonable assessment of need but must not exceed the highest of—
   SSI level $_________
   SSP level $_________
   Medically need level $ **________
   Other as follow $_________

*Any income over $30 ($60 for couples) for guardianship fees paid for court-appointed guardians up to a maximum amount of $95 per month for actual guardianship fees.

**Applicable protected income level for one person (see Supplement 1).
### Eligibility Conditions and Requirements

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Post-Eligibility Treatment of Institutionalized Individuals (continued)</td>
<td></td>
</tr>
<tr>
<td>3. For children, each family member:</td>
<td></td>
</tr>
<tr>
<td>AFDC level</td>
<td>$</td>
</tr>
<tr>
<td>Medically needy level</td>
<td>$ see Supplement 1</td>
</tr>
<tr>
<td>Other as follows</td>
<td>$</td>
</tr>
<tr>
<td>4. Amounts for incurred medical expenses not subject to payment by a third party:</td>
<td></td>
</tr>
<tr>
<td>a. Health insurance premiums, deductibles and co-insurance charges;</td>
<td></td>
</tr>
<tr>
<td>b. Necessary medical or remedial care not covered under the Medicaid plan (Reasonable limits on amounts are described in Supplement 3 to Attachment 2.6-A).</td>
<td></td>
</tr>
<tr>
<td>5. An amount for maintenance of a single individual’s home (includes apartments) for not longer than 6 months, if a physician has certified he or she is likely to return home within that period.</td>
<td></td>
</tr>
<tr>
<td>☒ Yes. Amount for maintenance of home to equal the federal SSI benefit rate per month</td>
<td></td>
</tr>
<tr>
<td>☐ No</td>
<td></td>
</tr>
<tr>
<td>1902(1) of the Act</td>
<td></td>
</tr>
<tr>
<td>6. SSI benefits paid under section 1611(e)(1)((E) and (G) of the Act to individuals who receive care in a hospital or NF.</td>
<td></td>
</tr>
</tbody>
</table>
7. Maintenance standards for community spouses and other dependent family members used to calculate monthly income allowances under Section 1924 of the Act.

a. Community spouses

1. A standard based on the formula contained in Section 1924 (d) is used.

2. The maximum standard contained in Section 1924 (d)(3)(C).

3. A fixed standard which is greater than the minimum standard described in Section 1924 (d) plus actual shelter costs not to exceed the maximum standard contained in Section 1924 (d)(3)(C). The standard used is $__________.

b. Other family members who are dependent

1. A standard based on the formula contained in Section 1924 (d)(1)(C) is used.

2. A fixed standard greater than the amount which would be used if the formula described in Section 1924 (d)(1)(C) were used. The standard used is $__________.

3. The standards described above are used for individuals receiving home and community-based waiver services in lieu of services provided in a medical or remedial care institution.
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
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<th>Citation(s)</th>
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</thead>
</table>
| 42 CFR 435.711, 435.721, 435.831 | **C. Financial Eligibility**

For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.

For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.

Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.

Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.

Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.

Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.

Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.

Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.

Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(z)(1) of the Act.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(r)(2) of the Act</td>
<td>1. Methods of Determining Income</td>
</tr>
<tr>
<td></td>
<td>a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</td>
</tr>
<tr>
<td></td>
<td>(1) In determining countable income for AFDC-related individuals, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>(a) The methods under the State's approved AFDC plan only; or</td>
</tr>
<tr>
<td></td>
<td>(b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</td>
</tr>
<tr>
<td>1902(e)(6) of the Act</td>
<td>(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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<thead>
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</thead>
<tbody>
<tr>
<td>42 CFR 435.721, 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act</td>
<td>b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>X The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

TN No. 22-1H Supersedes N/A Approval Date 04-16-92 Effective Date 01-01-92

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

For institutional couples, the methods specified under section 1611(e)(5) of the Act.

For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.

For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements—

- SSI methods only.
- SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
- Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.
Citation | Condition or Requirement
--- | ---
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act | c. Blind individuals. In determining countable income for blind individuals, the following methods are used:

- The methods of the SSI program only.
- **X** SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

For institutional couples, the methods specified under section 1611(e)(5) of the Act.

For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.

For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--

- SSI methods only.
- SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
- Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.
In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

42 CFR 435.721, and 435.831

1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act

d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:

- The methods of the SSI program.
- SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
- For institutional couples: the methods specified under section 1611(e)(5) of the Act.
- For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.
- For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--

SSI methods only.

SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State:** MICHIGAN

#### ELIGIBILITY CONDITIONS AND REQUIREMENTS

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<tr>
<th>Citation(s)</th>
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</tr>
</thead>
</table>
| 1902 (l)(3)(E) and 1902 (r)(2) of the Act | e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902 (a)(10)(A)(i)(IV), (VI), and (VII), and 1902 (a)(10)(A)(ii)(IX) of the Act—

  (1) The following methods are used in determining countable income:

  - The methods of the State's approved AFDC plan.
  - The methods of the approved title IV-E plan.
  - The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to Attachment 2.6-A.
  - The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to Attachment 2.6-A. |

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**TN No. 98-05**

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**Supersedes TN No. 95-01**

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

**State:** MICHIGAN

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

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<th>Citation(s)</th>
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<tbody>
<tr>
<td>1902(e)(6) of the Act</td>
<td>(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</td>
</tr>
<tr>
<td>1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act</td>
<td>(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</td>
</tr>
<tr>
<td></td>
<td>f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>X SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
</tbody>
</table>

**Revision:** HCFA-PM-92-1  
**FEBRUARY 1992**  
**ATTACHMENT 2.6-A**  
**Page 12**

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**Supersedes**  
**TN No. 92-14**  
**Approval Date 04-16-92**  
**Effective Date 01-01-92**

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If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.

1905(s) of the Act g. (1) Qualified disabled and working individuals.

In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.

1905(p) of the Act (2) Specified low-income Medicare beneficiaries.

In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.
### Citation

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(u) of the Act</td>
<td>(h) <strong>COBRA Continuation Beneficiaries</strong></td>
</tr>
</tbody>
</table>

In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:

- **X** The disregards of the SSI program;
- The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

**NOTE:** For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

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</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XIII) of the Act</td>
<td>(i) Working Individuals with Disabilities – BBA</td>
</tr>
</tbody>
</table>

In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied:

- The methodologies of the SSI program.
- The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A.
- The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

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<th>Condition or Requirement</th>
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</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act</td>
<td>(ii) Working Individuals with Disabilities - Basic Coverage Group TWWIIA</td>
</tr>
</tbody>
</table>

In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied:

- The agency does not apply any income or resource standard.

- The agency applies the following income and/or resource standard(s):

  - **Income Limit:** Individual's total countable income cannot exceed 250% of current federal poverty level guidelines.

  - **Resource Limit:** Individual's total countable assets cannot exceed the resource limit described in 1905(p)(1)(C)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

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<thead>
<tr>
<th>Citation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1902 (a)(10)(A) (ii)(XV) of the Act (cont.)</td>
<td>Income Methodologies</td>
</tr>
<tr>
<td></td>
<td>In determining whether an individual meets the income standard described above, the agency uses the following methodologies:</td>
</tr>
<tr>
<td></td>
<td>- The income methodologies of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>- The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A</td>
</tr>
<tr>
<td></td>
<td>- The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A</td>
</tr>
</tbody>
</table>

TN NO.: 04-03 Approval Date: Effective Date: 01/01/04

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TN No.: N/A new page
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### Eligibility Conditions and Requirements

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<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act (cont)</td>
<td><strong>Resource Methodologies</strong></td>
</tr>
</tbody>
</table>

In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.

Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.

- The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.
- The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 8a to Attachment 2.6-A.

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**Approval Date: 01/01/03**  
**Effective Date: 01/01/04**

Supersedes

**TN No.: N/A new page**
## Eligibility Conditions and Requirements

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act (cont)</td>
<td>The agency does not disregard funds in retirement accounts.</td>
</tr>
<tr>
<td></td>
<td>The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>The agency uses the resource methodologies of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A</td>
</tr>
</tbody>
</table>

**TN NO.: 04-03**

**Approval Date: 2002**

**Effective Date: 01/01/04**

Supersedes

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<table>
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<tr>
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</tr>
</thead>
</table>

in determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied:

- The agency does not apply any income or resource standard.
- The agency applies the following income and/or resource standard(s):

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October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
## Eligibility Conditions and Requirements

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<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XVI) of the Act (cont)</td>
<td><strong>Income Methodologies</strong></td>
</tr>
<tr>
<td></td>
<td>In determining whether an individual meets the income standard described above, the agency uses the following methodologies:</td>
</tr>
<tr>
<td></td>
<td>- The income methodologies of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>- The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>- The agency uses more liberal income methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

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**TN NO.: 04-03**  
**Approval Date:** [UNREADABLE DATE]  
**Effective Date:** 01/01/04

**Supersedes**  
**TN No.: N/A new page**
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<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XVI) of the Act (cont)</td>
<td>Resource Methodologies</td>
</tr>
</tbody>
</table>

In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.

Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.

- The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.
- The agency disregards funds in retirement accounts in a manner other than those listed above. The agency’s disregards are specified in Supplement 8b to Attachment 2.6-A.

TN NO.: 04-03

Approval Date: JUN 2 20XX

Effective Date: 01/01/04

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TN No.: N/A new page
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Eligibility Conditions and Requirements

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<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XVI) of the Act (cont)</td>
<td>The agency does not disregard funds in retirement accounts.</td>
</tr>
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<td></td>
<td>The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>The agency uses the resource methodologies of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.</td>
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TN NO.: 04-03  Approval Date: JUN 2,  Effective Date: 01/01/04

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<tbody>
<tr>
<td>1902(a)(10)(A)(ii)(XVI) and 1905 (v)(2) of the Act</td>
<td>Definition of Employed – Employed Medically Improved Individuals – TWWIA.</td>
</tr>
<tr>
<td></td>
<td>The agency uses the statutory definition of “employed”, i.e., earning at least the minimum wage and working at least 40 hours per month.</td>
</tr>
<tr>
<td></td>
<td>The agency uses an alternative definition of “employed” that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency’s threshold criteria are described below:</td>
</tr>
</tbody>
</table>

TN NO.: 04-03

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# Eligibility Conditions and Requirements

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<tbody>
<tr>
<td>1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act</td>
<td>Payment of Premiums or Other Cost Sharing Charges</td>
</tr>
</tbody>
</table>

For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of Attachment 2.2-A:

The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied, are described below:

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Supersedes
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

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<tbody>
<tr>
<td>1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act (cont)</td>
<td>For individuals eligible under the Basic Coverage Group described in No. 24 on page 23d of Attachment 2.2-A, and the Medical Improvement Group described in No. 25 on page 23d of Attachment 2.2-A: The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income. The premiums or other cost-sharing charges, and how they are applied, are described on page 120.</td>
</tr>
</tbody>
</table>

TN No.: 04-03 Approval Date: Jan 31 2004 Effective Date: 01/01/04

Supersedes
TN No.: N/A new page
### Citation

Sections 1902(a)(1O)(A)(ii)(XV), (XVI), and 1916(g) of the Act (cent)

### Condition or Requirement

**Premiums and Other Cost-Sharing Charges**

For the Basic Coverage Group and the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described below.

No premium will be assessed for individuals with income less than 138% of the FPL.

A premium of up to 7.5% per month of income for individuals with income between 138% of the FPL and the statutory limit described in 1916(g)(2) and subject to the mandatory increases in section 215(i)(2)(A)(ii).

Individuals with annual income exceeding the statutory limits described in 1916(g)(2) and subject to the mandatory increases in section 215(i)(2)(A)(ii) will pay a premium of 100% of the average Freedom to Work Program participant cost for an enrolled individual as determined by the Department of Community Health.
### 2. Medicaid Qualifying Trusts

In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.

The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.

### 3. Medically needy income levels (MNILs) are based on family size.

Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.
Citation: 42 CFR 435.732, 435.831
Condition or Requirement: 4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only

a. Medically Needy

(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either one or one month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.

(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:

(a) Health insurance premiums, deductibles and coinsurance charges.

(b) Expenses for necessary medical and remedial care not included in the plan.

(c) Expenses for necessary medical and remedial care included in the plan.

Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.

1902(a)(17) of the Act

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.
1903(f)(2) of the Act

a. Medically Needy (Continued)

(3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.732</td>
<td>The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:</td>
</tr>
<tr>
<td>(1)</td>
<td>Any SSI benefit received.</td>
</tr>
<tr>
<td>(2)</td>
<td>Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(X1) of the Act.</td>
</tr>
<tr>
<td>(3)</td>
<td>Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.</td>
</tr>
<tr>
<td>(4)</td>
<td>Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4.</td>
</tr>
<tr>
<td>(5)</td>
<td>Incurred expenses for necessary medical and remedial services recognized under State law.</td>
</tr>
<tr>
<td>1902(a)(17) of the Act, P.L. 100-203</td>
<td>Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>4.b. Categorically Needy - Section 1902(f) States Continued</td>
<td>1903(f)(2) of the Act. (6) Spenddown payments made to the State by the individual. NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TN No. 91-30</th>
<th>Approval Date 07-06-92</th>
<th>Effective Date 10-01-91</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supersedes N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HCFA ID: 7985E/
5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the State's approved AFDC plan; and

(b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
5. Methods for Determining Resources

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and (C), and 1902(r) of the Act</td>
<td>b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(II)(X) of the Act, the agency used the following methods for treatment of resources:</td>
</tr>
<tr>
<td></td>
<td>The methods of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>X SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.</td>
</tr>
</tbody>
</table>

TN No. 68-13  
Supersedes N/A  
Approval Date 03-19-92  
Effective Date 10-01-91  
HCFA ID: 7985E
In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.

1902(a)(10)(A), 1902(a)(10)(C), and 1902(m)(1)(B), and 1902(r) of the Act

c. Blind individuals. For blind individuals, the agency uses the following methods for treatment of resources:

- The methods of the SSI program.
- SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

- Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
### Citation | Condition or Requirement
--- | ---
1902(a)(10)(A), 1902(a)(10)(C), and 1902(m)(1)(B) of the Act | d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources:

- The methods of the SSI program.
- SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
- Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.


The agency uses the following methods in the treatment of resources:

- The methods of the SSI program only.
- The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.

**Supersedes**

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Approval Date</th>
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<tbody>
<tr>
<td>98-03</td>
<td>03-19-92</td>
<td>10-01-91</td>
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<tr>
<td>91-11</td>
<td></td>
<td></td>
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</tbody>
</table>

HCFA ID: 7985E
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>—</td>
<td>Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>X</td>
<td>Not applicable. The agency does not consider resources in determining eligibility.</td>
</tr>
</tbody>
</table>

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

1902(1)(3) and 1902(r)(2) of the Act


The agency uses the following methods for the treatment of resources:

— The methods of the State’s approved AFDC plan.

— Methods more liberal than those in the State’s approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.

— Methods more liberal than those in the State’s approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.

X Not applicable. The agency does not consider resources in determining eligibility.
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

#### State: MICHIGAN

#### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
<td>1. Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act. The agency uses the following methods for the treatment of resources:</td>
</tr>
<tr>
<td></td>
<td>- The methods of the State's approved AFDC plan.</td>
</tr>
<tr>
<td></td>
<td>- Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1902(1)(3)(C) of the Act</td>
<td>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1902(r)(2) of the Act</td>
<td>X Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</td>
</tr>
</tbody>
</table>

**TN No.**: 02-14  
**Supersedes**: 92-03  
**Approval Date**: 04-16-92  
**Effective Date**: 01-01-92
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
<td>2. Poverty level children under section 1902(a)(1)(A)(VII)</td>
</tr>
</tbody>
</table>

The agency uses the following methods for the treatment of resources:

- The methods of the State's approved AFDC plan.
- Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 5a of ATTACHMENT 2.6-A.
- Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8a to ATTACHMENT 2.6-A.

X Not applicable. The agency does not consider resources in determining eligibility.

In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1905(p)(l)</td>
<td>5. h. For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(l) of the Act the agency uses the following methods for treatment of resources:</td>
</tr>
<tr>
<td>(C) and (D) and</td>
<td>The methods of the SSI program only.</td>
</tr>
<tr>
<td>1902(r)(2) of</td>
<td>X The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>the Act</td>
<td></td>
</tr>
<tr>
<td>1905(s) of the</td>
<td>i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.</td>
</tr>
<tr>
<td>Act</td>
<td></td>
</tr>
<tr>
<td>1902(u) of the</td>
<td>j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources:</td>
</tr>
<tr>
<td>Act</td>
<td>X The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>____ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

TN No. 91-30
Supersedes Approval Date 07-06-92 Effective Date 10-01-91

TN No. N/A
HCFA ID: 7985E
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(E)(iii) of the Act</td>
<td>k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act-- The agency uses the same method as in 5.h. of Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

- Same as SSI resource standards.
- More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3)(A), (B) and (C) of the Act</td>
<td>c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard.</td>
</tr>
<tr>
<td></td>
<td>Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan.</td>
</tr>
<tr>
<td></td>
<td>X No. The agency does not apply a resource standard to these individuals.</td>
</tr>
<tr>
<td>1902(1)(3)(A) and (C) of the Act</td>
<td>d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard.</td>
</tr>
<tr>
<td></td>
<td>Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</td>
</tr>
<tr>
<td></td>
<td>X No. The agency does not apply a resource standard to these individuals.</td>
</tr>
</tbody>
</table>
e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is:

- Same as SSI resource standards.
- Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).

Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.
7. Resource Standard -- Medically Needy
   a. Resource standards are based on family size.
   b. A single standard is employed in determining resource eligibility for all groups.
   c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for –
      - Aged
      - Blind
      - Disabled

Supplement 2 to Attachment 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.C., Supplement 2 to Attachment 2.6-A so indicates.

8. Resource Standard – Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals

For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the Consumer Price Index.

9. Resource Standard – Qualified Disabled and Working Individuals

For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource limit.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(u) of the Act</td>
<td>For COBRA continuation beneficiaries, the resource standard is:</td>
</tr>
<tr>
<td></td>
<td>X  Twice the SSI resource standard for an individual.</td>
</tr>
<tr>
<td></td>
<td>More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TN No.</th>
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</thead>
<tbody>
<tr>
<td>91-30</td>
<td>07-06-92</td>
<td>10-01-91</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HCFA ID: 7985E
1902(u) of the Act 10. Excess Resources

a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

   Any excess resources make the individual ineligible.

b. Categorically Needy Only

   X This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

   Any excess resources make the individual ineligible.
Citation | Condition or Requirement
--- | ---
42 CFR 435.914 | 11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

- X Aged, blind, disabled.
- AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

- X Aged, blind, disabled.
- AFDC-related.

(2) For the retroactive period.**

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

- X Aged, blind, disabled.
- AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.

- X Aged, blind, disabled.
- AFDC-related.

* Applicable to certain spend-down cases.

** Eligibility is determined separately for each of the three retroactive months. For each month, coverage is available for the full month if eligible at any time during the month, except for certain spend-down cases in which coverage is available only for the period during each month for which the individual meets eligibility requirements.
# Eligibility Conditions and Requirements

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>11. Effective Date of Eligibility</strong></td>
<td></td>
</tr>
<tr>
<td>a. Groups Other Than Qualified Medicare Beneficiaries</td>
<td></td>
</tr>
<tr>
<td>(continued)</td>
<td></td>
</tr>
<tr>
<td>1920(b)(1) of the Act</td>
<td>X (3) For a presumptive eligibility for pregnant women only</td>
</tr>
<tr>
<td></td>
<td>Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in Attachment 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.</td>
</tr>
<tr>
<td>1902(e)(8) and 1905(a) of the Act</td>
<td>X b. For qualified Medicare beneficiaries defined in section 1905(P)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for</td>
</tr>
<tr>
<td></td>
<td>X 12 months</td>
</tr>
<tr>
<td></td>
<td>___ 6 months</td>
</tr>
<tr>
<td></td>
<td>___ ___ months (no less than 6 months and no more than 12 months)</td>
</tr>
</tbody>
</table>

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TN NO.: 05-05 Approval Date: 4/25/05 Effective Date: 01/01/2005

Supersedes
TN No.: 92-14

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October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902 (a) (18) and 1902 (f) of the Act</td>
<td>12. Pre-OBRA 93 Transfer of Resources- Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals</td>
</tr>
<tr>
<td></td>
<td>The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.</td>
</tr>
<tr>
<td></td>
<td>Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.</td>
</tr>
<tr>
<td>1917 (c)</td>
<td>13. Transfer of Assets-All eligibility groups</td>
</tr>
<tr>
<td></td>
<td>The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.</td>
</tr>
<tr>
<td></td>
<td>Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.</td>
</tr>
<tr>
<td>1917 (d)</td>
<td>14. Treatment of Trusts – All eligibility groups</td>
</tr>
<tr>
<td></td>
<td>The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.</td>
</tr>
<tr>
<td></td>
<td>☐ The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts:</td>
</tr>
<tr>
<td></td>
<td>☐ The agency meets the requirements in section 1917(d)(4)(B) of the Act for use of Miller trusts.</td>
</tr>
<tr>
<td></td>
<td>The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as determined in Supplement 10 to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other than Poverty Level Pregnant Women and Infants:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Need Standard</th>
<th>Payment Standard</th>
<th>Maximum Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Need Standard</td>
<td>See page 1b.</td>
<td>Maximum payment is 100% of the payment standard. See page 1a.</td>
</tr>
</tbody>
</table>

2. Pregnant Women and Infants under Section 1902(a) (10) (A) (i) (IV) of the Act:

Effective April 1, 1990, based on the following percent of the official Federal income poverty level --

- 133 percent
- √ 185 percent of the Federal Poverty Level as revised annually in the Federal Register

TN No. 95-01 Approval Date 6-16-95 Effective Date 02-01-95

Supersedes

TN No. 94-05
ELIGIBLE GRANTEE LIVING ARRANGEMENT

The amounts given in Tables 1-3 below are the basic shelter allowances.

In situations in which the heat and/or utilities are included in the rental expense, the basic shelter allowance must be adjusted by adding the appropriate heat and/or utility allowance from Table 4 or 5 below to the basic shelter allowance. The result becomes the actual shelter allowance. When the ADC/GA-F group pays for heat and/or utilities, the allowances in PRM 210-1 must be used.

### BASIC SHELTER ALLOWANCES

#### ZONE I & II

<table>
<thead>
<tr>
<th>Shelter Area</th>
<th>ALL ADC/GA-F GROUPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Shelter Areas</td>
<td>Basic Shelter Allowance is $50</td>
</tr>
</tbody>
</table>

**Table 3** - The basic shelter allowance is determined as follows:
- Go down the table to find the shelter area the county is in, then;
- Move across the table and find the ADC/GA-F group size.
- The amount given on the table is the amount of the basic shelter allowance.

#### Group Size

<table>
<thead>
<tr>
<th>ADC/GA-F Group Size</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>115</td>
<td>115</td>
<td>120</td>
<td>145</td>
<td>155</td>
<td>200</td>
</tr>
<tr>
<td>II</td>
<td>115</td>
<td>120</td>
<td>130</td>
<td>155</td>
<td>165</td>
<td>210</td>
</tr>
<tr>
<td>III</td>
<td>120</td>
<td>130</td>
<td>140</td>
<td>165</td>
<td>175</td>
<td>220</td>
</tr>
<tr>
<td>IV</td>
<td>135</td>
<td>145</td>
<td>155</td>
<td>180</td>
<td>190</td>
<td>235</td>
</tr>
<tr>
<td>V</td>
<td>150</td>
<td>160</td>
<td>170</td>
<td>195</td>
<td>205</td>
<td>250</td>
</tr>
<tr>
<td>VI</td>
<td>165</td>
<td>175</td>
<td>185</td>
<td>210</td>
<td>220</td>
<td>265</td>
</tr>
</tbody>
</table>

In home purchase situations, if the ADC/GA-F group's actual shelter expense is greater than the basic shelter allowance obtained from Table 3 above, the actual shelter allowance for the ADC/GA-F group is their actual shelter expense up to the basic shelter allowance for an ADC/GA-F group of 6 or more in the appropriate area. (The difference between the basic shelter allowance and the lesser of the ADC/GA-F group's actual shelter expense or the basic shelter allowance for an ADC/GA-F group of 6 or more in the appropriate area is called the home purchase increment.)

### ADJUSTMENT TO BASIC SHELTER ALLOWANCE RENTAL

#### ZONE I ONLY

<table>
<thead>
<tr>
<th>Rental Situation</th>
<th>Group Size</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heat Included</td>
<td></td>
<td>$47</td>
<td>$53</td>
<td>$54</td>
<td>$56</td>
<td>$62</td>
<td>$71</td>
</tr>
<tr>
<td>Utilities Included</td>
<td></td>
<td>$18</td>
<td>$21</td>
<td>$22</td>
<td>$23</td>
<td>$26</td>
<td>$30</td>
</tr>
<tr>
<td>Heat &amp; Utilities Included in Rent</td>
<td></td>
<td>$65</td>
<td>$74</td>
<td>$76</td>
<td>$79</td>
<td>$88</td>
<td>$101</td>
</tr>
</tbody>
</table>

#### ZONE II ONLY

<table>
<thead>
<tr>
<th>Rental Situation</th>
<th>Group Size</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heat Included</td>
<td></td>
<td>$51</td>
<td>$57</td>
<td>$58</td>
<td>$60</td>
<td>$66</td>
<td>$75</td>
</tr>
<tr>
<td>Utilities Included</td>
<td></td>
<td>$18</td>
<td>$21</td>
<td>$22</td>
<td>$23</td>
<td>$26</td>
<td>$30</td>
</tr>
<tr>
<td>Heat &amp; Utilities Included in Rent</td>
<td></td>
<td>$69</td>
<td>$78</td>
<td>$80</td>
<td>$83</td>
<td>$92</td>
<td>$105</td>
</tr>
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</table>

TN No. 98-04 Approval Date 5-3-93 Effective Date 1-1-93 Supersedes TN No. 87-1
## PAYMENT STANDARDS

<table>
<thead>
<tr>
<th>Group Size</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONE</td>
<td>$255</td>
<td>$255</td>
<td>$260</td>
<td>$276</td>
<td>$290</td>
<td>$305</td>
</tr>
<tr>
<td>TWO</td>
<td>341</td>
<td>346</td>
<td>356</td>
<td>371</td>
<td>386</td>
<td>401</td>
</tr>
<tr>
<td>THREE</td>
<td>424</td>
<td>434</td>
<td>444</td>
<td>459</td>
<td>474</td>
<td>489</td>
</tr>
<tr>
<td>FOUR</td>
<td>528</td>
<td>538</td>
<td>548</td>
<td>563</td>
<td>578</td>
<td>593</td>
</tr>
<tr>
<td>FIVE</td>
<td>624</td>
<td>634</td>
<td>644</td>
<td>659</td>
<td>674</td>
<td>689</td>
</tr>
<tr>
<td>SIX</td>
<td>757</td>
<td>767</td>
<td>777</td>
<td>792</td>
<td>807</td>
<td>822</td>
</tr>
<tr>
<td>SEVEN</td>
<td>833</td>
<td>843</td>
<td>853</td>
<td>868</td>
<td>883</td>
<td>898</td>
</tr>
<tr>
<td>EIGHT or more</td>
<td></td>
<td></td>
<td></td>
<td>Add $76 for each additional person.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TN No. 92-15** Approval Date: **11-23-92** Effective Date: **01-01-92**

Supersedes

**TN No. 92-04**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

Supersedes Approval Date 04-16-92 Effective Date 01-01-92

TN No. 92-04

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(1)(A)(ii)(IX) and 1902(1)(2) of the Act are as follows:

Based on ______ percent of the official Federal income poverty level (no less than 133 percent and no more than 185 percent).

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$________</td>
</tr>
<tr>
<td>2</td>
<td>$________</td>
</tr>
<tr>
<td>3</td>
<td>$________</td>
</tr>
<tr>
<td>4</td>
<td>$________</td>
</tr>
<tr>
<td>5</td>
<td>$________</td>
</tr>
</tbody>
</table>

N/A
### B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

#### 2. Children Between Ages 6 and 8

The levels for determining income eligibility for groups of children who are born after September 30, 1983 and who have attained 6 years of age but are under 8 years of age under the provisions of section 1902(1)(2) of the Act are as follows:

Based on ________ percent (no more than 100 percent) of the official Federal income poverty line.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>$</td>
</tr>
<tr>
<td>3</td>
<td>$</td>
</tr>
<tr>
<td>4</td>
<td>$</td>
</tr>
<tr>
<td>5</td>
<td>$</td>
</tr>
<tr>
<td>6</td>
<td>$</td>
</tr>
<tr>
<td>7</td>
<td>$</td>
</tr>
<tr>
<td>8</td>
<td>$</td>
</tr>
<tr>
<td>9</td>
<td>$</td>
</tr>
<tr>
<td>10</td>
<td>$</td>
</tr>
</tbody>
</table>

N/A

---

TN No. 94-04  
Supersedes TN No. 91-02  
Approval Date 5-3-93  
Effective Date 1-1-92  
HCFA ID: 7985E

**Revision:** HCFA-PM-91-4  
**(BPD)**  
**SUPPLEMENT 1 TO ATTACHMENT 2.6-A**  
**Page 4**  
**OMB No.: 0938-**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of age and disabled individuals under the provisions of section 1902(m) (1) of the Act are as follows:

Based on \_100\_ percent of the official Federal Poverty Level as revised annually in the Federal Register.

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

* NA, largest family size is 2.
### MA Monthly Protected Income Levels

By County Shelter Area

#### Zone I Counties

<table>
<thead>
<tr>
<th>Shelter Area</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Persons</td>
<td>Amount</td>
<td>Amount</td>
<td>Amount</td>
<td>Amount</td>
<td>Amount</td>
<td>Amount</td>
</tr>
<tr>
<td>1</td>
<td>333.</td>
<td>333.</td>
<td>341.</td>
<td>358.</td>
<td>375.</td>
<td>400.</td>
</tr>
<tr>
<td>2</td>
<td>450.</td>
<td>450.</td>
<td>466.</td>
<td>483.</td>
<td>500.</td>
<td>516.</td>
</tr>
<tr>
<td>3</td>
<td>481.</td>
<td>486.</td>
<td>499.</td>
<td>514.</td>
<td>529.</td>
<td>544.</td>
</tr>
<tr>
<td>4</td>
<td>512.</td>
<td>521.</td>
<td>531.</td>
<td>544.</td>
<td>558.</td>
<td>572.</td>
</tr>
<tr>
<td>5</td>
<td>604.</td>
<td>613.</td>
<td>622.</td>
<td>636.</td>
<td>649.</td>
<td>663.</td>
</tr>
<tr>
<td>6</td>
<td>730.</td>
<td>740.</td>
<td>749.</td>
<td>762.</td>
<td>776.</td>
<td>790.</td>
</tr>
<tr>
<td>7</td>
<td>804.</td>
<td>813.</td>
<td>823.</td>
<td>836.</td>
<td>850.</td>
<td>864.</td>
</tr>
<tr>
<td>8</td>
<td>878.</td>
<td>887.</td>
<td>896.</td>
<td>910.</td>
<td>924.</td>
<td>938.</td>
</tr>
<tr>
<td>9</td>
<td>952.</td>
<td>961.</td>
<td>970.</td>
<td>984.</td>
<td>998.</td>
<td>1,011.</td>
</tr>
<tr>
<td>10*</td>
<td>1,026</td>
<td>1,035</td>
<td>1,044</td>
<td>1,058</td>
<td>1,072</td>
<td>1,085</td>
</tr>
</tbody>
</table>

#### Zone II Counties

<table>
<thead>
<tr>
<th>Shelter Area</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Persons</td>
<td>Amount</td>
<td>Amount</td>
<td>Amount</td>
<td>Amount</td>
<td>Amount</td>
<td>Amount</td>
</tr>
<tr>
<td>1</td>
<td>341.</td>
<td>341.</td>
<td>350.</td>
<td>366.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>450.</td>
<td>458.</td>
<td>466.</td>
<td>491.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>483.</td>
<td>492.</td>
<td>500.</td>
<td>520.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>516.</td>
<td>525.</td>
<td>534.</td>
<td>548.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>607.</td>
<td>616.</td>
<td>625.</td>
<td>639.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>734.</td>
<td>743.</td>
<td>752.</td>
<td>766.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>808.</td>
<td>817.</td>
<td>826.</td>
<td>840.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>882.</td>
<td>891.</td>
<td>900.</td>
<td>914.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>956.</td>
<td>965.</td>
<td>974.</td>
<td>988.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10*</td>
<td>1,030</td>
<td>1,039</td>
<td>1,048</td>
<td>1,062</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*For each additional person, add $67.

---

TN 91-5   | Approval Date | Effective Date 07-01-91  
Supersedes | TN 91-5  
October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
D. MEDICALLY NEEDY

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net income level protected for maintenance for</th>
<th>Amount by which Column (2) exceeds limits specified in 42 CFR months</th>
<th>Net income level living in rural areas for Column (4) months</th>
<th>Amount by which 42 CFR 435.1007 1/</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Continued)</td>
<td></td>
<td></td>
<td>The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.</td>
</tr>
</tbody>
</table>

1. For each additional person, add: $ $ $ $ $ $ $ $ $ $ $ $ $ $ 

TN No. 22-44 Supersedes N/A Approval Date 5-3-92 Effective Date 1-1-92

HCFA ID: 7985E
### D. MEDICALLY NEEDY

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net income level protected for maintenance for</th>
<th>Amount by which exceeds limits specified in 42 CFR</th>
<th>Net income level for persons living in rural areas for specified in 42 CFR</th>
<th>Amount by which exceeds limits specified in 42 CFR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>6</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>7</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>8</td>
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<td>$</td>
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<td>$</td>
</tr>
<tr>
<td>9</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>10</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

For each additional person, add:

1/ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

TN No. 92-04
Supersedes Approval Date 5-3-93 Effective Date 1-1-92
TN No. N/A
HCFA ID: 7985E

Note: This plan is provided for informational use only and does not replace the original version.
## ADC/MA SHELTER AREAS

<table>
<thead>
<tr>
<th>SHELTER AREA I</th>
<th>SHELTER AREA II</th>
<th>SHELTER AREA III</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 Alger</td>
<td>06 Arenac</td>
<td>01 Alcona</td>
</tr>
<tr>
<td>07 Baraga</td>
<td>17 Chippewa</td>
<td>10 Benzie</td>
</tr>
<tr>
<td>27 Gogebic</td>
<td>21 Delta</td>
<td>16 Cheboygan</td>
</tr>
<tr>
<td>32 Huron</td>
<td>31 Houghton</td>
<td>20 Crawford</td>
</tr>
<tr>
<td>36 Iron</td>
<td>35 Iosco</td>
<td>22 Dickinson</td>
</tr>
<tr>
<td>42 Keweenaw</td>
<td>43 Lake</td>
<td>26 Gladwin</td>
</tr>
<tr>
<td>48 Luce</td>
<td>51 Manistee</td>
<td>30 Hillsdale</td>
</tr>
<tr>
<td>54 Mecosta</td>
<td>64 Oceana</td>
<td>38 Jackson</td>
</tr>
<tr>
<td>55 Menominee</td>
<td>66 Ontonagon</td>
<td>40 Kalkaska</td>
</tr>
<tr>
<td>71 Presque Isle</td>
<td>67 Osceola</td>
<td>49 Mackinac</td>
</tr>
<tr>
<td>77 Schoolcraft</td>
<td>68 Oscoda</td>
<td>53 Mason</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SHELTER AREA IV</th>
<th>SHELTER AREA V</th>
<th>SHELTER AREA VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>03 Allegan</td>
<td>08 Barry</td>
<td>25 Genesee</td>
</tr>
<tr>
<td>04 Alpena</td>
<td>09 Bay</td>
<td>33 Ingham</td>
</tr>
<tr>
<td>05 Antrim</td>
<td>19 Clinton</td>
<td>47 Livingston</td>
</tr>
<tr>
<td>11 Berrien</td>
<td>23 Eaton</td>
<td>50 Macomb</td>
</tr>
<tr>
<td>12 Branch</td>
<td>28 Grand Traverse</td>
<td>58 Monroe</td>
</tr>
<tr>
<td>13 Calhoun</td>
<td>39 Kalamazoo</td>
<td>63 Oakland</td>
</tr>
<tr>
<td>14 Cass</td>
<td>41 Kent</td>
<td>74 St. Clair</td>
</tr>
<tr>
<td>15 Charlevoix</td>
<td>44 Lapeer</td>
<td>81 Washtenaw</td>
</tr>
<tr>
<td>18 Clare</td>
<td>45 Leelanau</td>
<td></td>
</tr>
<tr>
<td>24 Emmet</td>
<td>46 Lenawee</td>
<td></td>
</tr>
<tr>
<td>29 Gratiot</td>
<td>56 Midland</td>
<td></td>
</tr>
<tr>
<td>34 Ionia</td>
<td>69 Otsego</td>
<td></td>
</tr>
<tr>
<td>37 Isabella</td>
<td>70 Ottawa</td>
<td></td>
</tr>
<tr>
<td>52 Marquette</td>
<td>73 Saginaw</td>
<td></td>
</tr>
<tr>
<td>60 Montmorency</td>
<td>80 Van Buren</td>
<td></td>
</tr>
<tr>
<td>72 Roscommon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75 St. Joseph</td>
<td></td>
<td></td>
</tr>
<tr>
<td>78 Shiawassee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>79 Tuscola</td>
<td></td>
<td></td>
</tr>
<tr>
<td>82 Wayne</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

TN No. **44-05**  
Approval Date **4-16-94**  
Effective Date **01-01-94**  
Supersedes TN No. **92-15**  

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
## MA Monthly Protected Income Levels

By County Shelter Area

<table>
<thead>
<tr>
<th>Shelter Area</th>
<th>Number of Persons</th>
<th>Amount</th>
<th>Amount</th>
<th>Amount</th>
<th>Amount</th>
<th>Amount</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>V</td>
<td>VI</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>341.</td>
<td>341.</td>
<td>350.</td>
<td>375.</td>
<td>391.</td>
<td>408.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>458.</td>
<td>466.</td>
<td>475.</td>
<td>500.</td>
<td>516.</td>
<td>541.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>493.</td>
<td>502.</td>
<td>512.</td>
<td>532.</td>
<td>547.</td>
<td>567.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>528.</td>
<td>538.</td>
<td>548.</td>
<td>563.</td>
<td>578.</td>
<td>593.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>624.</td>
<td>634.</td>
<td>644.</td>
<td>659.</td>
<td>674.</td>
<td>689.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>757.</td>
<td>767.</td>
<td>777.</td>
<td>792.</td>
<td>807.</td>
<td>822.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>909.</td>
<td>919.</td>
<td>929.</td>
<td>944.</td>
<td>959.</td>
<td>974.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>985.</td>
<td>995.</td>
<td>1,005.</td>
<td>1,020.</td>
<td>1,035.</td>
<td>1,050.</td>
<td></td>
</tr>
<tr>
<td>10*</td>
<td>1,061.</td>
<td>1,071.</td>
<td>1,081.</td>
<td>1,096.</td>
<td>1,111.</td>
<td>1,126.</td>
<td></td>
</tr>
</tbody>
</table>

* For each additional person, add $76.

**Approval Date:** 10-23-92  
**Effective Date:** 01-01-92  

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

Same as SSI resources levels.

Less restrictive than SSI resource levels and is as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

b. Optional Groups

Same as SSI resources levels.

Less restrictive than SSI resource levels and is as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

N/A

TN No. 92-04
Supersedes 87-11
Approval Date 5-3-93
Effective Date 1-1-93
HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD)
SUPPLEMENT 2 TO ATTACHMENT 2.6-A
AUGUST 1991
Page 1
OMB No.: 0938-
2. Infants

a. Mandatory Group of Infants

- Same as resource levels in the State's approved AFDC plan.
- Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

N/A

TN No. 92-04
Supersedes
Supersedes
TN No. 91-04
Approval Date 5-3-93 Effective Date 1-1-92
HCFA ID: 7985E
**State Plan Under Title XIX of the Social Security Act**

**State:** MICHIGAN

b. Optional Group of Infants

- Same as resource levels in the State's approved AFDC plan.
- Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

N/A

**TN No.** 82-04  **Supersedes** Approval Date 5-3-93  **Effective Date** 1-1-92

**TN No.** 89-05

HCFA ID: 7985E
**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State:** MICHIGAN

3. **Children**

   a. **Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)**

      - Same as resource levels in the State's approved AFDC plan.
      - Less restrictive than the AFDC levels and are as follows:

      | Family Size | Resource Level |
      |-------------|----------------|
      | 1           |                |
      | 2           |                |
      | 3           |                |
      | 4           |                |
      | 5           |                |
      | 6           |                |
      | 7           |                |
      | 8           |                |
      | 9           |                |
      | 10          |                |

      N/A

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**Supersedes Approval Date 04-16-92 Effective Date 01-01-92**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **MICHIGAN**

b. Mandatory Group of Children under Section 1902(a)(10)(i)(VII) of the Act. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19.)

- Same as resource levels in the State's approved AFDC plan.
- Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

**NOT APPLICABLE**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

4. Aged and Disabled Individuals

[X] Same as SSI resource levels.

[ ] More restrictive than SSI levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

[ ] Same as medically needy resource levels (applicable only if State has a medically needy program)

Supersedes Approval Date 6-16-95

Effective Date 01-01-95

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Resource Levels

B. Medically Needy

1. Applicable to all groups – the group limit for SSI related cannot exceed two.

   Except those specified below under the provision of Section 1902(f) of the Act:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2,000</td>
</tr>
<tr>
<td>2</td>
<td>3,000</td>
</tr>
</tbody>
</table>

TN NO.: 06-02  Approval Date: JAN 08 2007  Effective Date: 05/01/2006

Supersedes
TN No.: 97-14

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Reasonable Limits on Amounts for Necessary Medical or Remedial Care not Covered under Medicaid

Reasonable and necessary medical expenses not covered by Medicaid, incurred in the 3 month period prior to the month of application are allowable deductions. Expenses incurred prior to this three month period are not allowable deductions.

Medical and remedial expenses incurred as the result of imposition of a transfer of asset penalty period are limited to zero, unless application of these limits would result in undue hardship.

An undue hardship exists when the beneficiary’s physician (M.D. or D.O.) says necessary medical care is not being provided and the client needs treatment for an emergency condition.

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TN NO.: 09-03
Approval Date: MAR 09 2010
Effective Date: 07/01/2009

Supersedes
TN No.: 91-36

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

N/A

TN No. 28-04  Supersedes  Approval Date 5-3-93  Effective Date 1-1-92
TN No. 91-02

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

MORE RESTRICTIVE METHODS OF TREATING RESOURCES THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

N/A

TN No. 3-04 Supersedes Approval Date 5-3-93 Effective Date 1-1-92
TN No. 88-17

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

N/A

Supersedes

TN No. 114-04 Approval Date 5-3-93 Effective Date 1-1-93

TN No. 88-26

HCFA ID: 7985E
State: MICHIGAN

Standards for Optional State Supplementary Payments

<table>
<thead>
<tr>
<th>Payment Category</th>
<th>Administered by</th>
<th>Income Level</th>
<th>Income Disregards Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Reasonable Classification)</td>
<td>Federal</td>
<td>State</td>
<td>Gross 1 person</td>
</tr>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
</tr>
</tbody>
</table>

Approval Date: 05/16/86  Effective Date: 10/01/84

Supersedes: TN 85-7

TN 81-25
STATE OF MICHIGAN
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A) the Michigan Optional Supplemental program has a split in administration between the Social Security Administration and the state. The conditions and specifications of the portion administered by SSA are formally defined in (1) a written agreement between the Department of Community Health and the Secretary of Health and Human Services; and (2) 20 CFR, part 416, Subpart T, of the Code of Federal Regulations.

The Optional Supplemental Payment Standards are defined by Appendix A, Article I of the formal Agreement. These standards specify the total amounts of SSI to be paid to clients with no other income (about 40 percent of all SSI recipients). The amounts vary by living arrangement and marital status (individual or eligible couple). There is no variation across categorical lines.

State administered supplements are paid quarterly to individuals in independent living and household of another living arrangements. The quarterly payments are summations of the $14 per month for Independent Living and $9.33 per month for Household of Another.

SCHEDULE OF PAYMENTS (PAYMENT LEVELS)
Effective January 1, 1998

<table>
<thead>
<tr>
<th>Category of Eligible Individuals</th>
<th>Column A Independent Living</th>
<th>Column B Household of Another</th>
<th>Column C Domiciliary Care</th>
<th>Column D Personal Care</th>
<th>Column E Home for Aged Care</th>
<th>Column F Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged</td>
<td>$494.00</td>
<td>$329.34</td>
<td>$581.00</td>
<td>$651.50</td>
<td>$673.30</td>
<td>$37.00</td>
</tr>
<tr>
<td>Blind</td>
<td>$494.00</td>
<td>$329.34</td>
<td>$581.00</td>
<td>$651.50</td>
<td>$673.30</td>
<td>$37.00</td>
</tr>
<tr>
<td>Disabled</td>
<td>$494.00</td>
<td>$329.34</td>
<td>$581.00</td>
<td>$651.50</td>
<td>$673.30</td>
<td>$37.00</td>
</tr>
<tr>
<td>Aged &amp; Aged Spouse</td>
<td>$741.00</td>
<td>$494.00</td>
<td>$1,162.00</td>
<td>$1,303.00</td>
<td>$1,346.00</td>
<td>$74.00</td>
</tr>
<tr>
<td>Blind &amp; Blind Spouse</td>
<td>$741.00</td>
<td>$494.00</td>
<td>$1,162.00</td>
<td>$1,303.00</td>
<td>$1,346.00</td>
<td>$74.00</td>
</tr>
<tr>
<td>Disab &amp; Disab Spouse</td>
<td>$741.00</td>
<td>$494.00</td>
<td>$1,162.00</td>
<td>$1,303.00</td>
<td>$1,346.00</td>
<td>$74.00</td>
</tr>
<tr>
<td>Aged &amp; Blind Spouse</td>
<td>$741.00</td>
<td>$494.00</td>
<td>$1,162.00</td>
<td>$1,303.00</td>
<td>$1,346.00</td>
<td>$74.00</td>
</tr>
<tr>
<td>Aged &amp; Disab Spouse</td>
<td>$741.00</td>
<td>$494.00</td>
<td>$1,162.00</td>
<td>$1,303.00</td>
<td>$1,346.00</td>
<td>$74.00</td>
</tr>
<tr>
<td>Blind &amp; Disab Spouse</td>
<td>$741.00</td>
<td>$494.00</td>
<td>$1,162.00</td>
<td>$1,303.00</td>
<td>$1,346.00</td>
<td>$74.00</td>
</tr>
</tbody>
</table>

Supersedes
TN No. 97-03

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
SSI benefits for recipients with income are reduced by the Social Security Administration following regulations in 20 CFR, Part 416 of the Code of Federal Regulations. These regulations are interpreted and implemented by directions contained in the Social Security Administration Program Operations Manual. The State has no part in defining these computations beyond establishing the payment levels via Appendix A in the formal agreement.

The income disregards employed in the SSI program are defined in 20 CFR, Part 416 of the Code of Federal Regulations. These disregards are administered by the Social Security Administration following the directions contained in their Program Operations Manual. The disregards applied for Michigan supplement purposes are exactly the same as those applied for the federal portion of the SSI program.

Effective 10/1/81
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

N/A

TN No. 92-04 Supersedes Approval Date 5-3-93 Effective Date 1-1-92
TN No. 85-07

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

TN No. 92-04
Supersedes Approval Date Effective Date 10-01-91
TN No. 85-07

HCFA ID: 7985E

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

More Liberal Methods of Treating Income under Section 1902(r)(2) of the Act

1) For the groups covered by sections 1902(a)(10)(A)(ii)(X) and 1905(p) of the Act:
   Disregard the value of in-kind support and maintenance.

2) For children eligible under section 1902(a)(10)(A)(i)(VI) and defined in 1902(l)(1)(C) of the Act:
   Disregard income in the amount of the difference between 133% and 150% of the federal poverty level of the family size involved, as revised annually in the Federal Register.

3) For children eligible under section 1902(a)(10)(A)(i)(VII) and defined in 1902(l)(1)(D) of the Act:
   Disregard income in the amount of the difference between 100% and 150% of the federal poverty level of the family size involved, as revised annually in the Federal Register.

4) For qualified children under section 1902(a)(10)(A)(i)(III) and defined in section 1905(n) of the Act:
   Disregard income in the amount of the difference between the AFDC level and 150% of the federal poverty level of the family size involved plus $1, as revised annually in the Federal Register.

5) For pregnant women eligible under section 1902(a)(10)(A)(i)(IV) and defined in section 1902(l)(1)(A) of the Act:
   Disregard income in the amount of the difference between 133% and 185% of the federal poverty level of the family size involved, as revised annually in the Federal Register.
   Disregard parental income.

6) For qualified pregnant women under section 1902(a)(10)(A)(i)(III) and defined in section 1905(n) of the Act:
   Disregard income in the amount of the difference between the AFDC level and 185% of the federal poverty level of the family size involved plus $1, as revised annually in the Federal Register.

7) For all Medicaid categories subject to 1902(r)(2) of the Act, disregard the funds on deposit in an Individual Development Account (IDA), interest earned on an IDA, and matching funds deposited in the IDA.

8) Individuals eligible for assistance under 1902(a)(10)(A)(ii)(XV) of the Act may establish, Freedom Accounts (see Supplement 8b to Attachment 2.6-A) for a working disabled individual. The agency may disregard, for eligibility purposes, all earned income and unemployment benefits for a working...

Supersedes
TN No.: 04-03

Approval Date: 4/5/05
Effective Date: 04/01/2006

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
More Liberal Methods of Treating Income under Section 1902(r)(2) of the Act

disabled individual eligible for assistance under 1902(a)(10)(A)(ii)(XV) of the Act. To be eligible for this earned income disregard the income is subject to the following provisions:

- Only earnings that are deposited into a Freedom Account (see Supplement 8b to Attachment 2.6a) can be disregarded for eligibility purposes.
- Only funds earned after an individual's first enrollment in Medicaid under this section can be considered for the disregard.
- All funds deposited and their source will be identified and registered with the Department for which prior approval has been obtained from the Department, and for which the owner authorizes regular monitoring and/or reporting of these earnings and other information deemed necessary by the Department for the proper administration of this provision.

A spouse's income will not be deemed to the applicant when determining whether or not the individual meets the financial eligibility requirements for eligibility under this section.

Earned income is still used to establish a premium.

9) Wages paid by the Census Bureau for temporary employment related to census activities are excluded for the following eligibility groups:

- Poverty level pregnant women and infants (133 -185% FPL) under 1902(a)(10)(A)(i)(IV).
- Poverty level children under age 6 (133% FPL) under 1902(a)(10)(A)(i)(VI).
- Poverty level children under age 19 (100% FPL) under 1902(a)(10)(A)(i)(VII).
- Optional categorically needy groups under 1902(a)(10)(A)(ii) as listed below:
  - 1902(a)(10)(A)(ii)(l) – financially eligible for cash assistance or AFDC – all categories
  - 1902(a)(10)(A)(ii)(X) – aged/disabled to 100% FPL
  - 1902(a)(10)(A)(ii)(XV) - TWWIIA


- All aged, blind or disabled groups in 209(b) states under 1902(f).
- QMBs, SLMBs and Qls under 1905(p),

TN NO.: 08-13    Approval Date: MAR 18 2009    Effective Date: 10/01/2008

Supersedes
TN No.: 04-03
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

1) For the SSI-related categories of the Act:

   Resource exemptions are:
   - Homestead
   - Clothing, household good and personal effects regardless of value
   - One automobile regardless of how it is used or its value
   - Payment received for the planned repair or replacement of property that was lost, stolen, damaged, or destroyed. No time limit is imposed.

   - Un-salable property is not a countable resource. The property is un-salable when either: a) two knowledgeable sources state the property is un-salable due to a specified condition, or b) an actual sale attempt is made and no reasonable offer to purchase has been received. Conditional eligibility and repayment agreements are not required.

   - Resource eligibility exists for an entire calendar month if countable resources are equal to, or less than, the resource standard at any time during that calendar month.

2) For individuals eligible under sections 1902(a)(10)(A)(i)(III), (IV), (VI), (VII) and 1902(a)(10)(A)(ii)(VIII) of the Social Security Act (Act), pregnant women who meet the income and resource requirements of the Aid to Families with Dependent Children (AFDC) program as described at 42 CFR 435.210, medically needy pregnant women, and children under age 18, disregard all resources.

3) For all Medicaid categories subject to 1902(r)(2) of the Act, disregard the funds on deposit in an Individual Development Account (IDA), interest earned on an IDA, and matching funds deposited in the IDA.

4) For individuals under the ages of 19, 20, and 21 and caretaker relatives who meet the income and resource requirements of the AFDC program, medically needy individuals under the ages of 19, 20, and 21, and medically needy caretaker relatives, disregard $1,000 in resources.

5) Individuals eligible for assistance under 1902(a)(10)(A)(ii)(XV) of the Act, may establish Freedom Accounts. The agency will disregard up to $75,000 in resources held in Freedom Accounts for a working disabled individual. To be eligible for this resource disregard, Freedom Accounts are subject to the following provisions:

   - Balance of these accounts must not exceed a combined total of $75,000 except for Freedom Accounts consisting of IRS recognized retirement accounts which can have unlimited value. To be disregarded from countability, however,
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

Any IRS recognized retirement account must exist within or be identified as an authorized Freedom Account.

- These accounts will be held separate from non-exempt resources in accounts for which prior approval has been obtained from the Department, and for which the owner authorizes regular monitoring and/or reporting including deposits, withdrawals, and other information deemed necessary by the Department for the proper administration of this provision. The separateness requirement may be waived in the case of an employer's pension and/or a retirement account.

- A spouse's resources will not be deemed to the applicant when determining whether or not the individual meets the financial eligibility requirements for eligibility under this section.

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Supersedes
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

State Long-Term Care Insurance Partnership

The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:

1902(a)(10)(ii)(V); 1902(a)(10)(A)(ii)(X); 1902(a)(10)(A)(ii)(XV) and (XVI); and 1902(a)(10)(E)(i), (iii) and (iv) (and including individuals enrolled in 1902(a)(10)(A)(ii)(VI) who are eligible, based on use of institutional deeming rules, for 1902(a)(10)(A)(ii)(V), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(A)(ii)(XV) or (XVI)).

Any individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a “qualified State long-term care insurance partnership” policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term “long-term care insurance policy” includes a certificate issued under a group insurance contract.

Disregarded resources do not include resources in a trust under 1917(d)(4)(A) and (C) or annuities and similar legal instruments under 1917(e).

The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State’s Insurance Department.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.
- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.
- The policy was issued no earlier than the effective date of this State Plan amendment.
- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.
- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

State Long-Term Care Insurance Partnership

- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.
- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.
- The State Insurance Department assures that any company offering for sale a partnership policy has agreed that all its appointed LTC producers will have adequate training and each producer can demonstrate evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care. Such demonstration must occur before the producer may commence sales of a long-term care partnership policy. The State Insurance Department will assure compliance with this requirement through market conduct examinations.
- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

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Transfer of Resources

The agency provides for a period of ineligibility for nursing facility services and for a level of care in a medical facility equivalent to that of nursing facility services and for services under section 1915(c) due to disposal of resources for less than fair market value. The provisions of section 1917(c) of the Social Security Act are met.

An undue hardship exists when the client's physician (M.D. or D.O.) states that 1) necessary medical care is not being provided, and 2) the client needs treatment for an emergency condition.

A medical emergency is any condition for which a delay in treatment may result in the person's death or permanent impairment of the person's health.

A psychiatric emergency is any condition that must be immediately treated to prevent serious injury to the person or other.

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TN # 92-04

TN # 92-16

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

- Payments based on a level of care in a nursing facility;
- Payments based on a nursing facility level of care in a medical institution;
- Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

- Home health services (section 1905(a)(7));
- Home and community care for functionally disabled and elderly adults (section 1905(a)(22));
- Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

The following other long-term care services for which medical assistance is otherwise under the agency plan:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: _______________ MICHIGAN ________________

TRANSFER OF ASSETS

3. **Penalty Date** -- The beginning date of each penalty period imposed for an uncompensated transfer of assets is:
   
   X the first day of the month in which the asset was transferred;
   
   ___ the first day of the month following the month of transfer.

4. **Penalty Period - Institutionalized Individuals** --
   
   In determining the penalty for an institutionalized individual, the agency uses:
   
   X the average monthly cost to a private patient of nursing facility services in the agency;
   
   ___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. **Penalty Period - Non-institutionalized Individuals** --
   
   The agency imposes a penalty period determined by using the same method as is used for an institutionalized individualized individual, including the use of the average monthly cost of nursing facility services;
   
   ___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:
6. **Penalty period for amounts of transfer less than cost of nursing facility care** --

   a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

      X does not impose a penalty;

      ___ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

   b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

      X does not impose a penalty;

      ___ imposes a series of penalties, each for less than a full month.

7. **Transfers made so that penalty periods would overlap** --

   The agency:

      ___ totals the value of all assets transferred to produce a single penalty period;

      X calculates the individual penalty periods and imposes them sequentially.

8. **Transfers made so that penalty periods would not overlap** --

   The agency:

      X assigns each transfer its own penalty period;

      ___ uses the method outlined below:
State: MICHIGAN

TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

Divide the remaining penalty period equally between the spouses.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

For transfers of individual income payments, the agency will impose partial month penalty periods.

For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

The agency uses an alternate method to calculate penalty periods, as described below:
TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship--
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

Notices instruct the client to contact the worker if the client is denied treatment for an emergency condition.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

Undue hardship exists when the client's physician (MD or DO) says:

- necessary medical care is not being provided, and
- the client needs treatment for an emergency condition.

A medical emergency exists when a delay in treatment may result in the person's death or permanent impairment of the person's health.

A psychiatric emergency exists when immediate treatment is required to prevent serious injury to the person or others.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Transfer of Assets

1917 (c) For transfers of assets for less than fair market value made on or after February 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

- Nursing facility services;
- Nursing facility level of care provided in a medical institution;
- Home and community-based services under a 1915(c) or (d) waiver.

2. Non-institutionalized individuals:

The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act.

The eligibility groups are those described in:
- 1902(a)(10)(A)(i)(II); 1634(c); 1902(m)(1); 1902(a)(10)(A)(ii)(V);
- 1902(a)(10)(E)(i); 1902(a)(10)(E)(iii) and (iv); 1634(b); 1634(d); 1905(q);
- 1619(a) and (b); 1905(s); 1905(v)(1); and, 42 CFR 435.135

The agency withholds payment to non-institutionalized individuals for the following services:

- Home health services (section 1905(a)(7));
- Home and community care for functionally disabled elderly adults (section 1905(a)(22));
- Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(4).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Transfer of Assets

X The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

Services provided under a 1915(c) waiver.

3. Penalty Date – The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

X The State uses the first day of the month in which the assets were transferred.

___ The State uses the first day of the month after the month in which the assets were transferred.

Or

- the date on which the individual is eligible for medical assistance under the State Plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period would be covered by Medicaid;

and,

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

4. Penalty Period – Institutionalized Individuals

In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of nursing facility services in the State at the time of application;

___ the average monthly cost to a private patient of nursing facility services in which the individual is institutionalized at the time of application.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Transfer of Assets

5. Penalty Period – Non-institutionalized Individuals

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

 ___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care

Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

X The State adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. Penalty periods – transfer by a spouse that results in a penalty period for the individual

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Transfer of Assets

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

9. Imposition of a penalty would work an undue hardship

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) of medical care such that the individual's health or life would be endangered; or
(b) of food, clothing, shelter or other necessities of life

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) notice to a recipient subject to a penalty that an undue hardship exception exists;
(b) a timely process for determining whether an undue hardship waiver will be granted; and,
(c) a process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Transfer of Assets

of the individual with the consent of the individual or the individual's personal representative.

11. Bed Hold Waivers for Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

__ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed __ days. (may not be greater than 30)
The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

When assets are transferred to a trust, undue hardship exists when the client’s physician (M.D. or D.O.) says:

- necessary medical care is not being provided, and
- the client needs treatment for an emergency condition.

A medical emergency exists when a delay in treatment may result in the person’s death or permanent impairment of the person’s health.

A psychiatric emergency exists when immediate treatment is required to prevent serious injury to the person or others.

Payments actually made by a trustee to or on behalf of a beneficiary do not create an undue hardship.

Under the agency’s undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is $2,000 plus accumulated interest or dividend.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  

State of MICHIGAN  

Financial Eligibility  

ELIGIBILITY UNDER SECTION 1931 OF THE ACT  

The State covers low-income families and children under section 1931 of the Act. The following groups were included in the AFDC State plan effective July 16, 1996.  

___ Pregnant women with no other eligible children.  

___ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.  

___ In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 without modifications.  

X In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications:  

___ The agency applies lower income standards that are no lower than the AFDC standards in effect on May 1, 1998.  

___ The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996.  

___ The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996.  

X The agency uses less restrictive income and/or resources methodologies in determining eligibility on or after July 16, 1996 as follows:  

1. Countable resources – only count cash resources. Cash includes:  
   - Money/Currency  
   - Un-cashed checks  
   - Drafts and warrants  
   - Checking  
   - Savings  
   - Draft, share and money market accounts  
   - Time deposits such as certificates of deposit; investments such as stocks, bonds and mutual funds; retirement plans such as IRA's, Keogh plans, 401K plans, pension plans and annuities; and trusts  

Disregard the funds on deposit in an Individual Development Account (IDA), interest earned on an IDA and matching funds deposited in the IDA.  

Disregard funds on deposit in a 529 college savings plan (529 plan), interest earned on a 529 plan and matching funds deposited in the 529 plan.  

Disregard $2,000 of cash resources.  

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Financial Eligibility

Eligibility under Section 1931 of the Act (continued)

Resource eligibility exists for an entire calendar month if countable resources are equal to, or less than, the resources standard at any time during the month.

2. Income -
   • Disregard all income in excess of 185% gross income test for purposes of the 185% test.
   • Disregard the funds on deposit in an Individual Development Account (IDA), interest earned on an IDA and matching funds deposited in the IDA.
   • Disregard wages paid by the Census Bureau for temporary employment related to census activities.

3. Income deductions -
   • Allow purchase of capital assets and payments on the principal of business loans as a business expense.
   • For applicants who have not received LIF in at least one of the past four months, the state will apply an earned income disregard of $200 plus 20% of the remaining earned income.
   • For applicants or recipients who have received LIF in at least one of the past four months, the State will apply an earned income disregard of $30 plus 1/3 of the remaining income or an earned income disregard of $200 plus 20% of the remaining earned income whichever is most beneficial.

4. No time limit for the $30 plus 1/3 income disregard if a family received Medicaid using the Social Security Act 1931 provisions.

5. All income earned by dependent children who are students is excluded from income and resources.

The income and/or resource methodologies that the less restrictive methodologies replace (that were in place before July 16, 1996) are as follows:

1. Countable resources included both cash and noncash.
2. All cash resources were considered.
3. Resource eligibility exists if countable resources are equal to or less than the resources standard for each day in the month.
4. All income was considered for purposes of the 185% gross income test.
5. Did not allow as a business expense, purchase of capital assets and payments on the principle of business loans.
6. The $30 plus 1/3 income disregard was time limited.
7. For applicants that did not receive LIF in at least one of the past 4 months, no earned income disregard was available.
   For applicants and beneficiaries that did receive LIF in at least one of the past 4 months, only the $30 plus 1/3 earned income disregard was available.
STATE OF MICHIGAN
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Michigan

ELIGIBILITY UNDER SECTION 1931 OF THE ACT (continued)

8. All income earned by dependent children who are students was counted as income and resources.

[X] The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

[X] The agency continues to apply the following waivers of provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

1. Waiver of 402(a)(41) and various provisions of the regulations at 45 CFR 233.100(a)(1)(i) and 233.100(c)(1)(iii): 100 Hour Rule - to allow the state to provide Medicaid benefits to unemployed parent recipient families in which the principal earner works 100 or more hours per month.

2. Waiver of 406(a), 45 CFR 233.10(b)(2)(ii)(a)(1), 45 CFR 233.90(b)(3), expanding the definition of a dependent child to include a child who is age 18 or 19, attending high school full-time, and reasonably expected to graduate before age 20.

3. Waiver of 406(a) and 406(b), 45 CFR 233.10(b)(2)(ii)(a)(3), 233.10(b)(ii)(b), 45 CFR 233.90(c)(1)(v), 45 CFR 237.50(b)(2)(ii), expanding the definition of caretaker relative to include:
   - Persons who are legal guardians of a child, and
   - Persons at least age 21, who have petitioned for legal guardianship, and
   - The parent of the child’s putative father.

4. Waiver of 402(a), expanding eligibility to include in the group:
   - The spouse of a nonparent caretaker who chooses to be included in the filing unit, and
   - The spouse of a pregnant woman must be included in the filing unit.

5. Waiver of 402(a) and various provisions of the regulations at 45 CFR 233.20(a): Standard Against Which Income is Budgeted – to allow the state to budget against the payment standard.

6. 402(a) Eligibility of Pregnant Women: to allow the state to determine as eligible for Medicaid, pregnant women in any state of pregnancy.

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Supercedes
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State MICHIGAN

A. Income and resource eligibility policies to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.

B. In the determination of resource eligibility the State resource standard is $79,020.

C. An institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible under Title XIX of the Social Security Act, per section 1924(c) (3) (C), where the State determines that denial of eligibility on the basis of having excess resources would work an undue hardship.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME AND RESOURCE REQUIREMENTS FOR TUBERCULOSIS (TB) INFECTED INDIVIDUALS

For TB infected individuals under §1902(z)(1) of the Act, the income and resource eligibility levels are as follows:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Asset Verification System

1940(a) of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

   (1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
   (2) The system cannot be based on mailing paper-based requests.
   (3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department’s National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the agency’s AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant’s home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual’s eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

2. System Development

☐ A. The agency itself will develop an AVS.

   In 3 below, provide any additional information the agency wants to include.

☒ B. The agency will hire a contractor to develop an AVS.

   In 3 below provide any additional information the agency wants to include.

☐ C. The agency will be joining a consortium to develop an AVS

   In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Asset Verification System

2. System Development (continued.)

☐ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

   In 3 below, describe how the existing system meets the requirements in Section 1.

☐ Other alternative not included in A. – D. above

   In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Disqualification for Long-Term-Care Assistance for Individuals with Substantial Home Equity

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

$500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is________________________

_____ This higher standard applies statewide.

_____ This higher standard does not apply statewide. It only applies in the following areas of the State:

_____ This higher standard applies to all eligibility groups.

_____ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

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The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on January 28, 2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.
Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

<table>
<thead>
<tr>
<th>Covered Populations Within New Adult Group</th>
<th>Applicable Population Adjustment</th>
</tr>
</thead>
</table>
| Population Group                          | Relevant Population Group Income Standard For each population group, indicate the lower of:  
|                                            | • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or  
|                                            | • 133% FPL.  
|                                            | If a population group was not covered as of 12/1/09, enter "Not covered". | Resource Proxy | Enrollment Cap | Special Circumstances | Other Adjustments |
| Parents/Caretaker Relatives                | Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan | Yes | No | No | No |
| Disabled Persons, non-institutionalized    | Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan | Yes | No | No | No |
| Disabled Persons, institutionalized        | Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan | Yes | No | No | No |
## State Plan Under Title XIX of the Social Security Act

**State:** Michigan

### METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

<table>
<thead>
<tr>
<th>Children Age 19 or 20</th>
<th>Attachment A, Column C, Line 4 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.</th>
<th>Yes</th>
<th>No</th>
<th>No</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childless Adults</td>
<td>Not covered</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

TN NO.: 14-010  
Supersedes
TN No.: 14-03

Approval Date: **OCT 9, 2015**  
Effective Date: **04/01/2014**

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
State Plan Under Title XIX of the Social Security Act

State: Michigan

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. ☐ Michigan applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

☐ Michigan does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B)

Table 1 indicates the group or groups for which Michigan applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

Michigan:

☐ Applies existing state data from periods before January 1, 2014.

☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied (complete items 2 through 4).

☐ An enrollment cap adjustment is not applied (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009, that are applicable to populations that Michigan covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. Michigan applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

☐ Yes. The combined enrollment cap adjustment is described in Attachment C

☐ No.
State Plan Under Title XIX of the Social Security Act

State: Michigan

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. Michigan applies special circumstances adjustment(s).
   - Michigan does not apply a special circumstances adjustment.

2. Michigan applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).
   - Michigan does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

   - Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

   - Michigan does not apply any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

   - Michigan:
     - Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 4)
     - Michigan meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated INSERT DATE

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State Plan Under Title XIX of the Social Security Act

State: Michigan

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

Michigan:

☑ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated **INSERT DATE**. The Michigan will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual’s eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

☑ Attachment A – Most Recent Updated Summary Information for Part 2 of the Modified Adjusted Gross Income (MAGI) Conversion Plan

☑ Attachment B – Resource Criteria Proxy Methodology

☐ Attachment C – Enrollment Cap Methodology

☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology

☐ Attachment E – Transition Methodologies

TN NO.: 14-010 Approval Date: **OCT 9, 2015** Effective Date: 04/01/2014

Supersedes TN No.: 14-03

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
SECTION 3: Covered Services
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

PREFACE to Attachment 3.1-A

The following statement applies to all services provided, as listed on the following pages of this Attachment:

Items or services that are determined to be experimental or investigational are not covered benefits. Such determinations will be made by the Medical Services Administration, based on qualified medical advice that the items or services have not been generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are being used or are to be used. This advice will originate from established sources such as Medicare, National Institutes of Health, Food and Drug Administration (FDA), the AMA's Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc. The determinations are not judgments that a physician's choice is inappropriate or that a patient does not need treatment.

WE MAKE NO DIFFERENTIATION BETWEEN CATEGORICALLY AND MEDICALLY NEEDY. THEREFORE, ATTACHMENT 3.1-A REFERS TO BOTH OF THESE CATEGORIES.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy

1. Inpatient hospital services other than those provided in an institution for mental diseases.
   ☒ Provided ☐ No Limitations ☒ With Limitations*

2.a. Outpatient hospital services.
   ☒ Provided ☐ No Limitations ☒ With Limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the state plan).
   ☒ Provided ☐ No Limitations ☒ With Limitations* ☐ Not Provided

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
   ☒ Provided ☐ No Limitations ☒ With Limitations*

3. Other laboratory and x-ray services.
   ☒ Provided ☒ NO LIMITATIONS ☐ With Limitations*

* Description provided on an attachment.

TN NO.: 12-21  Approval Date: MAR 22 2013  Effective Date: 01/01/2013

Supersedes
TN No.: 92-05

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
State/Territory: MICHIGAN

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No limitations X With limitations

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: ___ No limitations X With limitations

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ___ No limitations X With limitations

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations X With limitations

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: ___ No limitations X With limitations

* Description provided on attachment.

TN No. 93-06  Approval Date 12-7-93  Effective Date 10-01-93
b. Optometrists’ services.

- Provided: [ ] No Limitations [x] With Limitations*
- Not Provided

c. Chiropractors’ services.

- Provided: [x] No Limitations [ ] With Limitations*
- Not Provided

d. Other practitioners’ services.

- Provided: Identified on attached sheet with description of limitations, if any.
- Not Provided

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

- Provided: [ ] No Limitations [x] With Limitations*

b. Home health aide services provided by a home health agency.

- Provided: [ ] No Limitations [x] With Limitations*

c. Medical supplies, equipment, and appliances suitable for use in any setting in which normal activities take place and does not include services in a hospital, nursing facility including Nursing Facility for the Mentally Ill (NF/MI), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

- Provided: [ ] No Limitations [x] With Limitations*

*Description provided on attachment.
d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☑ Provided: ☐ No limitations ☑ With limitations*
☐ Not provided.

8. Private duty nursing services.

☐ Provided: ☐ No limitations ☑ With limitations*
☑ Not provided.

*Description provided on attachment.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Amount, Duration and Scope of Medical and Remedial Care
Services Provided to the Categorically and Medically Needy

9. Clinic Services

X Provided  ___ No Limitations  X With Limitations*

___ Not Provided

10. Dental services

X Provided  ___ No Limitations  X With Limitations*

___ Not Provided

11. Physical therapy and related services:
   a. Physical therapy
      X Provided  ___ No Limitations  X With Limitations*
      ___ Not Provided
   b. Occupational therapy
      X Provided  ___ No Limitations  X With Limitations*
      ___ Not Provided
   c. Speech-Language Therapy/Services for individuals with speech, hearing, and language disorders
      (provided by or under the supervision of a speech pathologist or audiologist)
      X Provided  ___ No Limitations  X With Limitations*
      ___ Not Provided

*Description provided in Supplement to Attachment 3.1-A

TN NO.: 17-0001  Approval Date: AUG 6, 2018  Effective Date: 01/01/2018

Supersedes
TN No.: 05-06

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICAL NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.
   - Provided: ___ No Limitations   ___ With Limitations*
   - Not Provided

b. Dentures
   - Provided: ___ No Limitations   ___ With Limitations*
   - Not Provided

c. Prosthetic and Orthotic Devices
   - Provided: ___ No Limitations   ___ With Limitations*
   - Not Provided

d. Eyeglasses
   - Provided: ___ No Limitations   ___ With Limitations*
   - Not Provided

*Description provided on attachment
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

[X] Provided: [□] No limitations [X] With limitations*

[□] Not provided.

*Description provided on attachment

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TN No. 88-5
Supersedes
TN No. 85-22

Approval Date 04-06-88
Effective Date 01-01-88

HCFA ID: 0069P/0002P

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*Description provided on attachment

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October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy

b. Screening services

X Provided:   _ No limitations   X With limitations*
___ Not Provided

c. Preventive services

X Provided:   _ No limitations   X With limitations*
___ Not Provided

d. Rehabilitative services

X Provided:   _ No limitations   X With limitations*
_ Not Provided

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services

X Provided:   _ No limitations   X With limitations*
_ Not Provided

b. Skilled nursing facility services

X Provided:   _ No limitations   X With limitations*
_ Not Provided

c. Intermediate care facility services.

_ Provided:   _ No limitations   _ With limitations*
X Not Provided

*Descriptions provided on attachment

TN NO.:  16-0017  Approval Date:  MAR 10 2017  Effective Date: 07/01/2017

Supersedes
TN No.:  10-01

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an
institution for mental diseases) for persons determined, in accordance
with section 1902(a)(31)(A) of the Act, to be in need of such care.

[✓] Provided: [✓] No limitations [✓] With limitations*
[✓] Not provided.

b. Including such services in a public institution (or distinct part
thereof) for the mentally retarded or persons with related conditions.

[✓] Provided: [✓] No limitations [✓] With limitations*
[✓] Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years
of age.

[✓] Provided: [✓] No limitations [✓] With limitations*
[✓] Not provided.

17. Nurse-midwife services.

[✓] Provided: [✓] No limitations [✓] With limitations*
[✓] Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

[✓] Provided: [✓] No limitations [✓] With limitations*
[✓] Not provided.

*Description provided on attachment.

TN No. 87-7 Supersedes Approval Date 03-11-88 Effective Date 04/01/87
TN No. _____

HCFA ID: 0069P/0002P

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ___________________________ MICHIUAN

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

   a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1903(a)(19) or section 1915(g) of the Act).

       X Provided:   X With limitations

       __________ Not provided.

   b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

       __________ Provided:   ___ With limitations*

       X ________ Not provided.

20. Extended services for pregnant women

   a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

       X ________ Additional coverage ++

   b. Services for any other medical conditions that may complicate pregnancy.

       X ________ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

TN No. 94-26 Supersedes Approval Date 11-10-94 Effective Date 10/01/94
TN No. 94-11
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

*Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy*

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

- [x] Provided
- [ ] No Limitations
- [x] With Limitations
- [ ] Not Provided

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

- [ ] Provided
- [ ] No Limitations
- [ ] With Limitations
- [x] Not Provided

23. Certified pediatric or family nurse practitioners' services.

- [x] Provided
- [ ] No Limitations
- [x] With Limitations
- [ ] Not Provided

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TN NO.: 12-18  Approval Date: JAN 13 2013  Effective Date: 10/01/2012

Supersedes
TN No.: 05-05

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
   a. Transportation.
      \[\checkmark\] Provided: \[\square\] No limitations \[\checkmark\] With limitations*
      \[\square\] Not provided.
   b. Services of Christian Science nurses.
      \[\square\] Provided: \[\square\] No limitations \[\checkmark\] With limitations*
      \[\checkmark\] Not provided.
   c. Care and services provided in Christian Science sanitoria.
      \[\checkmark\] Provided: \[\square\] No limitations \[\checkmark\] With limitations*
      \[\square\] Not provided.
   d. Nursing facility services for patients under 21 years of age.
      \[\checkmark\] Provided: \[\square\] No limitations \[\checkmark\] With limitations*
      \[\square\] Not provided.
   e. Emergency hospital services.
      \[\checkmark\] Provided: \[\square\] No limitations \[\checkmark\] With limitations*
      \[\square\] Not provided.
   f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
      \[\checkmark\] Provided: \[\square\] No limitations \[\checkmark\] With limitations*
      \[\square\] Not provided.

*Description provided on attachment.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

provided X not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided X State Approved (Not Physician) Service Plan

X Allowed

X Services Outside the Home Also Allowed

Limitations Described on Attachment

Not Provided.
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

27. Program Of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

- Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

- No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.
Freestanding Birth Center Services

28 (i). Licensed or otherwise State-Recognized covered professionals providing services in Freestanding Birth Centers

Provided:
☐ No limitations  ☐ With limitations  ☒ None licensed or approved

28 (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided:
☐ No limitations  ☐ With limitations  ☒ Not applicable

(There are no licensed or State approved Freestanding Birth Centers)

Please check all that apply:

(a) ☐ Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

(b) ☐ Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licenses midwife).*

(c) ☐ Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

* For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Michigan

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

1. INPATIENT HOSPITAL SERVICES (other than services in an institution for tuberculosis or mental disease) when furnished by a certified hospital under the direction of a physician.

   a. Covered Services: All admissions must be necessary for the physical or mental health of the patient and must be made upon the direction of a physician.

   Prior approval from the Medical Services Administration or its designated contractor is required for elective* admissions. Admissions to a state-owned psychiatric hospital do not require this approval.

   For admissions to a separate inpatient unit which, under contract with the Michigan Department of Mental Health, provides inpatient hospital services to youth who are enrolled in a special program for those who are both developmentally disabled and emotionally impaired, prior approval from the Michigan Department of Mental Health is required for elective* admissions and readmissions.

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*"Elective" is defined as a condition that is neither an emergency nor an urgent condition. "Emergency" is any condition for which a delay in treatment may result in the recipient's death or permanent impairment of health. "Urgent" is an acute condition, not as serious as an emergency, yet one in which medical necessity dictates a hospital environment.

Rev. 04/01/90

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Prior approval from the Medical Services Administration or its designated contractor is required for all readmissions within 15 days. However, if the admission was to a state-owned psychiatric hospital, approval is only required for the readmission if it is elective and to a facility not owned by the state.

Prior approval from the Medical Services Administration or its designated contractor is required for elective transfers between hospitals. Urgent or emergent transfers require approval immediately following the transfer. Such approval is not required if the transfer is to or from a state-owned psychiatric hospital.

Claims will be reviewed by the Medical Services Administration or its designated contractor on a pre- or post-payment basis to assure the medical necessity of admissions, transfers, and readmissions and the appropriateness of diagnosis and procedure coding. Claims requesting outlier reimbursement will be reviewed for appropriateness by the Medical Services Administration or its designated contractor.

Rev. 10/01/90
Inpatient hospital benefits in a freestanding rehabilitation hospital are limited to thirty (30) days per admission unless medical necessity dictates an extension beyond the benefit limitation. Hospitals must obtain approval from the Medical Services Administration or its designated contractor for inpatient stays which exceed thirty (30) days. An additional approval must be obtained for inpatient stays which exceed sixty (60) days.

Admission authorization and continued stay review authorization from the Medical Services Administration or its designated contractor is required for an Inpatient Hospital stay in a freestanding psychiatric hospital or a Medicare-certified distinct-part psychiatric unit of a general hospital. For elective admissions, admission authorization is required prior to admission, and for urgent/emergent admissions, authorization is required within one working day.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ___ Michigan ___

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

Payment will not be made for services of staff in residence, e.g., interns and residents, or medical staff functioning in an administrative or supervisory capacity (including physician-owners) who are paid by the hospital or other sources.

"Elective" is defined as a condition that is neither an emergency nor an urgent condition.

"Emergency" is any condition for which a delay in treatment may result in the recipient's death or permanent impairment of health.

"Urgent" is an acute condition, not as serious as an emergency, yet one in which medical necessity dictates a hospital environment.

Services Included in DRG Calculation/Payment

All routine services (e.g., room and board, nursing) are included in the DRG payment.

All diagnostic services (radiology, pathology, etc.) are included in the DRG payment.

Diagnostic services that are performed at a second hospital because the services are not available at the first hospital (e.g., CT scan) are included in the first hospital's DRG payment. Arrangements for payment to the second hospital where the services were actually performed must be between the first hospital and second hospital.

All pathology services that are performed by the pathologist but do not relate directly to a specific recipient's care are included in the DRG payment.

Anatomic pathology services provided directly by the pathologist are not included in the DRG payment. If the pathologist who provides these professional services is employed by the hospital or directly contracts with the hospital, that pathologist must also enroll as a Medicaid provider for separate payment to be made. Medicaid's fee-for-service policy applies to pathologists.

All ancillary services provided by the hospital or performed by another entity (e.g., hospital having a contractual agreement with an enrolled independent laboratory) are included in the hospitals' DRG payment. EXCEPTION: Ancillary services provided by a hospital enrolled with Medicaid as a separate Medicaid provider code are excluded from the DRG payment.

All emergency room services provided by the hospital resulting in an inpatient admission are included in the hospital's DRG payment.

NOTE: The above list is not inclusive.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Michigan

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

Services Excluded from DRG Calculation/Payment

Hospital-based professional services are excluded from the DRG payment.

Services provided by a nurse-midwife are excluded from the DRG payment.

Services provided within the scope of their profession by registered nurses certified by the Council on Certification of Nurse Anesthetists or recertified by the Council on Recertification of Nurse Anesthetists are excluded from the DRG payment.

Ambulance services for recipients who are transported to a second hospital for diagnostic services are excluded from the DRG payment.

If a service is excluded from the DRG payment (e.g., ambulance, nurse-midwife), that service may remain a covered benefit. Since the service is not included in the hospital's DRG payment, that service must be separately billed by that enrolled provider. Separate reimbursement for covered services is then issued when the services are billed using the correct provider ID Number and the appropriate claim form.

NOTE: The above list is not inclusive.

The Specific Items of Services Covered are:

Bed and board, including special dietary services in a semi-private room, or if medically necessary, in a private room as ordered by the attending physician.

Medical, obstetrical, surgical, and anesthesiology services, including use of operating room, delivery room, etc.;

Drugs and medicine;

Laboratory services when specifically ordered in writing by the attending physician or other responsible practitioner (e.g., consultant, intern) for a specific recipient.

Radiology services including x-ray, radium, radioactive isotopes, etc., when specifically ordered in writing by the attending physician for a specific patient.

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1. Inpatient Hospital Services
   a. Covered Services – Specific Items of Services Covered are (continued):
      
      General nursing service incidental to the care and treatment of the patient.

      Whole blood (when not available from other sources).

      Other items and services ordinarily provided by the hospital for the care and treatment of inpatients.

      The use of all prosthetic and surgical appliances and any other equipment essential to the treatment of the patient.

      Physical therapy services must be either restorative or specialized maintenance programs to be covered. Physical therapy must be ordered, in writing, by a physician or other Medicaid approved licensed practitioner within the scope of his or her practice under State law. Therapy services must be provided by a physician, a physical therapist currently licensed in Michigan, or physical therapy assistant under the appropriate supervision of an appropriately licensed physical therapist. A treatment plan must be developed, identifying the individual modalities to be employed and how they relate to the condition being treated. Each restorative plan must include the expected results of the therapy and the time frames needed to achieve those results.

      Inpatient occupational therapy services of a restorative nature, ordered, in writing, by a physician or other Medicaid approved licensed practitioner within the scope of his or her practice under State law, are covered. Therapy services must be performed by an occupational therapist currently registered in Michigan, an appropriately supervised certified occupational therapy assistant, or an appropriately supervised student completing his/her clinical affiliation.

      Inpatient psychiatric occupational/recreational therapy is covered when ordered, in writing, by a physician or other Medicaid approved licensed practitioner within the scope of his or her practice under State law as part of the beneficiary's active psychiatric treatment plan. It must be provided by a psychiatrist, an occupational therapist currently registered in Michigan, an appropriately supervised certified occupational therapy assistant, or an appropriately supervised student completing his/her clinical affiliation, in a psychiatric hospital or a psychiatric unit of a general hospital.

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1. Inpatient Hospital Services
   a. Covered Services - Specific Items of Services Covered are (continued):

   Speech-language therapy services must be restorative and ordered, in writing, by a physician or other Medicaid approved licensed practitioner within the scope of his or her practice under State law to be covered. Services must be rendered by a licensed speech-language pathologist an appropriately supervised speech-language pathologist candidate or an appropriately supervised student completing his/her clinical affiliation.

   Substance Abuse Services

   If a hospital has a sub-acute substance unit, that unit must meet the requirements in Attachment 3.1-A, pp. 26, 26a, 13(d) 1 to receive reimbursement for these services described in that section.

   If acute care detoxification is warranted, it will be covered. However, once the beneficiary’s condition is stabilized, he or she must be referred to an appropriate treatment service.

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b. Excluded Services

The specific items or services excluded are:

Services of special nurses.

All personal comfort or convenience items, e.g., telephone, radio, television, etc.

Occupational therapy provided for educational, vocational, or recreational purposes.

Speech therapy provided for educational, vocational or recreational purposes. Speech therapy when another public agency can assume the responsibility of the service for the recipient.

Laboratory services when performed as routine procedures, e.g., because of existing hospital policy or attending physician's standing orders.

Radiology services when performed as routine procedures, e.g., because of existing hospital policy or attending physician's standing orders.

Certain selected surgeries, as specified by the MA program, that may be performed on an outpatient basis, unless there are medical factors that contraindicate the performance of the procedure on an outpatient basis.

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All of the following if the primary reason for admission was to receive one or more of these services:

1) observation.
2) diagnostic procedure which can be performed on an outpatient basis.
3) physical, occupational, or speech therapy.
4) laboratory work.
5) basal metabolism.
6) electrocardiogram.
7) diagnostic x-ray.
8) covered dental procedures which can be performed in the office.

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c. Special conditions for admissions for oral surgery or other dental services (Hospital admission for any non-emergency dental procedure requires prior authorization.)

1) Admission for Oral Surgery

  a) Inpatient hospital services for recipients who require surgery by a licensed oral surgeon are covered (including payment to the surgeon) as physicians' services if the services can be performed by either a physician or dentist and only if they would constitute physicians' services when provided by a physician.

     NOTE: Such services are also covered on a hospital outpatient basis and in the office.

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  b) The patient is admitted to receive the services of an oral surgeon for the removal of unerupted, impacted teeth or other dental procedures because the extent of the procedure or the patient's condition rules out surgery on other than an inpatient basis. Dental procedures must be prior-authorized.

     NOTE: The above dental procedures are also covered on a hospital outpatient basis or in the practitioner's office.


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2) Admission for other Dental Services

Inpatient hospital services for dental procedures such as the care, filling, removal of teeth, replacement of teeth (including bridges and dentures), treatment of gum areas, and surgery or other services related to such procedures are not covered, unless prior authorized.

NOTE: Apprehension on the part of the patient, regardless of age, is not an acceptable reason, in itself, for admission.
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2. OUTPATIENT HOSPITAL SERVICES

Professional fees for services provided in the outpatient department of a hospital will be paid only when such payment does not duplicate payment to the hospital.

Educational costs associated with the outpatient department will be reimbursed to hospitals with approved training programs (as described in 404.1 of the HIM-15 manual).

Payment will not be made for services of staff in residence, e.g., interns and residents or medical staff functioning in an administrative or supervisory capacity (including physician - owners) who are paid by the hospital or other sources.

Outpatient services relating to routine examinations only, i.e., unrelated to a specific illness, symptom, complaint, or injury, are not covered, except when provided to eligible children under age 21 as part of a program of early and periodic screening, diagnosis and treatment. (See Item 4b.)

Outpatient hospital services include prenatal and postnatal care; and services listed below when medically necessary for the diagnosis or treatment of an illness or injury when ordered by and under the direction of a physician (M.D. or D.O.), and services performed by the physician and/or physical therapist for physical therapy only:

1) radium treatment
2) therapeutic x-ray
3) diagnostic x-ray
4) emergency treatment
5) physical therapy, provided in accordance with 42 CFR 440.110, and as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is required if services are medically necessary and exceed the time or frequency limits as described in Medicaid policy for:
   - initial treatment (144 units in 12 months) or
   - maintenance/monitoring (four times in the 90-day allowed period)
6) laboratory tests
7) electrocardiogram
8) electroencephalogram
9) basal metabolism
10) hemodialysis

NOTE: The patient who receives hemodialysis in his home is considered to be a hospital outpatient. Therefore, payment for the cost of hemodialysis supplies, such as plastic tubing, chemicals, disposable coils, etc., may be made under the Program.

Services are furnished in an institution that is licensed or formally approved as a hospital by an officially designated authority for state standard-setting and meets the requirements for participation in Medicare as a hospital.
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11) individual and group psychotherapeutic treatment rendered by a psychiatrist or physician (M.D. or D.O.) in the outpatient department of a licensed psychiatric hospital or of a general hospital with a licensed psychiatric unit.

12) play therapy (for children) and family therapy rendered by a psychiatrist or physician (M.D. or D.O.) in the outpatient department of a licensed psychiatric hospital or of a general hospital with a licensed psychiatric unit.

13) psychological testing (may be administered by a psychologist, for diagnostic purposes, when ordered and billed for by the physician).

14) prescribed drugs and medications dispensed by the outpatient facility in connection with treatment received at the facility and administration of such drugs.

NOTE: Nonlegend drugs, with the exception of insulin, family planning drugs and supplies, and those drugs necessary for the treatment of chronic renal disease, are not covered. Certain anti-anxiety, analgesic, anorectic, cough and cold, antacid, laxative anti-vertigo, hematinic, vitamins, nutritional supplements, and other drugs specified by the department are not covered.

15) covered oral surgical procedures, as listed under Inpatient Hospital Services, specified in 1.a.

16) occupational therapy as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is the same as presented for physical therapy at 5) above.

17) psychiatric occupational/recreational therapy, as defined in 1.a, only in conjunction with partial hospitalization.

18) speech-language therapy services, as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is the same as presented for physical therapy at 5) above.

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2b. Rural Health Clinic Services

The following services are covered when furnished by a rural health clinic which has been certified in accordance with 42 CFR 481:

1) Rural health clinic services as specified in 42 CFR 440.20(b)
2) Ambulatory services, other than rural health clinic services, which are included in the Plan and are furnished in accordance with the requirements specified in the Plan.

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3. OTHER LABORATORY AND X-RAY SERVICES (Same for categorically needy and medically needy clients)

Covered services include laboratory tests which are medically necessary for diagnosis and treatment of illness or injury when ordered by a physician or other licensed practitioner included in the Plan within the scope of his profession (see Items 5 and 6) and made by an independent laboratory which is an eligible provider.
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4a. NURSING FACILITY SERVICES (other than services in an institution for tuberculosis or mental diseases) for patients 21 years of age or older.

The following services are included when furnished by (or, in the case of physical therapy through a subcontract) a facility meeting the standards of a nursing facility:

1. Bed and board including a private room, if medically necessary, and special dietary services.

2. Nursing care, other medical services related to nursing care and use of equipment that is owned by the facility and is ordinarily provided in the care and treatment of the patient.

3. Specialized nursing services for patients who have been determined to be mentally retarded (or mentally ill) and have other infirmities requiring nursing care, who are treated in facilities or distinct units of nursing facilities that are approved for treatment of the mentally retarded (or mentally ill) and authorized for Title XIX certification by the Michigan Department of Community Health.

4. Routine physical therapy, occupational therapy and speech pathology consisting of repetitive services required to maintain function. The instructions for development of the therapy and treatment are included in the per diem rate. Such therapy does not require the therapist to perform the service, nor does it require complex and sophisticated procedures.

The period of covered nursing facility services is the minimum period necessary in this type of facility for the proper care and treatment of the patient. There is no requirement for prior hospitalization; however, admission to a nursing facility must be upon the written order of a physician or certified religious nonmedical health care practitioner certifying the need for continuous nursing facility care and the patient must meet Medicaid specified functional/medical eligibility criteria for nursing facility level of care.
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Except For State Veterans Homes, the following services are excluded from the nursing facility per diem rate:

1. Physical therapy, as defined in 1.a. Prior Authorization is required.
2. Occupational therapy, as defined in 1.a. Prior Authorization is required.
3. Speech pathology, as defined in 1.a. Prior Authorization is required.

The following service may be covered when billed by county medical care facilities and/or hospital long term care units:

Oxygen

Medicare and Medicaid Coordination

For nursing facilities, county medical care facilities, hospital long term care units, ventilator dependent care units, hospital swing beds and nursing facilities for the mentally ill, Medicaid will reimburse consistent with the methodology for coordination of Title XIX with Title XVIII as specified in Supplement 1 to Attachment 4.19-B, page 1 of this plan. The services subject to co-insurance and deductible payments, and how to bill the co-insurance and deductible for these services, are listed in the Medicaid Nursing Facility Procedure Code Appendix.

A dually eligible beneficiary who resides in a Medicaid-only certified bed may be admitted to a hospital for acute care services and, at the time of the beneficiary’s hospital discharge, may be eligible for Medicare-reimbursed Skilled Nursing Facility (SNF) benefits. However, the beneficiary may wish to return to the Medicaid NF bed from which he was originally transferred. In these situations, Medicaid will reimburse the Nursing Facility for any days (i.e. 100 days) that would have been covered by Medicare.

Medicaid will reimburse for all medically necessary nursing facility days and other medically necessary services for dually eligible beneficiaries who wish to return to their Medicaid NF bed and refuse their Medicare SNF benefit.
4b. The EPSDT program is available to all Medicaid beneficiaries under the age of 21. This program was established to detect and correct or ameliorate defects and physical and mental illnesses and conditions discovered in children.

EPSDT visits are recommended according to the periodicity schedule by the American Academy of Pediatrics.

EPSDT services are provided as defined in section 1905 (r) (5) of the Act. Medically necessary screening, preventive, diagnostic services and treatment will be covered under other appropriate service categories.

Of the services listed on 3.1-A preprint pages of the State Plan, religious non-medical health care nursing services (formerly Christian Science nurses’ services) and private duty nursing services may be prior authorized by the single state agency for medically necessary follow-up services to treat detected conditions for beneficiaries under the age of 21 years when the following requirements are met:

- the beneficiary requires continuous skilled nursing care on a daily basis and is either dependent daily on technology-based medical equipment to sustain life or has had frequent episodes of medical instability within the past 3 to 6 months, requiring skilled nursing assessments, judgments or interventions due to a substantiated progressively debilitating physical disorder
- the beneficiary is eligible for Medicaid in the home/community setting; and appropriate nursing services, considering the beneficiary's health and medical care needs, can be safely provided in the home/community setting
- the beneficiary, his/her family (or guardian), the beneficiary’s physician, the Medicaid case manager, and the care giving nurse have collaborated and developed an integrated plan of care that identifies and addresses the beneficiary’s need for nursing services

Private duty nursing services must be provided by a registered nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN, under the direction of the beneficiary’s physician.

Determinations regarding the quantity of services provided will consider the beneficiary's care needs which establish medical necessity for nursing services.

Blood lead follow-up services are not listed in the preprint pages but are covered for children discovered to have elevated blood lead levels. The on-site investigation of a child’s home or primary residence to determine the environmental source of lead is covered under the diagnostic service benefit at 42 CFR 440.130(a).

Assessments are performed by assessors certified by the state.

Diagnostic services are limited to lead investigation to determine the source of lead poisoning for a child who is diagnosed with an elevated blood lead level. The investigation will be conducted in the child's home or primary residence. A maximum of two sites may be investigated. Lead investigations beyond the child's home or primary residence, such as in community settings, or schools, are not reimbursable. The state follows recommended guidelines established by the Centers for Disease Control and Prevention (CDC) for assessment and investigation activities associated with elevated blood lead levels.
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4b. EPSDT (continued)

In addition, the EPSDT program covers medically necessary screening and preventive support services for children, including nutritional and at-risk assessments as well as resulting health education and mental health services. These services are provided to all Medicaid-eligible children for the purpose of screening and identifying children that may be at risk for, but not limited to, drug or alcohol abuse, child abuse or neglect, failure to thrive, low birth weight, low functioning/impaired parent, or homeless or dangerous living situations. The screening and preventive support services are provided by Medicaid enrolled providers.

Behavioral Health Treatment (BHT) - 1905 (a)(13)(c) Preventative Services

Behavioral Health Treatment (BHT) services, including applied behavior analysis (ABA), prevent the progression of autism spectrum disorder (ASD), prolong life, and promote the physical and mental health and efficiency of the beneficiary. The recommendation for BHT services is made by a physician, or other licensed practitioners in the state of Michigan. Direct patient care services that treat or address ASD under the state plan are available to children under 21 years of age as required by the early and periodic screening, diagnosis and treatment (EPSDT) benefit.

Evaluations Prior to Receiving Behavioral Health Treatment (BHT)

These evaluations are covered under the Physician Services or Other Licensed Practitioner benefit category, as applicable. These evaluations must be performed before the individual receives treatment services.

a) Medical / Physical Evaluation: This evaluation is a review of the individual’s overall medical health, hearing, speech, and vision, including relevant information and should include a validated ASD screening tool. The evaluation is also designed to rule out medical or behavioral conditions other than ASD, including those that may have behavioral implications and/or may co-occur with ASD. These evaluations are provided by a physician, advanced practice registered nurse (APRN) / nurse practitioner, or physician assistant.

b) Comprehensive Diagnostic Evaluation: This evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should use validated evaluation tools. Based on the evaluation, the practitioner determines the individual’s diagnosis, recommends general ASD treatment interventions, and refers the individual for a behavior assessment. The practitioner who conducts the behavior assessment recommends more specific ASD treatment interventions. These evaluations are performed by a qualified licensed practitioner (physician with a specialty in psychiatry or neurology; physician with a sub-specialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline; physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
Behavioral Health Treatment (BHT) – (continued)

Psychologist; advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health; physician assistant with training, experience, or expertise in ASD and/or behavioral health; or clinical social worker) working within their scope of practice and who is qualified and experienced in diagnosing ASD.

Prior Authorization or Other Requirements

BHT services are authorized for a time period not to exceed 365 days. The 365 day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a licensed professional.

Behavioral Assessment

Behavior assessments must use a validated assessment instrument and can include direct observational assessment, observation, record review, data collection and analysis. Examples of behavior assessments include function analysis and functional behavior assessments. The behavior assessment must include the current level of functioning of the individual using a validated data collection method. Behavioral assessments and ongoing measurements of improvement must include behavioral outcome tools. Examples of behavioral outcome tools include Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic Language and Learning Skills revised (ABLLS-R), and Assessment of Functional Living Skills (AFLS).
Behavioral Intervention

- ASD treatment services include a variety of behavioral interventions, which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized substantial scientific and clinical evidence. These services are designed to be delivered primarily in the home and in other community settings. These services include, but are not limited to, the following categories of evidence-based interventions:

  o Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis);
  o Adapting environments to promote positive behaviors and learning while reducing negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports);
  o Applying reinforcement to change behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction);
  o Teaching techniques to increase positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting);
  o Teaching parents to provide individualized interventions for their child, for the benefit of the child (e.g., parent implemented intervention);
  o Using typically developing peers (e.g., individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups); and
  o Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software).

- In addition to the categories of interventions listed immediately above, covered ASD treatment services not specifically listed above also include any other intervention supported by credible scientific and/or clinical evidence, as appropriate to each individual.

- Based on the behavioral plan of care, which is adjusted over time based on data collected by the provider to maximize the effectiveness of ASD treatment services, the provider selects and adapts one or more of these services, as appropriate for each individual.

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4b. EPSDT (continued)
Behavioral Health Treatment (BHT) – (continued)

Behavioral Observation and Direction

Behavioral observation and direction is the clinical direction and oversight by a qualified provider to a lower level provider based on the required provider standards and qualifications regarding the provision of services to a child. The qualified provider delivers face-to-face observation and direction to a lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. This service is for the direct benefit of the child and provides a real time response to the intervention to maximize the benefit for the child. It also informs any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the Individual Treatment Plan.

Behavioral Health Treatment (BHT) Provider Qualifications

Board Certified Behavior Analyst (BCBA, BCBA-D)

- Services Provided: Behavioral assessment, behavioral treatment, and behavioral observation and direction.
- License / Certification: Current certification as a BCBA through the Behavior Analyst Certification Board (BACB). The BACB is the national entity accredited by the National Commission of Certifying Agencies.
- Education and Training: Minimum of a master’s degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.

Board Certified Assistant Behavior Analyst (BCaBA)

- Services Provided: Behavioral assessment, behavioral treatment, and behavioral observation and direction.
- License / Certification: Current certification as a BCaBA through the BACB. The BACB is the national entity accredited by the National Commission of Certifying Agencies.
- Education and Training: Minimum of a bachelor’s degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.

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4b. EPSDT (continued)
Behavioral Health Treatment (BHT) – (continued)

- Other Standard: Work is overseen by a BCBA.

Qualified Behavioral Health Professional (QBHP)

- Services Provided: Behavioral assessment, behavioral treatment, and behavioral observation and direction.

- License / Certification: A license or certification is not required, but is optional as explained below.

- Education and Training: QBHP must meet one of the following state requirements:
  - must be a physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD, or;
  - hold a minimum of a master’s degree in a mental health-related field or a BACB approved degree category from an accredited institution who is trained and has one year of experience in the examination, evaluation, and treatment of children with ASD. Works within their scope of practice, works under the supervision of a BCBA, and have extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having taken documented course work at the graduate level at an accredited university in at least three of the six following areas:

  1. Ethical considerations
  2. Definitions & characteristics and principles, processes & concepts of behavior
  3. Behavioral assessment and selecting interventions outcomes and strategies
  4. Experimental evaluation of interventions
  5. Measurement of behavior and developing and interpreting behavioral data
  6. Behavioral change procedures and systems supports

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Behavioral Health Treatment (BHT) – (continued)

Licensed Psychologist (LP)

- Services Provided: Behavioral assessment, behavioral treatment, and behavioral observation and direction.

- License / Certification: Licensed psychologist means a doctoral level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements.

- Education and Training: Minimum doctorate degree from an accredited institution. Works within their scope of practice and have extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having taken documented course work at the graduate level at an accredited university in at least three of the six following areas:

  1. Ethical considerations
  2. Definitions & characteristics and principles, processes & concepts of behavior
  3. Behavioral assessment and selecting interventions outcomes and strategies
  4. Experimental evaluation of interventions
  5. Measurement of behavior and developing and interpreting behavioral data
  6. Behavioral change procedures and systems supports

A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the caseload, progress, and treatment of the child with ASD.
Limited Licensed Psychologist (LLP)

- Services Provided: Behavioral assessment, behavioral treatment, and behavioral observation and direction.

- License / Certification: Limited licensed psychologist means a doctoral or master level psychologist licensed by the State of Michigan. Limited psychologist master’s limited license is good for one two year period. Must complete all coursework and experience requirements.

- Education and Training: Minimum of a master’s or doctorate degree from an accredited institution. Works within their scope of practice and have extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having taken documented course work at the graduate level at an accredited university in at least three of the six following areas:

  1. Ethical considerations
  2. Definitions & characteristics and principles, processes & concepts of behavior
  3. Behavioral assessment and selecting interventions outcomes and strategies
  4. Experimental evaluation of interventions
  5. Measurement of behavior and developing and interpreting behavioral data
  6. Behavioral change procedures and systems supports

A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the progress and treatment of the child with ASD.
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4b. EPSDT (continued)
Behavioral Health Treatment (BHT) – (continued)

Behavior Technician

- Services Provided: Behavioral treatment.
- License / Certification: A license or certification is not required.
- Education and Training: Will receive BACB-registered behavioral technician (RBT) training conducted by a professional experienced in BHT services (BCBA, BCaBA, LP, QBHP, and/or LLP), but is not required to register with the BACB upon completion to furnish services. Work under the supervision of the BCBA or other professional overseeing the BHT services (QBHP, LLP, LP, or BCaBA).

Must be at least 18 years of age, be able to practice universal precautions to protect against the transmission of communicable disease, be able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, be able to report on activities performed, and be in good standing with the law (i.e. not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed or an illegal alien). Must be able to perform and be certified in basic first aid procedures, and is trained in the individual plan of service utilizing the person centered planning process.

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4b. EPSDT (continued)

Pediatric Outpatient Intensive Feeding Services

1905(a)(4)(b) of the Act provides early and periodic screening, diagnostic, and treatment (EPSDT) services (as defined in subsection (r)) for individuals who are eligible under the state plan and are under the age of 21. EPSDT services include medically necessary pediatric outpatient intensive feeding services.

A. Services

Individualized services for the evaluation and treatment of the beneficiary for significant feeding disorders are provided within an outpatient day program, generally five days per week, six to eight hours per day for a period up to six weeks. Covered services are comprised of:

- Physician services as defined under 42 CFR §440.50; and
- Medical or remedial care provided by licensed practitioners as defined under 42 CFR §440.60; and
- Rehabilitative services as defined under 42 CFR § 440.130(d); and
- Occupational therapy as defined under 42 CFR §440.110(b); and
- Services for individuals with speech, hearing and language disorders, 42 CFR §440.110(c).

B. Provider Criteria

Services are provided by a multi-disciplinary team of licensed medical and behavioral health professionals operating within their State law defined scope of practice. Licensed providers assume professional responsibility for the services provided by any unlicensed practitioners under their supervision and delegation, consistent with applicable state law. At a minimum, the team must include the following:

- Licensed Pediatrician in possession of or eligible for pediatric specialty board certification; and
- Licensed physician subspecialist in possession of or eligible for pediatric subspecialty board certification; and
- Licensed behavioral health professional including a licensed psychologist, or licensed master's social worker with at least two years of professional pediatric experience; and
- Licensed speech Pathologist with at least one year of professional pediatric experience; and
- Licensed occupational therapist with at least one year of professional pediatric experience; and
- Registered Dietitian or registered dietitian nutritionist in possession of a master degree of one of the following; human nutrition, public health or a health-related field, and one year of professional pediatric experience.

In addition, the team may also include the services of the following:

- Licensed Advanced Practice Nurse; and
- Licensed physician assistant; and
- Licensed physical Therapist; and
- Licensed Registered Nurse.

C. Prior Authorization

Pediatric outpatient intensive feeding services are authorized for a period not to exceed six weeks. Medically necessary services may be re-authorized at the request of a physician.
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4.b. Medicaid Services that may be provided by Intermediate School Districts:

1. Occupational Therapy

Definition:

Occupational therapy services are available to Medicaid-eligible beneficiaries when medically necessary and as documented in an Individualized Education Program/Individualized Family Service Plan. To be covered, occupational therapy services must require the skills, knowledge and education of an occupational therapist registered (OTR), certified occupational therapist assistant (COTA) or a certified orientation and mobility specialist.

Services:

Occupational therapy services must be prescribed by a physician. Medically necessary services are health care, diagnostic services, treatments and other measures to correct or ameliorate any disability and/or chronic condition. Services include:

A. Evaluations and assessments for the identification of beneficiaries with occupational therapy needs;
B. Evaluation for the purpose of determining the nature, extent and degree of the need for occupational therapy services (or for the assessment of performance levels e.g. strength, dexterity, range of motion, sensation perception, etc.);
C. Evaluations, assessments and training for beneficiaries with loss or lack of vision;
D. Improving, developing, or restoring functions impaired or lost through illness, injury or deprivation;
E. Improving ability to perform tasks for independent functioning when functions are impaired or lost;
F. Direct assistance with the selection, acquisition or use of assistive technology device. Training and coordination using therapies, interventions or services with the device.
G. Preventing, through early intervention, initial or further impairment or loss of function;
H. Evaluation of the needs related to assistive technology device services including a functional evaluation of the beneficiary;
I. Direct assistance with the selection, acquisition or use of assistive technology device. Training and coordination using therapies, interventions or services with the device;
J. Assessment of the beneficiary's skill and performance levels affecting their ability to function or comprehend;
K. Manual therapies (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction, one or more regions).
L. Wheelchair management/propulsion training.

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Occupational therapy services may be provided in an individual or group setting.

Providers:

Occupational therapy services must be provided by a qualified Medicaid provider who meets the requirements of 42 CFR §440.110(b) and in accordance with applicable state and federal law or regulation. Services may be provided by:

A. An occupational therapist currently registered in Michigan
B. A certified and registered occupational therapy assistant under the direction of a certified and registered occupational therapist (i.e., the COTA’s services must follow the evaluation and treatment plan developed by the OTR and the OTR must supervise and monitor the COTA’s performance with continuous assessment of the beneficiary’s progress). All documents must be reviewed and signed by the appropriate supervising OTR.
C. An orientation and mobility specialist certified by the Academy for Certification of Vision Rehabilitation and Education Professionals under the direction of a certified and registered occupational therapist.

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4.b. Medicaid Services that may be provided by Intermediate School Districts:

2. Physical Therapy

Definition

Physical therapy services are available to Medicaid-eligible beneficiaries when medically necessary and documented in an Individualized Education Program/Individualized Family Service Plan. To be covered, physical therapy services must require the skills, knowledge and education of a Licensed Physical Therapist (LPT) or an appropriately supervised Certified Physical Therapy Assistant (CPTA). Medically necessary services are health care, diagnostic services, treatments and other measures to correct or ameliorate any disability and/or chronic conditions.

Services

Physical therapy services must be prescribed by a physician and updated annually. These services include:

A. Evaluations and assessments for the identification of beneficiaries with physical therapy needs;
B. Evaluation for the purpose of determining the nature, extent and degree of the need for physical therapy services;
C. Physical therapy services provided for the purpose of preventing or alleviating movement dysfunction and related functional problems;
D. Obtaining, interpreting and integrating information appropriate to program planning;
E. Direct assistance with the selection, acquisition or use of assistive technology device. Training and coordination using therapies, interventions or services with the device.
F. Training in functional mobility skills (e.g. ambulation, transfers and wheelchair mobility);
G. Stretching and improved flexibility;
H. Instruction of family or caregivers;
I. Training in the use of orthotic/prosthetic devices.

Physical therapy services may be provided in an individual or group setting.

Providers

Physical therapy services must be provided by a qualified Medicaid provider who meets the requirements of 42 CFR § 440.110(a) and in accordance with applicable state and federal law or regulation. Services may be provided by:

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A. A qualified physical therapist licensed by the State of Michigan (LPT);
B. A Michigan certified physical therapy assistant when the assistant is acting under the direction of a licensed physical therapist (i.e., the LPT supervises and monitors the CPTA's performance with continuous assessment of the student's progress). All documentation must be reviewed and signed by the appropriately licensed supervising LPT.

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4.b. Medicaid Services that may be provided by Intermediate School Districts

3. Speech, Language and Hearing

Definition

Speech therapy services are available to Medicaid-eligible beneficiaries when medically necessary and documented in an Individualized Education Program/Individualized Family Service Plan. Medically necessary health services are health care, diagnostic services, treatments and other measures to correct or ameliorate any disability and/or chronic condition. To be covered, services must require the skills, knowledge and education of a qualified speech language pathologist (SPL) or audiologist.

Services

Speech and language services require a referral from a physician. Covered services include:

A. Evaluations and assessments for the identification of beneficiaries with speech, language or hearing disorders;
B. Diagnosis and appraisal of specific speech or language disorders;
C. Determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing;
D. Provision of amelioration activities, such as language amelioration, auditory training, speech reading (lip reading), hearing evaluation and speech conversation;
E. Speech defect corrective therapy;
F. Needs assessment for group and individual amplification;
G. Fitting and testing of hearing aids and other communication devices;
H. Referral for medical or other professional attention necessary for the habilitation of speech or language disorders;
I. Provision of speech or language services for the habilitation or prevention of communicative disorders;
J. Direct assistance with the selection acquisition or use of assistive technology devices. Training and coordination using therapies, interventions or services with the device;
K. Esophageal speech training therapy;
L. Speech reading/aural rehabilitation
M. Fitting and testing of hearing aids.

Speech and language therapy services may be provided in an individual or group setting.

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Providers

Services must be provided by a Medicaid qualified provider who meets the requirements of 42 CFR §440.110(c) and in accordance with other applicable state or federal law.

Services may be provided by:

A. A licensed speech-language pathologist possessing a current Certificate of Clinical Competence (CCC) from the American Speech-Language Hearing Association;

B. An appropriately supervised speech-language pathologist and/or audiology candidate (i.e., in his/her clinical fellowship year or having completed all requirements for but has not yet obtained a state-issued license), under the direction of licensed speech-language pathologist or licensed audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising speech-language pathologist or audiologist.

C. A qualified teacher of students with speech and language impairments with a current Michigan Department of Education specialty certificate of endorsement for speech and language impairments in the school setting.

D. A licensed audiologist.
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4.b. Medicaid Services that may be provided by Intermediate School Districts

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4.b. Medicaid Services that may be provided by Intermediate School Districts

5. Psychological, Counseling and Social Work

Definition

Psychological, Counseling and Social Work services are available to Medicaid-eligible beneficiaries when medically necessary and documented in an Individualized Education Program/Individualized Family Service Plan. To be covered, services must require the skills, knowledge and education of a physician, psychiatrist, psychologist, counselor or social worker.

Services

Medically necessary services are health care, diagnostic services, treatments and other measures to correct or ameliorate any disability and/or chronic condition. These services are intended for the benefit of the Medicaid eligible beneficiary and include:

A. Services provided to assist the beneficiary and/or parents in understanding the nature of the beneficiary's disability;
B. Services provided to assist the beneficiary and/or parents in understanding the special needs of the beneficiary;
C. Services provided to assist the beneficiary and/or parents in understanding the beneficiary's development;
D. Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health problems;
E. Counseling services
F. Psychotherapy services to include interactive, insight-oriented or supportive psychotherapy;
G. Administering psychological and developmental tests and other assessment procedures, interpreting testing and assessment results;
H. Obtaining, integrating and interpreting information about beneficiary behavior and conditions related to learning and functional needs, planning and managing a program of psychological services;
I. Evaluating a beneficiary for the purpose of determining the needs for specific psychological, health or related services;
J. Assessing the effectiveness of the delivered services on achieving the goals and objectives of the beneficiary's individual educational program;
K. Assessing needs for specific counseling services;
L. Crisis intervention.

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Psychological, Counseling and Social Work services may be provided in an individual or group setting.

Providers

Services must be provided by qualified providers who meet the requirements of, and in accordance with, 42 CFR §440.50, through §440.60(a) and other applicable state and federal law or regulations. Services may be provided by:

A. A licensed Psychologist;
B. A limited licensed Psychologist, under the supervision of a licensed Psychologist;
C. A licensed Psychiatrist (MD);
D. A licensed Physician (MD or DO);
E. A licensed Counselor;
F. A limited licensed Counselor, under the supervision of a licensed Counselor;
G. A licensed Social Worker;
H. A limited licensed Social Worker, under the supervision of a licensed Social Worker.

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4.b. Medicaid Services that may be provided by Intermediate School Districts:

6. Nursing

Definition

Nursing services are available to Medicaid-eligible beneficiaries when medically necessary and documented in an Individualized Education Program/Individualized Family Service Plan. Nursing services are professional services relevant to the medical needs of the beneficiary, provided through direct intervention. Direct nursing service interventions are provided: within the scope of the professional practice of the Registered Nurse (RN) or Licensed Practical Nurse (LPN); during a face-to-face encounter. Services considered observational or stand-by in nature are not covered. Medicaid policy will follow current Michigan Public Health Code scope of practice guidelines for nursing services.

Services

Covered services include:

A. Catheterization or catheter care
B. Care and maintenance of tracheotomies
C. Prescribed medication administration that is part of the nursing plan of care
D. Oxygen administration
E. Tube feeding
F. Suctioning
G. Ventilator care
H. Evaluations and assessments (RNs only)

Providers – Nursing services must be provided by a qualified nurse who meets the requirements of, and in accordance with, 42 CFR §440.60 and other applicable state and federal law or regulation. Services may be provided by:

A. A licensed registered nurse (RN);
B. A licensed practical nurse (LPN).

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4.b. Medicaid Services that may be provided by Intermediate School Districts

7. Physician

Definition

Physician services are available to Medicaid-eligible beneficiaries when medically necessary and documented in an Individualized Education Program/Individualized Family Service Plan. Physician services are provided with the intent to diagnose, identify or determine the nature and extent of a student's medical or other health related condition.

Services

Covered services include:

A. Evaluation and consultation with providers of covered services for diagnostic and prescriptive services including participation in a multi-disciplinary team assessment;
B. Record review for diagnostic and prescriptive services;
C. Diagnostic and evaluation services to determine a beneficiary's medically related condition that results in the beneficiary's need for Medicaid services.

Providers

Physician services must be provided by a qualified physician or psychiatrist who meets the requirements of, and in accordance with, 42 CFR §440.50(a) and other applicable state and federal law or regulation. Services may be provided by:

A. A licensed physician (MD or DO);
B. A licensed psychiatrist (MD).
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4.b. Medicaid Services that may be provided by Intermediate School Districts

8. Personal Care

Definition

Personal care services are available to Medicaid-eligible beneficiaries when medically necessary and documented in an Individualized Education Program/Individualized Family Service Plan. Personal care services are a range of human assistance services provided to persons with disabilities and chronic conditions. The provision of such services enables them to accomplish tasks that they, if they did not have a disability, would normally do for themselves. Assistance may be in the form of hands on assistance or cueing so that the person performs the task by him/herself.

Services

Covered services include:

A. Eating/feeding
B. Toileting
C. Bathing
D. Grooming
E. Dressing
F. Transferring
G. Ambulation
H. Assistance with self-administered medications
I. Maintaining continence
J. Personal hygiene
K. Mobility
L. Positioning
M. Assistance with food, nutrition and diet activities

Providers

Personal care services must be provided in accordance with 42 CFR §440.167, by a qualified provider who is 18 years or older and has been trained to provide the personal care services required by the client. Services may be provided by:

A. Teacher Aides
B. Health Care Aides
C. Instructional Aides
D. Bilingual Aides
E. Program Assistants
F. Trainable Aides

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4.b. Medicaid Services that may be provided by Intermediate School Districts

9. Specialized Transportation

**Definition**

Specialized transportation services are available to Medicaid-eligible beneficiaries when medically necessary and documented in an Individualized Education Program/Individualized Family Service Plan.

**Services**

Services must be provided on the same date that a Medicaid covered service is received. Transportation must be on a specially adapted school bus and provided to transport the beneficiary to and/or from the location where the Medicaid service is received. Transportation services are not covered on a regular school bus.

**Providers**

Transportation services include direct services personnel (e.g. bus drivers, aides, etc.) employed by or under contract with the school district.

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4c. Family Planning Services (same for categorically and medically needy clients, but limited to clients of child-bearing age).

Family planning services are any medically approved means, including diagnostic evaluation, drugs, supplies, voluntarily preventing or delaying pregnancy. These services can be furnished under the supervision of a physician or dispensed by a pharmacy, for individuals of child-bearing age including minors who can be considered to be sexually active, for purposes of enabling such individuals to voluntarily choose not to risk initial pregnancy or to limit the number and spacing of their children.

Covered services include an office call for a complete exam, drugs, supplies, and devices when such services are provided by or under the supervision of a medical doctor, osteopath, or other eligible family planning provider. Family planning supplies not furnished by the provider as part of the medical services must be prescribed by a physician and purchased at a pharmacy. An exception is condoms and similar supplies which do not require a prescription.

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Tobacco Cessation Counseling Services for Pregnant Women

4.d. 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

- (i) By or under supervision of a physician;
- (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; * or
- (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

*describe if there are any limits on who can provide these counseling services

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: ☒ No limitations ☐ With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:
5. PHYSICIANS’ SERVICES (same for categorically needy and medically needy clients).

Physicians’ services are defined as services provided with the scope of his/her profession by a doctor of medicine or osteopathy licensed under State law where the services are performed:

No payment will be made for services of staff in residence (e.g., interns and residents) or medical staff functioning in an administrative capacity for a hospital, nursing home, or medical care facility, including physician-owners. In relation to outpatient services, physicians’ fees for covered services are payable only when such payment does not duplicate payment to the facility.

Physicians’ services are covered whether furnished in the office, a patient's home, a hospital, a nursing facility or elsewhere, except that:

a) Services must be related to either:
   1) a diagnosed mental or physical health condition calling for therapeutic management; or
   2) an examination to diagnose a mental deficiency or retardation; or
   3) family planning;

b) Physician visits in the nursing home setting are limited to one visit per patient per month; additional visits must be documented as medically necessary;

c) Speech and/or language evaluations by a physician are limited to a not more than two in a 12 month period unless documented as medically necessary.

Physician services include services of the type which an optometrist is also legally authorized to perform and such services are reimbursed whether furnished by a physician or an optometrist.
d) Inpatient services related to a diagnosed mental health condition are covered only when rendered by a psychiatrist or physician (M.D. or D.O.), or psychological testing by a licensed psychologist under the direction of psychiatrist or physician (M.D. or D.O.); and

e) The following specific items are excluded:

1) routine physician examinations not medically necessary for diagnosis or treatment of an illness, injury, or for the prevention of disability with the following exceptions:

   a. screening and preventive services are covered under the EPSDT program for children under the age of 21. See item 4B under this attachment;

f) Certain selected surgeries, as specified by the MA program, that may be performed on an outpatient basis are not covered when performed on an inpatient hospital basis unless there are medical factors that contraindicate the performance of the procedures on an outpatient basis.

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Services Provided Individuals with Special Health Care Needs

Therapeutic, rehabilitative or palliative services are covered when rendered in a free standing specialty facility serving a disproportionate percentage of Medicaid eligible children with specific medical conditions. The provision of these services is critical to the safety net service system for children with special health care needs. Physicians must be designated by the Director of Michigan’s Title V program and concurred with by the Medical Services Administration.

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5a. Physician Services (continued)

   g. Laboratory services performed in the physician’s office are limited to those determined to be reasonable and appropriate for that site. Other laboratory services are covered upon determination by the department to be medically necessary for the setting and specific patient.

   h. Physical therapy services as defined in 1.a of this attachment.

5b. Medical and Surgical Services provided by a dentist

   Services provided by a licensed oral surgeon are covered as follows:

   a. For hospital inpatients under the conditions specified in item 1.c;

   b. For treatment provided on a hospital outpatient basis, or, in the office for treatment of conditions specified in item 1.c.1) a).

6. Medical Care Furnished by Practitioners within the Scope of their Practice as Defined by State Law

   No payment will be made for services of staff in residence or medical staff functioning in an administrative capacity for a hospital or nursing care facility, including practitioner-owners. In relation to outpatient services, practitioner fees for covered services are payable only when such payment does not duplicate payment to the facility.

   a. Podiatry Services:

      Covered services include those falling within the scope of practice under state laws, as limited by the Department, necessary to diagnose and/or treat illness, injury, the prevention of disability, or services provided recipients suffering from specific systemic diseases for which self-treatment would be hazardous.

      Services provided by a podiatrist are covered when those services are rendered on behalf of an organization, clinic or group practice. Covered services are limited to those allowed under the podiatrist’s scope of practice as defined by State law.

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6. Medical Care Furnished by Practitioners within the Scope of their Practice as Defined by State Law (continued)

b. Optometry Services:

i) Covered services as limited by the department, are those provided to individuals under the EPSDT program.

ii) Covered for beneficiaries 21 years of age and older are limited to those services relating to eye trauma and eye disease and low vision evaluations, services and aids (which must be prior authorized).

iii) Vision/Optometrist Services are covered for adults. Certain services and supplies may be subject to meeting stipulated criteria and/or prior authorization. Routine eye exam once every two years; non-routine exams limited to those services relating to eye trauma and eye disease and low vision evaluations, services and aids (which must be prior authorized). Authorization required in excess of limitation.

c. Chiropractor Services:

Covered services are limited to those allowed under the Chiropractor’s scope of practice as defined by state law. Chiropractic benefits are limited to 18 visits per calendar year. Chiropractic services are limited to spinal manipulation. Benefit includes one set of spinal x-rays per beneficiary, per year. Authorization required in excess of limitation.

d. Other Practitioner Services:

~ Certified Nurse Anesthetists (CRNAs)

Services provided by registered nurses certified by the council on Certification of Nurse Anesthetists or re-certified by the Council on Re-certification of Nurse Anesthetists are covered. Services are limited to those provided on an inpatient or outpatient basis and reimbursement is directed through to the provider or the provider’s employer.

~ Registered/Licensed Dental Hygienists (RDHs)

Services provided by registered dental Hygienists (RDHs) are covered when those services are rendered on behalf of an organization, clinic or group practice. Covered services are limited to those allowed under the RDH’s scope of practice as defined by State law. Prior authorization is generally not required. However, authorization required in excess of limitation.
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Certified Pediatric and Family Nurse Practitioners

Services provided by certified family or pediatric nurse practitioners will be covered to the extent the service is covered when provided by an MD, DO, or DPM. The certified family or pediatric nurse practitioner can be separately enrolled and assigned a unique provider ID number to bill and be reimbursed directly or services can be provided as physicians' services and billed by the employing physician.

To be eligible for separate reimbursement, the nurse practitioner must be licensed to practice as a registered nurse, certified by the state licensing authority as a nurse practitioner, and certified as a pediatric nurse practitioner by the American Nurses' Association or the National Board of Pediatric Nurse Practitioners, or certified as a family nurse practitioner by the American Nurses' Association. Services must be provided in collaboration with a physician (MD, DO, DPM) pursuant to the written provisions of a current collaborative practice agreement which is mutually agreed to by both professionals. The physician must provide delegation/supervision as appropriate.

Eff. 06/01/91

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6. Medical Care Furnished by Practitioners within the Scope of their Practice as Defined by State Law (continued)

d. Other Practitioner Services (continued)

  Pharmacists –

  1) Effective June 1, 2015, the administration of vaccines is covered when provided by a licensed pharmacist as authorized by the State within their scope of practice. Limited to administration of vaccines and toxoids as allowed by applicable state authority. Prior authorization is generally not required.

  2) Effective April 1, 2017, Medication Therapy Management Services are provided by qualified, licensed pharmacists to recipients taking a prescription drug to treat or prevent one or more chronic conditions as identified in the list of chronic conditions for medication therapy management eligibility located at www.Michigan.gov/medicaidproviders. Pharmacists must have completed a Medication Therapy Management Program approved by the American Council of Pharmaceutical Education.

     A qualified pharmacist may provide MTM services via telepractice. Services are subject to the same provision of services that are provided to a recipient in person. Providers must ensure the privacy of the recipient and secure any information shared via telepractice.

  3) One initial and seven follow-up services are reimbursable per beneficiary per 365-day period unless additional visits are justified due to medical necessity.

  4) Up to 75 minutes of time spent with the beneficiary per service is reimbursable.
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6. Medical Care Furnished by Practitioners within the Scope of their Practice as Defined by State Law (continued)

d. Other Practitioner Services (continued)

  Psychologists – Effective September 1, 2015, limited licensed, Master’s level Psychologists and fully licensed, Doctoral level Psychologists will be enrolled to provide behavioral health services. Covered services are limited to those under the Psychologist’s scope of practice as defined by State law.

  Social Workers – Effective September 1, 2015, fully licensed, Master’s level Social Workers will be enrolled to provide behavioral health services. Covered services are limited to those under the Social Worker’s scope of practice as defined by State law.

  Professional Counselors - Effective September 1, 2015, fully licensed, Master’s or Doctoral level Professional Counselors will be enrolled to provide behavioral health services. Covered services are limited to those under the Professional Counselor’s scope of practice as defined by State law.

  Marriage and Family Therapists – Effective April 1, 2016, fully licensed, Master’s level Marriage and Family Therapists will be enrolled to provide behavioral health services. Covered services are limited to those under the Marriage and Family Therapist’s scope of practice as defined by State law. Marriage Counseling is not a Medicaid covered service.

Supersedes

TN No.: 17-0005

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TN NO.: 17-0012
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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7. Home Health Care Services (Same for categorically needy and medically needy beneficiaries)
   a. Covered Services

      The services and items listed below are covered by Medicare certified home health agency when provided to a beneficiary in any setting in which normal activities take place and does not include services in a hospital, nursing facility including Nursing Facility for Mentally Ill (NF/MI), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

      All services must be ordered by the beneficiary's physician pursuant to a face-to-face or telemedicine encounter occurring within in 90 days prior or 30 days after the start of services, and documented in a comprehensive written plan of care, which is reviewed by the physician at least every 60 days. An exception to this rule applies to medical supplies and durable medical equipment when provided by a Medicaid enrolled medical supplier. For these items, the physician must review the medical need on an annual basis.

      Medicaid will not cover any services provided by a home health agency that are not medically necessary.

      1) Intermittent or part-time nursing services provided by a Medicaid enrolled home health agency. In areas where no home health agency exists, nursing services may be covered when provided by a registered nurse who:
         • is licensed to practice in Michigan;
         • receives written orders from the beneficiary’s physician;
         • documents the services provided; and,
         • has received instructions in acceptable clinical and administrative record keeping from a public health department nurse.

      2) Home health aide services are not covered for beneficiaries:
         • In a hospital, nursing facility including Nursing Facility for Mentally Ill (NF/MI), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);
         • In a home for the aged or adult foster care facility such services are already provided as part of residential care; or,
         • When not medically necessary.

      3) Medical supplies, equipment and appliances suitable for use in any setting in which normal activities take place and does not include services in a hospital, nursing facility including Nursing Facility for Mentally Ill (NF/MI), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

      A Medicaid enrolled home health agency is allowed to provide a select number of medical supply items when:
         • Medical supplies, durable medical equipment and oxygen suitable for use in any setting in which normal activities take place and does not include services in a home for the aged, adult foster care facility, hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID);
         • Medically necessary; and,
         • Provided by a Medicaid enrolled medical supplier. The following outlines Medicaid policies for a medical supplier dispensing items.
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7. Home Health Care (continued)

Covered services

3. Medical supplies (continued)

Supplies

Coverage includes: Hypodermic syringes/needles, ostomy supplies, dressings necessary for the medical management of the beneficiary, etc.

Certain items require prior authorization.

Exclusion: Incidental first-aid supplies (e.g., adhesive bandages).

Freedom of choice of providers is waived in authority with 1915(a) for diapers and selected incontinence supplies (medical devices) in acceptance of certification that adequate services and devices will be provided. Diapers and selected incontinence supplies must be obtained for the State’s contractor.

Durable Medical Equipment

Durable medical equipment (DME) is a benefit for beneficiaries under age 21. DME is a benefit for beneficiaries age 21 or older under the following conditions:

• When a beneficiary is enrolled in Medicare Part B and Medicare has made payment on the equipment, Medicaid may cover the co-insurance and/or deductible amounts as described in Attachment 3.2-A.

• When the equipment is needed to prevent frequent hospitalization or institutionalization, is life sustaining or replaces a malfunctioning body member, Medicaid may cover the equipment.

Prior authorization of DME is required for beneficiaries of all ages except where exempted for selected diagnostic codes.

Program coverage of mobility and custom fabricated seating systems for all beneficiaries must be ordered by a physician and prior authorized. Prior authorization is determined based on a completed standardized mobility assessment performed by a licensed/certified medical professional defined as an Occupational Therapist, Physical Therapist or Rehabilitation Registered Nurse who has at least 2 years experience in rehabilitation.
The program determines if the equipment is to be rented or purchased. Such determination includes consideration of costs versus benefit.

Oxygen

Oxygen is covered for the beneficiary residing in any setting in which normal activities take place and does not include services in a hospital, nursing facility including Nursing Facility for Mentally Ill (NF/MI), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) when medically necessary and when ordered by a physician.
4) Physical therapy, as described in 1.a of Supplement to Attachment 3.1-A when provided by a Medicaid-enrolled home health agency. Prior approval is required if services exceed the time or frequency for:

- initial treatment (24 times in 60 consecutive calendar days) or
- maintenance/monitoring (four times in the 60-day allowed period)

5) Occupational therapy services, as described in 1.a of Supplement to Attachment 3.1-A, of a restorative nature, are covered when ordered in writing by a physician, and provided by a Medicaid-enrolled home health agency. Prior approval is the same as presented at 4) above.

6) Home health aide services when provided by a Medicare certified and Medicaid enrolled home health agency. Prior authorization is required if services exceed the initial 90-day period. Prior authorization is based on medical necessity, physician’s orders, the plan of care, related documentation, and cost-effectiveness when compared with other care options.

b. Excluded services

"Non-covered care" under the Medical Assistance Program, Le., care which is designed essentially to assist the individual in meeting the activities of daily living and does not require the additional services of trained medical or paramedical personnel.
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9a. CLINIC SERVICES

Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services are covered with the same limitations as services provided in the practitioner’s office (see Items 5 and 6), when furnished to an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients.

9b. MENTAL HEALTH CLINIC SERVICES

Mental health clinic services are covered benefits when provided under the auspices of an approved mental health clinic. To obtain approval, clinics must demonstrate the capacity to provide, either directly or under contract, a full continuum of mental health services, which includes the services listed below.

Services must be primarily medical, as well as medically necessary, and must be preventive, diagnostic, therapeutic, rehabilitative, or palliative. They must be provided under the direction of a physician and delivered according to a physician-approved plan of service, under client services management, and by staff meeting appropriate professional qualifications.

Covered services are available for persons living in their own homes or in supervised residential situations, who require a continuum of mental health services to meet their needs.

Persons who, upon assessment at intake are determined to require only psychotherapy provided by a physician, and who do not require access to a continuum of mental health services, will be subject to the same services limitations as are applicable to non-mental health clinic services recipients.

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Covered services include:

A. Psychological Testing
B. Other Assessments and Testing
C. Psychiatric Evaluation
D. Quarterly Review of Treatment
E. Medication Review and Administration
F. Treatment Planning
G. Mental Health Interventions
   1. Individual Therapy
   2. Group Therapy
   3. Family Therapy
   4. Child Therapy
   5. Crisis Intervention
H. Physical Therapy
I. Occupational Therapy
J. Speech, Hearing and Language Services
K. Health Services
L. Transportation
M. Professional Treatment Monitoring
N. Nursing Home Mental Health Monitoring

9c. PUBLIC CLINIC SERVICES

Public Clinic Services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a public facility (defined below) that is not part of a hospital but is organized and operated to provide medical care to outpatients. Public clinic services include services furnished at the clinic by, or under the direction of, a physician or dentist. Public clinic services may include EPSDT screenings, maternal support services, family planning services, laboratory services, dental services, as well as child health, prenatal and primary care services and immunizations.

A public facility is defined at one of the following sections of the Michigan Public Health Code (PA 368 of 1978, as amended): Section 333.2413, Section 333.2415, or Section 333.2421.

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Supersedes
TN No. 91-21

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
10. Dental Services

Services provided within the scope of his/her profession, as defined by State law by a licensed dentist, are

A. covered for beneficiaries ages 21 and older:

1. Diagnostic and therapeutic services necessary to diagnose and treat conditions relating to a specific medical problem. Approval for these services will be given only when the physician and the dentist concur that the dental care is critical to the treatment of the medical problem for which the attending physician is treating the client.

2. Emergency treatment such as extraction of teeth or palliative treatment for relief of pain or acute infection.

3. Examinations and preventive and therapeutic services as needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

4. Preparation for, adjustments to, and repair of necessary dentures as described in item 12.b. of this attachment.
10. Dental Services (CONTINUED)

Services provided within the scope of his/her profession, as defined by State law by a licensed dentist, are

B. covered for beneficiaries under the EPSDT program:

1. Examinations and preventive services in accordance with the State’s periodicity schedule; therapeutic services as needed for pain relief, infections, restoration of teeth and maintenance of dental health.

2. Diagnostic and therapeutic services necessary to diagnose and treat conditions relating to a specific medical problem. Approval for these services will be given only when the physician and the dentist concur that the dental care is critical to the treatment of the medical problem for which the attending physician is treating the client.

3. Emergency treatment such as extraction of teeth or palliative treatment for relief of pain or acute infection.

4. Preparation for, adjustments to, and repair of necessary dentures as described in item 12.b. of this attachment.

5. Other medically necessary dental services.

6. Any limitations to these dental services can be exceeded based on medical necessity under the early and periodic screening diagnostic and treatment (EPSDT) program.

Supersedes
TN No.: 05-22
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11. Physical Therapy and Related Services

A. Physical Therapy –

1. Rehabilitative Service – Outpatient Therapy Services: Rehabilitative services do not include and FFP is not available for habilitation services.

   a) Services are provided in accordance with 42 CFR 440.110 and covered as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is required when services are medically necessary and exceed the time or frequency limits as described in Medicaid policy for:

      1. Initial treatment (144 units in 12 months); or,
      2. Maintenance/monitoring (four times in the 90 day allowed period)

   b) Services may be provided and billed by any of the following:

      1. Medicare-enrolled comprehensive outpatient rehabilitation facility as defined under 42 CFR 485.58;
      2. Medicare-enrolled outpatient rehabilitation agency as defined under 42 CFR 485.717;
      3. Commission on Accreditation of Rehabilitation Facilities (CARF) accredited outpatient medical rehabilitation program; or
      4. Independent physical therapist

B. Occupational Therapy –

1. Rehabilitative Service – Outpatient Therapy Services: Rehabilitative services do not include and FFP is not available for habilitation services.

   a) Services are provided in accordance with 42 CFR 440.110 and covered as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is required when services are medically necessary and exceed the time or frequency limits as described in Medicaid policy for:

      1. Initial treatment (144 units in 12 months); or,
      2. Maintenance/monitoring (four times in the 90 day allowed period)

   b) Services may be provided and billed by any of the following.

      1. Medicare-enrolled comprehensive outpatient rehabilitation facility as defined under 42 CFR 485.58;
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11. Physical Therapy and Related Services (continued)
   B. Occupational Therapy (continued)
      2. Medicare-enrolled outpatient rehabilitation agency as defined under 42 CFR 485.717;
      3. Commission on Accreditation of Rehabilitation Facilities (CARF) accredited outpatient medical rehabilitation program; or
      4. Independent occupational therapist

C. Speech-Language Therapy/Services for individuals with speech, hearing and language disorders (provided by or under the direction of a qualified speech pathologist or audiologist).
   1. Rehabilitative Service – Outpatient Therapy Services: Rehabilitative services do not include and FFP is not available for habilitation services.
      a) Services are provided in accordance with 42 CFR 440.110 and covered as defined in 1.a of Supplement to Attachment 3.1-A. Prior approval is required when services are medically necessary and exceed the time or frequency limits as described in Medicaid policy for:
         1. Initial treatment (36 visits in 12 months); or,
         2. Maintenance/monitoring (four times in the 90 day allowed period)
      b) Services may be provided and billed by any of the following.
         1. Medicare-enrolled comprehensive outpatient rehabilitation facility as defined under 42 CFR 485.58;
         2. Medicare-enrolled outpatient rehabilitation agency as defined under 42 CFR 485.717;
         3. University Speech-Language Pathology graduate education program accredited by the American Speech-Language Hearing Association Council on Academic Accreditation in Speech-Language Pathology;
         4. Commission on Accreditation of Rehabilitation Facilities (CARF) accredited medical rehabilitation program; or
         5. Independent speech-language pathologist
      c) Covered audiology services include hearing screening, diagnostic and evaluative services, hearing aid selection, hearing aid conformity check, cochlear implant analysis, fitting and programming/reprogramming and hearing therapy when referred in writing by a physician.
      d) Providers must meet the minimum federal requirements as outlined at 42 CFR 440.110(3).

Note: page 23 has been deleted. The next page is 24.

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12. Drug Products, Dentures, Prosthetic and Orthotic Devices, Eyeglasses

a. Drug Products

1. Drug products are covered when prescribed or ordered by a physician, dentist or other licensed practitioner within the scope of his/her practice and when obtained from a licensed pharmacy.

2. Coverage of selected legend and over the counter products from manufacturers that have not entered into or have in effect a rebate agreement as required are limited to those products essential to the health of the beneficiary and that have an 1-A rating by the Food and Drug Administration. Coverage requires prior authorization.

3. Prior authorization may be applied to any drug product, in compliance with federal law.

(A) A request for prior authorization is processed within 24 hours of receipt

(B) A 72-hour supply of medically necessary covered drug products is provided in an emergency situation.

4. Drug products may be restricted from coverage when use is not for medically accepted indication or when the drug is excluded from Michigan’s drug product list, in compliance with federal law.

5. To provide economies and efficiencies in the Medicaid program, the state applies the same prior authorization requirements and supplemental rebate provisions utilized in the Medicaid program to its Maternity Outpatient Medical Services (MOMS) state-sponsored non-Medicaid pharmacy program. By applying the same provisions to this program, the state is able to maintain the current level of pharmacy benefits to the Medicaid population. Furthermore, providing pharmacy benefits to the financially needy potential Medicaid population improves the overall health status of this population, thereby slowing their rate of enrollment for full Medicaid benefits. The non-Medicaid pharmacy program population affected is the Maternity Outpatient Medical Services (MOMS) program, as in effect on October 2002 and as consistent with the documentation provided to CMS related to submission of SPA TN 02-19.

Individuals in the MOMS program include teenagers age 17 and under, who because of confidentiality concerns, choose not to apply for Medicaid. These individuals are likely to be Medicaid eligible, but the prenatal care offered through MOMS, including the pharmacy benefit offer the opportunity for prenatal care to be given without providing the complete Medicaid benefit.

6. Other drug restrictions include: i) dosage and quantity limits, ii) refill limits, and iii) other parameters necessary to ensure appropriate utilization or to prevent fraud and abuse.

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12. Drug Products, Dentures, Prosthetic and Orthotic Devices, Eyeglasses (continued)
   a. Drug Products (continued)

   7. A drug use review program, including prospective and retrospective drug utilization review, has been implemented in compliance with federal law.

   8. Claims management is electronic in compliance with federal law.

   9. The state is in compliance with Section 1927 of the Social Security Act. Based on the requirements for Section 1927 of the Act, the state has the following policies for the supplemental rebate program for the Medicaid population:

      (A) CMS has authorized the State of Michigan to enter into the Michigan multi-state pooling agreement (MMSPA) also referred to as the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on February 1, 2008, have been authorized for pharmaceutical manufacturers’ existing agreements through their current expiration dates. The updated NMPI SRA submitted to CMS on September 25, 2013, has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.

      (B) New contracts will be submitted to CMS for prior approval.

      (C) Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national drug rebate agreement.

      (D) All drugs covered by the program, irrespective of a prior authorization requirement, will comply with provisions of the national drug rebate agreement.

   b. Dentures

   Dentures are a covered benefit for recipients under the EPSDT program if determined necessary by a licensed dentist (Item 10 of this attachment) to correct masticatory deficiencies likely to impair general health. Prior authorization is required. If the client has an existing denture, replacement is permissible only if the existing denture cannot be relined or rebased, whether or not the existing denture was obtained through the Michigan Medical Assistance Program.

   Reimbursement for complete or partial dentures includes the costs of any necessary adjustments within six months of insertion. Dentures will be replaced when medically necessary. Prior authorization is required.

   c. Prosthetic and Orthotic Devices

   Such devices are provided under the following conditions only:

   1. when provided to a hospital inpatient, upon a physician’s order indicating that the device is essential to the client’s medical treatment plan; or,

   2. when prior authorized as medically necessary and provided on an outpatient basis or for a recipient in a long term care facility.
d. Eyeglasses

Corrective lenses and/or frames are covered if determined to be medically necessary by a licensed Optometrist or Ophthalmologist.

Determination of medical necessity is based on specific diopter criteria and/or concurrent complicating medical conditions. Criteria for diopter change are defined for the State Agency by the Michigan Department of Community Health.

The replacement of lost, stolen, broken or outgrown frames and/or lenses is covered without prior authorization as follows:

- One pair of replacement eyeglasses or contact lenses in a year for recipients age 21 and over
- Two pair of replacement eyeglasses or contact lenses in a year for recipients under age 21

Prior authorization is required for eyeglasses that exceed the replacement limits.

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f. Durable Medical Equipment

Durable medical equipment (DME) is a benefit for recipients under age 21 if they are not confined to a long term care facility. DME for a recipient in a long term care facility is considered included in the facility's per diem rate. However, if the DME is customized for the recipient's own full-time use, it is not considered included in the per diem rate and is separately reimbursable to an appropriately enrolled provider.

DME is a benefit for recipients age 21 or older under the following conditions:

1. When the recipient is in a long term care facility, DME is covered only if it is customized for the recipient's full-time use. It is separately reimbursable to an appropriately enrolled medical supplier. The medical supplier is responsible for requesting prior authorization.

2. When a recipient is enrolled in Medicare Part B, and Medicare has made payment on the equipment, Medicaid may cover the coinsurance and/or deductible amounts, as described in 3.2-A.

3. When the equipment is needed to prevent frequent hospitalization or institutionalization, is life sustaining, or replaces a malfunctioning body member, Medicaid may cover the equipment.

Prior authorization of DME is required for recipients of all ages, except where exempted for selected diagnostic codes, and for equipment that is considered included in a long term care facility's per diem rate.

The Program determines if the equipment is to be rented or purchased. Such determination includes consideration of cost versus benefit.

g. Oxygen

Oxygen is covered for the recipient residing in his/her home or in a long term care facility when medically necessary and when ordered by a physician.

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Superseded

(TN No.  92-17  Approval Date 4-23-92  Effective Date  05-15-92)

(TN No.  90-26)
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12. Drug Products, Dentures, Prosthetic and Orthotic Devices, Eyeglasses (continued)

h. Hearing Aids

i.) Under the EPSDT program, hearing aids and accessories are provided under the following conditions:

• A physician provides medical concurrence that there are no contraindications to the use of a hearing aid(s). A medical concurrence must be within six months prior to dispensing the hearing aid(s).

• A licensed audiologist must complete a written recommendation for the hearing aid. Services may be provided and billed by an audiologists or a Medicaid enrolled outpatient hospital or hearing center.

ii) Effective for dates of service on and after September 1, 2018, hearing aids will be covered for beneficiaries age 21 and over. The same conditions apply as stated in 12. h. i.) above.
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13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES

a. Diagnostic Services  Provided With Limitations
   The program covers medically necessary diagnostic services when provided in accordance with currently accepted standards of medical or professional practice.

b. Screening services  Provided With limitations
   The program covers medically necessary screening services when provided in accordance with currently accepted standards of medical or professional practice.

c. Preventive Services – Provided With limitations
   The program covers medically necessary preventive services when provided in accordance with currently accepted standards of medical or professional practice.

   The program covers one preventive medicine visit annually. Additional visits may be covered per recommended clinical guidelines.

   All United States Preventive Services Task Force (USPSTF) Grade A and B preventive services and approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration, are covered without beneficiary cost sharing.

   In compliance with Section 4106 of the Affordable Care Act, the State assures that it has a method in place to update coverage and billing codes to comply with any changes made to USPSTF or ACIP recommendations. Additionally, the State assures that it has documentation to support the claiming of any additional federal match for such services.

d. Rehabilitative Services

   1) Substance abuse rehabilitation services
      The program covers medically necessary rehabilitation services for persons with a chemical dependency diagnosis. Medical necessity is documented by physician referral or approval of the treatment plan.

      Services may be provided in residential settings or on an outpatient basis. Reimbursement will be excluded for rehabilitation services provided to any individual who is a patient in an IMD.

      Substance Abuse Treatment Programs have been defined as those meeting the following criteria which assure that providers have the capacity to provide services but do not restrict client freedom of choice:
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- hold a standard Department of Public Health/Center for Substance Abuse Services (CSAS) license
- be accredited by any one of the following accrediting organizations:
  - JCAHO (Joint Commission on Accreditation of Healthcare Organizations),
  - CARF (Commission on Accreditation of Rehabilitation Facilities),
  - AOA (American Osteopathic Association),
  - COA (Council on Accreditation of Services for Families and Children)
- have a designated medical director (MD or DO) who assumes responsibility for the administration of all medical services performed by the program.
- have arrangements for medical emergencies and provision of first aid.
- have demonstrated experience, with positive outcomes, in delivery of substance abuse treatment services.
- have in place an evaluation process of program effectiveness.
- conform to CSAS licensing requirements for treatment plans, and for recipient rights and compliance.
- comply with the requirements of the CSAS Counselor Certification System for all program staff rendering treatment services.
- develop aftercare planning and referral services as appropriate.
- submit client data in accordance with the Statewide Substance Abuse Data System requirements for evaluation of services.
- In addition, an Intensive Outpatient Program (IOP) provider must submit a complete program description to CSAS.

Substance Abuse Treatment Programs may include the following and will be designated as qualified to render: residential subacute detoxification, residential rehabilitation, intensive outpatient programs (IOP) and programs and/or counseling (individual or group.) Detoxification, rehabilitation, and IOP require prior authorization. Intensive outpatient, individual and group counseling visits will be subject to program limits.

Medically necessary acute care detoxification will continue to be an inpatient benefit.

Reimbursement will be fee for service. Reasonable rates will be set in relationship to similar services for other provider types and comparable to other state agencies.

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13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES

d. Rehabilitative Services (cont.)

4) Rehabilitation Service for Persons with a Neurological Damage - The program covers, upon prior authorization, medically necessary rehabilitation services for persons with neurological damage. Medical necessity is documented by an authorized assessment and physician approval of a care plan which has been developed by an interdisciplinary team. Services may be provided in supervised residential settings or on an outpatient basis.

Rehabilitation programs for persons with neurological damage must meet the program and staffing requirements stipulated by the single state agency. These requirements are based on the relevant standards established by the Commission on the Accreditation of Rehabilitation Facilities (CARF). All Medicaid enrolled providers of these services must have/maintain a three year CARF accreditation as a condition of participation in the Medicaid program.
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Residential programs must be conducted in facilities licensed by the state as foster care facilities. Residential programs include the following services when provided by, or under the direction of, appropriately qualified persons: diagnosis and evaluation, physician services, rehabilitative nursing services, cognitive rehabilitation services, physical therapy services, occupational therapy services, hearing and speech/language services, social work services, behavioral and psychological services, substance abuse services, and rehabilitation aide services. Appropriate orthotic and prosthetic services may also be provided on an ancillary basis.

Outpatient programs include the following, when provided by appropriately qualified persons, in either the outpatient or in-home setting: diagnosis and evaluation, rehabilitative nursing services, cognitive rehabilitation services, physical therapy services, occupational therapy services, hearing and speech/language services, social work services, behavioral and psychological services and rehabilitative aide services. Appropriate orthotic and prosthetic services may also be provided on an ancillary basis.

(5) Mental Health Community Rehabilitation Services

Mental health community rehabilitation services (MHCRS) are medically necessary services that are structured to achieve maximum reduction of assessed disability and/or restoration of a client to his/her best possible functional level. Medical necessity will be documented by a signed individual plan of service developed by an interdisciplinary team consistent with client assessments and approved by the physician or a licensed or approved practitioner of the healing arts.

MHCRS are covered benefits when provided under the auspices of an approved mental health rehabilitation service provider. To obtain approval, MHCRS providers must demonstrate the capacity to provide, either directly or under contract, a full continuum of mental health services, including the MHCRS defined herein.

Services are provided by staff with appropriate professional qualifications. Appropriateness of services and service delivery shall be monitored by qualified staff for consistency with the goals and objectives identified in the individual plan of service.
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Covered Services, as listed below, are available for persons living in their own homes or in supervised residential situations and who require access to MHCRS site or in community settings as specified in the individualized plan of service.

Covered services include:

A. Mental Health Community Rehabilitation Treatment Services to include:

1. Medication monitoring and review
2. Medication administration
3. Crisis intervention
4. Individual, group, child and/or family therapy
5. Behavioral management
6. Occupational therapy

B. The following services when provided by the client's enrolled MHCRS team members:

1. Treatment planning
2. Health services
3. Psychiatric evaluation
4. Psychological testing
5. Physical therapy
6. Other professional assessments
7. Speech, language and hearing services
8. Professional treatment monitoring
9. Quarterly review
10. Transportation
11. Nursing home mental health monitoring

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State of Michigan

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG-TERM CARE FACILITIES)

13. d. (6) Mental Health Psychosocial Rehabilitation Programs (PSR)

PSR programs form an array of client-directed and professionally provided supports for individuals with serious mental illness. The programs are founded on the principles of client choice and active involvement in the operation of various aspects of the program and delivery of services. Services are provided during an "ordered day." The setting is made purposefully informal to reduce the psychological distance between staff and clients.

The PSR program uses the qualified staff from the Medicaid-enrolled mental health clinic and must be certified by the Department of Mental Health. Each client will have an individual plan of service that is monitored using existing mental health procedures (e.g., professional treatment monitoring, quarterly reviews).

The PSR program contains Medicaid-covered services (symptom identification and care, competency building, and environmental support) and noncovered services (vocational services and social/recreational services). Services must be provided at, originate from, a PSR center. Only that portion of the PSR that is covered by Medicaid may be billed to the program.
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13d. 7)

This item (7) has been deleted. The next page is 27h (SPA TN 05-06).
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13. Other Diagnostic, Screening, Preventive and Rehabilitative Services (continued)

d. Rehabilitative Services (continued)

8) Outpatient Hearing Services

Services are covered as defined in 11.C of Supplement to Attachment 3.1-A.

9) Intensive/Crisis Residential Services

Intensive/crisis residential services are intended to provide a short-term alternative to psychiatric inpatient services. Services are intended to avert psychiatric admissions or to shorten the length of stay in a psychiatric inpatient setting. Services will be available to adults and children who meet psychiatric inpatient admission criteria, but who can be appropriately served in settings less intensive than a hospital. Intensive/crisis residential services may be provided to beneficiaries who are assessed by, and admitted through the authority of an enrolled mental health clinic (Provider Type 21).

Services will be provided under the auspices of a Medicaid-enrolled mental health clinic. Services will be provided in licensed residential settings that do not exceed 16 beds. Services will not be provided in hospitals or institutional settings. Services in the crisis residential setting will be time limited. Appropriate follow-up services will be provided by the mental health clinic, under its responsibilities as the mental health case management agency.
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13. Other Diagnostic, Screening, Preventive and Rehabilitative Services (continued)

d. Rehabilitative Services (continued)

9.) Intensive/Crisis Residential Services (continued)

Medicaid covered intensive/crisis residential services include: psychiatric supervision, therapeutic support services, nursing services, medication management/stabilization and education, behavioral services and milieu therapy. Services will be provided by qualified mental health staff, under psychiatric supervision, and according to an individual plan of service.

Services may be provided for a period up to 14 calendar days per crisis residential episode and may be extended for up to 30 days per admission, if justified by clinical need as determined by the inter-disciplinary team.

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Supersedes
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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

10) INTENSIVE/CRISIS STABILIZATION SERVICES

Intensive/crisis stabilization services are structured treatment and support activities, provided by a mental health crisis team, and designed to provide a short-term alternative to inpatient psychiatric services. Services may only be used to avert a psychiatric admission, or to shorten the length of an inpatient stay.

These services are for persons who have been assessed to meet criteria for psychiatric hospital admissions, but who, with intense interventions can be stabilized and served in their usual community environments. These services may also be provided to persons leaving inpatient psychiatric services if such services will result in a shortened inpatient stay.

Medicaid covered intensive/crisis stabilization services include: psychiatric supervision, therapeutic support services, intensive individual counseling/psychotherapy, assessments, and family therapy. Services will be provided by qualified mental health staff, under psychiatric supervision, and according to an individual plan of service.

Intensive/crisis stabilization services may not exceed four weeks in duration, per crisis episode.
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Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy

Moved to Section 11 – Physical Therapy and Related Services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Amount, Duration and Scope of Medical and Remedial Care
Services Provided to the Categorically and Medically Needy

Moved to Section 11 – Physical Therapy and Related Services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of ____ Michigan _____

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

14a. INPATIENT HOSPITAL SERVICES FOR INDIVIDUALS 65 YEARS OF AGE OR OVER IN AN INSTITUTION FOR MENTAL DISEASES (Same for categorically needy and medically needy clients)

Medical Assistance will be provided on behalf of patients who are 65 years of age or older in certified public or private institutions for mental diseases. Public institutions must comply with the standards required by the Department of Mental Health for public mental institutions and must be certified by the Department of Public Health as meeting the standards for psychiatric hospitals under Title XVIII. Private institutions must be licensed by the Department of Mental Health and must be certified by the Department of Public Health as meeting the standards for psychiatric hospitals under Title XVIII.

Included are those items and services which are ordinarily furnished by the institution under the direction of a psychiatrist to inpatients or patients on a day care or night care program.

The period of covered services is the minimum period necessary in these types of facilities for the proper care and treatment of the individual. Periodic recertification of the need for care by the attending physician is required.

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
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14b. NURSING FACILITY SERVICES FOR INDIVIDUALS 65 YEARS OF AGE OR OLDER
IN INSTITUTIONS FOR MENTAL DISEASES (Same for categorically needy and
medically needy clients)

The following services are covered when furnished by a facility licensed by the
Department of Public Health as a nursing facility for care of mentally ill patients. The
facility must be certified as a nursing facility and have an agreement with the Michigan
Department of Social Services to provide skilled nursing facility services. It must also
meet other requirements as established under agreement with the Michigan
Department of Mental Health and approved by the Department of Social Services.

The following services are included when furnished by (or, in the case of physical
therapy, through a subcontract to) a facility meeting the standards of a nursing facility:

a. bed and board, including special dietary services, in a semiprivate room, or if
medically necessary, in a private room.

b. nursing care, other medical services related to nursing care, and use of
equipment which is owned by the facility and is ordinarily provided in the care
and treatment of the patient.

c) Routine physical therapy, occupational therapy, and speech pathology
consisting of repetitive services required to maintain function. The instructions
for development of the therapy and treatment are included in the per diem rate.
Such therapy does not require the therapist to perform the service, nor does it
require complex and sophisticated procedures.

The period of covered nursing facility services is the minimum period necessary in this
type of facility for the proper care and treatment of the patient. There is no
requirement for prior hospitalization; however, admission to a nursing facility must be
upon the written direction of a physician or a certified Christian Science practitioner
who must periodically recertify the need for care. Admission also must be prior
authorized by the Michigan Department of Mental Health and the Michigan
Department of Social Services.

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14c. Intermediate Nursing Facility Services For Individuals 65 Years of Age or Older in Institutions for Mental Diseases are a non-covered service under Michigan Medicaid.
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Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy

15. Intermediate Care Facility Services

An intermediate care facility is an institution licensed and/or certified by the appropriate State authority to provide, on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of the mental or physical condition require care and services above the level of room and board that can be made available only in institutional facilities.

a. Intermediate care services are provided based on the level of care appropriate to the patient’s medical needs. Admission to an intermediate care facility must be upon the written direction of a physician, who must periodically recertify the need for care. Admission must also be prior authorized by the Michigan Department of Community Health or its designee. The period of covered services is the minimum period necessary for the proper care and treatment of the patient.

b. Medical Assistance is provided for individuals who are developmentally disabled (or for persons with related conditions) in properly certified and/or licensed public or private institutions (or distinct part thereof) for the developmentally disabled.

Services regularly provided in these settings are in compliance with the provisions of 42 CFR 440.150 and include health related and programmatic care, supervised personal care, as well as room and board.
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16. INPATIENT PSYCHIATRIC HOSPITAL SERVICES FOR INDIVIDUALS UNDER 22
(Same for categorically needy and medically needy clients)

Medical Assistance will be provided on behalf of patients who are 21 years of age or younger in certified public or private institutions for mental diseases. Public institutions must comply with the standards required by the Department of Mental Health for public mental institutions and must be certified by the Department of Public Health as meeting the standards for psychiatric hospitals under Title XVIII. Private institutions must be licensed by the Department of Mental Health and must be certified by the Department of Public Health as meeting the standards for psychiatric hospitals under Title XVIII.

In addition to the foregoing, the facility must meet the requirements of §1905(h) of the Social Security Act (added by §299B of P.L. 92-603), which requires accreditation by the Joint Commission on Accreditation of Hospitals.

Services in institutions for mental diseases are covered only if the recipient is receiving active treatment for a mental health condition amenable to favorable modification, according to generally accepted professional standards. In addition, services provided must meet the standards prescribed under Title XVIII.

The period of covered services is the minimum period necessary in these types of facilities for the proper care and treatment of the individual. Periodic recertification of the need for care by the attending physician is required.

10/01/94
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17. NURSE-MIDWIFE SERVICES

Services rendered by nurse-midwives certified by the American College of Nurse-midwives are covered. The nurse midwife must have an alliance agreement that provides a safe mechanism for physician consultation, collaboration and referral. Services include family planning, limited laboratory work, minor gynecological services, and maternity care for normal uncomplicated deliveries.

The scope of nurse-midwifery involves the independent management of care of essentially normal pregnancies. The management of medically complicated pregnancies is the responsibility of the physician, and is beyond the scope of nurse-midwifery. Patients with high-risk conditions or complications must be referred to the care of a physician. Nurse-midwife services provided to women with medical complications are covered only if provided under physician supervision. They must be billed by the supervising physician. The supervising physician must be available to the nurse-midwife through direct communication, in person or by radio, telephone or telecommunication. The physician does not have to be on the premises.
18. Hospice Care

With one exception, Medicaid uses Medicare guidelines for hospice coverage.

For a Medicare/Medicaid beneficiary, the hospice must complete a Medicaid enrollment form.

If a Medicare/Medicaid beneficiary revokes his/her Medicare hospice benefit, he/she is not eligible to enroll in the Medicaid hospice benefit. However, if the beneficiary becomes inappropriate for hospice care during Medicare’s fourth benefit period, he/she may be discharged from hospice, then enroll in Medicaid’s hospice benefit when again appropriate for hospice care.

The exception to the Medicare guidelines allow for the provision of hospice services in adult foster care facilities and homes for the aged if the facility is licensed in Michigan and has a contract with the Medicaid enrolled hospice.

Effective March 23, 2010, in accordance with Section 2302 of the Affordable Care Act (ACA), the Michigan Medicaid program covers hospice care for children concurrent with curative treatment of the child’s terminal illness. This allows the beneficiary to elect the hospice benefit, when the need for hospice care, or the terminal diagnosis, is certified by a physician and the hospice director, without forgoing any curative service to which the child is entitled under Medicaid for treatment of the terminal condition.
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19. Case Management

See Supplement 1 to Attachment 3.1-A

20. Extended Services to Pregnant Women

a. The Program covers extended services for 60 days after delivery.

   b. All necessary medical services related to pregnancy or services associated with medical conditions that may complicate pregnancy are covered, including

      1) Psychosocial/nutritional screening and assessments are covered when the service is provided through a Maternal Infant Health Program (MIHP) provider certified to render this service by the Department of Community Health, Public Health Administration. The assessment is administered by a licensed social worker and/or licensed public health nurse. The assessment process identifies the existence, nature or extent of psychosocial/nutritional deviation, if any, in a beneficiary.

      2) The MIHP provider, must be certified by the Department of Community Health, Public Health Administration. Practitioners rendering the service must be either staff of the certified MIHP provider or under direct contract to that certified agency and must be state licensed, rendering services within the scope of practice as defined by state law. MIHP services consist of:

         a) professional visits/interventions of a licensed social worker and/or a licensed public health nurse for counseling to prevent disease, disability, other health conditions or their progression and coordination of care to promote physical and mental health and efficiency, and

         b) childbirth/parenting education programs that have been certified by the Department of Community Health, Public Health Administration and delivered by a licensed practitioner as defined under this item.

21. Ambulatory Prenatal Care for Pregnant Women during Presumptive Eligibility

Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider eligible for payment under the State plan.

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24. OTHER MEDICAL CARE

Any other medical care, and any other type of remedial care recognized under State law, and specified by the Secretary in accordance with section 1905(a)(28) of the Social Security Act and 42 CFR 440.170.

a. Transportation (Same for categorically needy and medically needy clients)

Ambulance service to a hospital for inpatient services, or from a hospital on completion of an inpatient stay, is an allowable benefit when a physician has ordered the service. The physician’s name must be indicated on the claim for payment when submitted by the provider service.

Ambulance service to a hospital for emergency care is an allowable benefit. (Emergency is defined as any condition in which a delay in treatment may result in permanent injury or loss of life.) A physician’s order is not required if the definition of emergency is met. However, the nature of the affliction which gave cause for emergency service must be clearly described on the claim for payment when submitted by the provider of the service. The return trip from an emergency situation is a covered service, if ordered by a physician because the patient required ambulance transportation based on his medical condition, whether or not there was an inpatient stay.

If the ambulance service is by air, it is covered only under the following circumstances:

1) Time and distance would be hazard to the life of the patient, either to or from the hospital, and

2) The reason for hospitalization at the distantly located hospital is that comparable care and medical services are not available locally, and the reason for hospital admission is for medical or surgical therapy, not for diagnosis only.

a.1 ☑ Non-emergency transportation is provided in accordance with 42 CFR 431.53 as an administrative service.

☐ Without limitations ☑ With limitations

The Michigan Department of Community Health (MDCH) administers the provision of Fee For Service (FFS) Non-Emergency Medical Transportation (NEMT) through an agreement with the Michigan Department of Human Services (DHS). MDCH pays DHS for transportation costs and administration. DHS administers NEMT in all Michigan counties except Wayne, Oakland, and Macomb, where NEMT is administered through a brokerage program. The NEMT program includes transportation for FFS beneficiaries and transportation to dental, substance abuse, and community mental health services for beneficiaries enrolled in a Medicaid managed care plan.

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Transportation is requested through the county DHS office. DHS reviews the request for appropriateness and approves accordingly. DHS conducts all activities necessary to administer the NEMT program, including provider registration, receipt, screening, and approval of requests for transportation; and payment to providers and beneficiaries for approved transportation services. MDCH administrative oversight includes examination and evaluation of monthly and quarterly financial reports submitted by DHS; and monitoring, tracking and responding to client contacts in order to identify and resolve transportation access issues.

- Non-emergency transportation is provided without a broker in accordance with 42 CFR 440.170 as an optional medical service, excluding “school-based” transportation.

- Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

MDCH contracts with a single broker to administer FFS NEMT in Wayne, Oakland, and Macomb Counties.

The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36(b)(i).

1) The State will operate the broker program without regard to the requirements of the following paragraphs of section 1902(a):

- (1) state-wideness – the State operates the broker program in Wayne, Oakland and Macomb counties.
- (23) freedom of choice

2) Transportation services provided will include:

- wheelchair van
- taxi
- stretcher car
- bus passes
- tickets
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☐ secured transportation
☒ other transportation:
  ☒ volunteer mileage
  ☒ beneficiary mileage
  ☒ meals and lodging
  ☒ airplane

3) The State assures that transportation services will be provided under a contract with a broker who:
   
   (i) is selected through a competitive bidding process based on the State’s evaluation of the broker’s experience, performance, references, resources, qualifications and costs;
   (ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport is timely and transport personnel are licensed, qualified, competent and courteous;
   (iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services; and,
   (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).

4) The broker contract will provide transportation to the following mandatory categorically needy and medically needy populations:

☒ Low-income families with children (section 1931)
☐ Deemed AFDC-related eligibles
☐ Poverty-level related pregnant women
☐ Poverty-level infants
☐ Poverty-level children 1 through 5
☐ Poverty-level children 6 – 18
☐ Qualified pregnant women AFDC-related
☐ Qualified children AFDC-related
☐ IV-E foster care and adoption assistance children
☐ TMA recipients (due to employment) (section 1925)
☐ TMA recipients (due to child support)
☐ SSI recipients
☐ Individuals eligible under 1902(a)(10)(a)(i) - new eligibility group vii (very low income adults who are not otherwise eligible under any other mandatory eligibility group)

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- Under age 21, or under age 21, 19 or 18 (as the State may choose)
- Relatives specified in section 406(b)(1) with whom a child is living if child is a dependent child under part A of title IV
- Aged (65 years of age or older)
- Blind with respect to States eligible to participate under title XVI
- Permanently or totally disabled individuals 18 or older under title XVI
- Persons essential to recipients under title I, X, XIV or XVI
- Blind or disabled as defined in section 1614 with respect to States not eligible to participate in the State Plan program under title XVI
- Pregnant women
- Individuals provided extended benefits under section 1925
- Individuals described in section 1902(u)(1)
- Employed individuals with a medically improved disability (as defined in section V)
- Individuals described in section 1902(aa)
- Individuals screened for breast or cervical cancer by CDC program
- Individuals receiving COBRA continuation benefits

5) The broker contact will provide transportation to the following categorically needy optional populations:

- Optional poverty level – related pregnant women
- Optional poverty-level – related infants
- Optional targeted low income children
- Non IV-E children who are under State adoption assistance agreements
- Non IV-E independent foster care adolescents who were in foster care on their 18th birthday
- Individuals who meet income and resource requirements of AFDC or SSI
- Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
- Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- Children aged 15-20 who meet AFDC income and resource requirements
- Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- Individuals infected with TB
- Individuals screened for breast or cervical cancer by CDC program
- Individuals receiving COBRA continuation benefits
- Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
- Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution

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☐ Individuals terminally ill if in a medical institution and will receive hospice care
☒ Individuals aged or disabled with income not above 100% FPL
☐ Individuals receiving only an optional State supplement in a 209(b) State
☐ Individuals working disabled who buy into Medicaid (BBA working disabled group)
☐ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
☒ Working individuals with disabilities who buy in to Medicaid under TWWIIA basic coverage Group
☒ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)
☒ Individuals ages 19-64 years, with income at or below 133% of the federal poverty level as determined by the modified adjusted gross income methodology, and meet all eligibility requirements for the Healthy Michigan Plan

1) Payment Methodology

(A) Describe the methodology used by the state to pay the broker:

MDCH payment to the broker is a fixed fee monthly prepayment reimbursement for services/deliverables. The fee is an all-inclusive rate that includes all costs associated with the contract. The contract allows for adjustments to the rate annually.

(B) Describe how the transportation provider will be paid:

The broker contracts with providers to provide NEMT services to Medicaid beneficiaries and issues direct vendor payments to providers. The broker may also issue payment for beneficiary mileage reimbursement. Beneficiaries that can provide their own transportation or receive transportation from a family member, relative, or friend are expected to do so without reimbursement. Reimbursement is approved when no other means of transportation is available.

(C) What is the source of the non-Federal share of the transportation payments?

The State share is from state general funds appropriated by the legislature.

☒ (D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

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(E) The State assures that payments proposed under this State Plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provider to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

(F) The state has included federal Medicaid matching funds as state match when drawing down FTA SAFETEA-LU grants.

7) The broker is a non-governmental entity:

- The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 42 CFR 440.170(a)(4)(ii).

- The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:

  - Transportation is provided in a rural area as defined at 42 CFR 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

  - Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

  - The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

- Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

- Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

- Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the rate charged to other human services agencies for the same service.
9) The NEMT brokerage program operates as follows:

MDCH contracts with a single broker to administer FFS NEMT services for beneficiaries in the following three counties in Michigan: Wayne, Oakland, and Macomb. The broker administers and oversees the NEMT program by:

1) assuring NEMT is provided to eligible Medicaid beneficiaries according to the policies that govern the FFS NEMT program. The broker develops outreach and general information materials describing the availability of NEMT services, eligibility, access, use, and other policies and procedures;

2) Establishing a comprehensive network of transportation providers that includes public, not-for-profit, for-profit organizations and individual qualified operators, including relatives, and diverse modes of available transportation capable of serving beneficiaries from a variety of cultural and geographic areas. The broker educates transportation providers regarding rules, regulations, policies, practices and laws relating to the delivery of NEMT to eligible Medicaid beneficiaries, and ensures providers meet health and safety standards for vehicle maintenance, operation and inspection, and driver qualifications;

3) Establishing an adequately staffed, toll-free, telephone call center to respond to requests and questions from beneficiaries, beneficiary designated representatives, providers, Medicaid technicians, and MDCH. The call center fields requests for transportation, provides information about transportation services, and handles calls to register complaints;

4) verifying beneficiary Medicaid eligibility through MDCH-provided online access;

5) approving and arranging for the most appropriate transportation for the beneficiary's condition and needs, including chronic and ongoing treatment, prescriptions, medical supplies and one time, occasional and ongoing visits for medical care, travel outside the normal service delivery area, overnight stays (including meals and lodging), commercial non-emergency transport vehicle (wheelchair lift/medivan), and attendant (parent, caretaker, etc);

6) providing reimbursement to NEMT providers for authorized services rendered and, if appropriate, to beneficiaries for mileage. The broker will conduct random pre-payment claim checks and validation of information required on invoices; and

7) collecting, monitoring, and reporting monthly data on beneficiaries, providers, services, approvals, denials, calls, complaints, utilization, and trends, and submitting encounter data.
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MDCH administers and oversees the NEMT brokerage contract through:

1) inspection of work performed;
2) scheduled and unscheduled onsite visits;
3) examination of records;
4) action plans to address and resolve deficiencies, concerns, and/or audit recommendations;
5) scheduled, periodic meetings;
6) review of broker charges, reports, and data, including encounter data;
7) beneficiary satisfaction surveys;
8) issue and change management processes, including complaint, appeal and escalation;
9) approval of all NEMT written materials prior to distribution; and
10) online access to broker complaint tracking system.

c. Care and services provided in Christian Science sanatoria (Same for categorically needy and medically needy clients)

Admission must be upon the written direction of a physician or a certified Christian Science practitioner, who must periodically recertify need for care. The facility must be operated or listed and certified by the First Church of Christ Scientist, Boston, Massachusetts. The primary items and services covered include nursing and related services, bed and board and certain supplies, equipment, and appliances used as part of the Christian Science method of healing.

TN NO.: 10-10 Approval Date: DEC 16 2011 Effective Date: 10/01/2010
Supersedes TN No.: new

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
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24. Other Medical Care (continued)

d. Nursing Skilled Facility Services

Coverage of nursing facility services is the same for persons of all ages with
the following exception:

Children under the age of 15 who need skilled nursing care must be referred
to a facility specifically licensed by the Michigan Department of Community
Health to care for children. However, the Director of the Department of
Community Health may authorize individual exceptions upon written
application by the child’s parent or guardian.

e. Emergency Hospital Services

Emergency services include all medically necessary inpatient and outpatient
services that are furnished by a provider that is qualified to furnish such
services and the services are necessary to evaluate or stabilize an
emergency medical condition.

25. Home and Community Care for Functionally Disabled Elderly Individuals – not
provided.
26. Personal Care Services

Personal Care Services, under the Home Help Program in Michigan, address physical assistance needs and enable individuals to remain in their home by avoiding or delaying the need for long-term care services in an institutional setting. These services are furnished to individuals who are not currently residing in a hospital, nursing facility, intermediate care facility for persons with developmental disabilities or institution for mental illness and are provided in accordance with 42 CFR 440.167.

Personal care services are available to persons who require hands-on assistance in activities of daily living (ADLs): eating, toileting, bathing, grooming, dressing, ambulation, and transferring, as well as hands-on assistance in instrumental activities of daily living (IADL services include personal laundry, light housekeeping, shopping, meal preparation, and medication administration). Hour limits per calendar month are applied to the following IADL services as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHOPPING</td>
<td>5 HOURS</td>
</tr>
<tr>
<td>LIGHT HOUSEKEEPING</td>
<td>6 HOURS</td>
</tr>
<tr>
<td>LAUNDRY</td>
<td>7 HOURS</td>
</tr>
<tr>
<td>MEAL PREPARATION</td>
<td>25 HOURS</td>
</tr>
</tbody>
</table>

Personal Care Services are only available to beneficiaries who are identified as medically and/or physically disabled, or cognitively impaired by a Medicaid enrolled physician, occupational therapist, physical therapist and/or nurse practitioner, and provided in accordance with a plan of care, and rendered by a qualified person.

Personal care services are available to beneficiaries living in their own homes, the home of another, licensed residential facilities of 16 or fewer beds, and licensed homes for the aged. Services also may be provided outside the home, for the specific purpose of enabling a beneficiary to be employed.

An individual assessment assists in identification of service needs. Beneficiaries with more basic needs may be served by adults who are capable of communicating with the individual and being responsive to his/her needs. Beneficiaries with more complex needs or more specialized problems must be...
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served by individuals who can demonstrate their competence by experience or training.

When provided for minor children, personal care services must be shown to be a necessary supplement to usual parental care, justified by the high service needs of the family. High service needs are those which arise from a physical, medical, emotional, or mental impairment of the minor child, and which require significantly higher levels of intervention than those required by a child of the same age without similar impairments.

Providers shall be qualified individuals or individuals who contract with or are employed by an agency. Providers may not be legally responsible relatives (i.e., spouse, parents or guardians).
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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

a) Case Management: 1) For clients in general FC/HA, including Veteran's Administration clients, a services worker is responsible for personally completing or coordinating the completion of items (2)(a) through (2)(e); 2) For clients in FC where the Department of Mental Health (DMH) or a Community Mental Health (CMH) agency has placement and service delivery responsibility, the case manager is responsible for items (2)(a) through (2)(d) but does not perform payment authorization. Contract residences directly bill DMH for personal care services; 3) For clients in FC where DMH/CMH has placement responsibility only, the case manager is to complete or coordinate items (2)(a) through (2)(e).

b) Nursing Supervision: 1) For clients in general FC/HA, registered nurses employed by the state agency perform annual reviews of needs assessment and plans of care, or more frequently if the client's condition warrants change(s) in the service plan; 2) For clients in FC where DMH/CMH has case management responsibility, registered nurses perform reviews at least annually and are employed or contracted by these agencies.

c) Providers: FC/HA providers must meet state licensing requirements, including training specifications.

d) Recordkeeping: The provider will retain the provider log with other pertinent client records at the residence.

Heading Rev. 04/01/89
29 Integrated Care Model (ICM) Services

Goals of the ICM

ICM services are provided to beneficiaries enrolled with primary care practices that meet patient-centered medical home (PCMH) designated criteria and contract with Physician Organizations or Physician Hospital Organizations (PO/PHO) that have entered into an agreement with the Michigan Department of Community Health (MDCH) to participate in the Michigan Primary Care Transformation Project (MiPCT). The PCMH is an approach to providing comprehensive primary care in a healthcare setting that facilitates partnerships between individual patients and their personal physician.

MiPCT addresses the shortcomings in the current system by enabling providers to hire care managers, implement disease registries to track and follow-up with patients (especially those with multiple chronic diseases), and develop the infrastructure and organizational changes characteristic of patient-centered medical homes. In addition, MiPCT pays physicians to expand office hours, offer same-day appointments, and offer supplemental communication with patients (e.g., via email). MiPCT rewards physicians for improving their patients’ health and avoiding emergency room and inpatient use for ambulatory sensitive conditions. MiPCT provides clinical models, resources, and support to reduce fragmentation of care among providers, and involves the patient in decision-making thereby strengthening the Patient–Care Team relationship. These transformations in the delivery of primary care support the overall goal of MiPCT based on the Institute for Healthcare Improvement’s Triple Aim: to improve patient health status; enhance patients’ overall experience of care; and stabilize or decrease the cost of care.

Providers

Providers who will serve as primary care case managers (PCCM) may be primary care physicians, licensed physician assistants, and licensed nurses who are certified as nurse practitioners working under supervision of a physician, as defined in the Michigan Public Health Code, Act 368.

Provider Qualifications

Primary care case managers must have a PCMH designation to participate. MiPCT PCMH designation means a practice that received PCMH designation through the Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP) in 2010 and/or NCQA recognition as a Level 2 or 3 PCMH prior to July 2010. Providers who want to participate after 2010 can participate by demonstrating that they meet the criteria established as of 2010 for the Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP) and/or the criteria established as of July 2010 for NCQA recognition as a Level 2 or 3 PCMH. PCMH designation must be maintained throughout the term of the project. PCCMs must also be affiliated with a PO/PHO participating in the Physician Group Incentive Program (PGIP) of Blue Cross Blue Shield of Michigan which provides supportive services to enhance the practice’s medical home capabilities and enables continuous quality improvement. These practitioners will employ or arrange with their respective PO/PHO to employ a care manager as part of a care management team (called the Care Team). Care managers must meet MiPCT education and training requirements and conform to MiPCT clinical guidelines.
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Service Descriptions

Providers of this service will provide for the location, coordination, and monitoring of primary care services through ongoing collaboration with the Care Team, consisting of a primary care case manager as defined above, care managers who meet MiPCT program requirements, and other members of the care team who may include nurses, medical assistants, and other clinical support staff who jointly participate to manage care for the entire patient panel as well as distinct subsets of patients.

Limitations

Functional tiers are used to describe the acuity levels of PCMH services provided to patients for the location, coordination, and monitoring of services. Each progressive tier includes and builds on all aspects of the previous tier(s).

- Tier 1 PCMH services focus on navigating the medical neighborhood. Services include provider-led Care Team interactions designed to optimize relationships with other providers, specialists, and hospitals; coordinate referrals and tests; and link patients to community resources.
- Tier 2 services align care transitions. Services in this tier provide for notification of admission and discharge from hospitals and other institutional care settings; PCP and/or specialist follow-up; and medication reconciliation.
- Tier 3 care management services use planned visits to optimize the care of chronic conditions; emphasize self-management support and patient education; and the informed use of advance directives.
- Tier 4 complex care management services include arrangements for a home care team; a comprehensive care plan; and palliative and end-of-life care.

The PCMH model expands access to primary care and improves care coordination. Assistance and support for practice transformation takes place through a collaborative network of POs/PHOs and shared learning opportunities facilitated by the MiPCT administrative staff. Focus areas for transformation include care management, self-management support, care coordination, and linkages to community services.

Quality Assurance

In terms of cost and efficiency, Michigan will measure overall costs, and assess both cost and utilization in areas that were shown to drive costs including hospitalizations, 30-day all-cause readmissions, and emergency department visits. Exploratory work will investigate the direction of costs in the following categories: primary care, specialty care, and high-cost radiology. Readmissions will be examined in common diagnostic categories for purposes of providing actionable feedback to participants.

Experience of care outcomes will be assessed for both patients and practices. For patients, a Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH survey will be conducted to address the following PCMH domains: access, communication, coordination, comprehensiveness, shared decision-making, whole person orientation, and self-management support.

Experiential data will be collected from program participants including patients, POs/PHOs, practices, and others. Formal surveys, as well as analysis of project documents will be the main mechanism to collect both experience and process data. Standardized tools will be selected with additional questions added to meet project specific informational needs.

TN NO.: 12-06 Approval Date: 12/5/13 Effective Date: 01/01/2012

Supersedes TN No. N/A – New

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Assurances

All services provided to MiPCT participants are in accordance with 1905(t) of the Social Security Act. Individuals with a favorable health status are not selectively recruited and conversely, individuals are not discriminated against based on health status. Beneficiaries that have selected or been assigned by their Medicaid Health Plan to a MiPCT eligible primary care provider will receive care coordination services. In accordance with 1932(a)(4), beneficiaries who do not wish to receive any form of care coordination may opt out. Beneficiary personal information is utilized by MiPCT providers for HIPAA permissible purposes of treatment, payment, and/or operations. The use of beneficiary information for measurement and evaluation purposes is permitted according to the Data Use Agreement between MDCH and its contracted MiPCT administrative support partners, as well as the Data Use Agreement between MDCH and CMS; and CMS and the MiPCT-participating POs and practices.

TN NO.: 12-06 Approval Date: 12/5/13 Effective Date: 01/01/2012

Supersedes
TN No. N/A – New

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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CASE MANAGEMENT SERVICES

A. Target Group:

See attached targeted group A.

B. Areas of State in which services will be provided:

| X | Entire State |

| | Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide. |

C. Comparability of Services

| | Services are provided in accordance with section 1902(a)(10)(B) of the Act. |

| X | Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act. |

D. Definition of Services

Assessment; care/services plan development; linking/coordination of services; reassessment/follow-up; monitoring of services.

E. Qualification of Providers:

See attached.

TN No. 86-5

Approval Date 8-6-92  Effective Date 07-01-92

Supersedes

TN No. 86-5

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

CASE MANAGEMENT SERVICES

A. TARGET GROUP:

Targeted Group A: This targeted group consists of functionally limited persons with multiple needs or a high level of vulnerability who, as shown by an assessment, require mental health case management. Such persons must have a primary diagnosis of either mental illness or developmental disability and a documented need for access to the continuum of mental health services offered by a Medicaid-enrolled mental health clinic services provider. Moreover, these persons must have a documented lack of capacity for independently accessing, and sustaining involvement with, needed services.

A person in this targeted group may reside in his own home, the household of another, or in a supervised residential setting.

D. Definition of Services (for all targeted groups)

1. Assessment - A case management provider must have the capacity to perform a written comprehensive assessment of a person's assets, deficits and needs. The following areas must be addressed when relevant.

   a. Identifying information (referral source, marital status, living arrangements, emergency-contacts, source of assessment information).

   b. Physical health (health problems or concerns, current diagnosis, medications, treatments, sensory impairments, nutritional status, elimination problems).

   c. Activities of daily living (mobility levels, personal care, household chores, personal business, amount of assistance required).

   d. Social/emotional status (intellectual functioning, behavior problems or concerns, mental impairments, alcohol/drug abuse).

   e. Social relationships/support (informal care givers, i.e., family, friends, volunteers, pets; formal service providers; significant issues in relationships or social environment).

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f. Physical environment (safety and mobility in home; accessability).

g. In-depth resource analysis and planning (coordination of insurance and veterans benefits, other sources of financial and in-kind assistance).

h. Vocational/Educational Status (prognosis for employment; educational/vocational needs; appropriateness/availability of educational programs).

i. Legal Status (guardian relationships, involvement with the legal system).

Assessments must be done by a person from a discipline that matches the apparent needs or dysfunctions identified in the prescreening. Persons from other relevant disciplines should be used to interpret the results of the assessment. Using the assessment to document service gaps and unmet needs, the case management provider is able to act as an advocate for the recipient and at the same time assist other human services providers in their planning and program development.

Should the assessment reveal that the person does not need case management services, appropriate referrals should be made to meet other client needs.

2. Care/Services Plan Development - Following the assessment and determination of need for case management, a written plan of care is developed as a vehicle to address the needs of the recipient. To the maximum extent possible, the development of a care plan is a collaborative process involving the recipient, his/her family or other support systems, and the case management provider.

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Supersedes

TN No. 86-5
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CASE MANAGEMENT SERVICES

Case management services must be guided by a written care plan. The plan should include, at a minimum:

a) problems identified during the assessment.
b) goals to be achieved.
c) reference to all formal services arranged, including costs and specific providers.
d) reference to all services and contributions provided by the information support system; there should be evidence of effort by the case management provider to develop the support system.
e) documentation of who has been involved in the care planning; the recipient, if responsible, must be involved; his/her continued participation in the care program is evidence of his/her involvement.
f) schedules of service initiation and frequency; anticipated dates of delivery; schedules for case management monitoring and reassessment.
g) documentation of unmet needs and service gaps.

3. Linking/Coordination of Services - Through negotiation and referrals, the case manager links the client to various providers of care. The case manager may refer to his/her own agency for some of the direct services but he/she may not restrict the recipient's choice of service provider in violation of Section 1902(a)(23). In many cases it will be necessary to mobilize one or more sets of resources to make adequate services available. This requires the case manager to act as an advocate for the recipient.

4. Reassessment/Follow-up - A standardized re-examination of the client's status and needs is conducted on a periodic basis (related to indicators in plan of care and the time frames for service delivery). This allows adjustments in the plan of care as well as a determination of the appropriate level of involvement by the case manager.

TN No.  \[\text{N/A}\] Approval Date 26-02 Supersedes Date 07-01-92

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5. Monitoring of Services - The case management provider ascertains on an ongoing basis what services have been delivered and whether they are adequate for the needs of the client. Client satisfaction is also monitored. Adjustments in the plan of care or arrangements for service providers may be required. This monitoring function does not preclude or take the place of independent monitoring for purposes of evaluation or Medicaid quality assurance.

E. QUALIFICATION OF PROVIDERS

Providers: Case management provider organizations must be certified by the single state agency as meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management services including:
   a) Comprehensive client assessment;
   b) Comprehensive care/service plan development;
   c) Linking/coordination of services;
   d) Monitoring and follow-up of services;
   e) Reassessment of the client's status and needs.

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

3. Demonstrated experience with the target population.

4. A sufficient number of staff to meet the case management service needs of the target populations.

5. An administrative capacity to ensure quality of services in accordance with State and federal requirements.

6. A financial management capacity and system that provides documentation of services and costs.

7. Capacity to document and maintain individual case records in accordance with State and federal requirements.

TN No. 98-24 Approval Date 8-6-92 Effective Date 07-01-92

Supersedes

TN No. N/A

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CASE MANAGEMENT SERVICES

Providers of mental health case management services to targeted group A must meet the qualifications for Medicaid enrollment as mental health clinic services providers.

Qualifications of Case Managers: A mental health case manager must:

1. Be either a Qualified Mental Retardation Professional (QMRP) as defined at 42 CFR, 442.40, or a Qualified Mental Health Professional (QMHP) as defined in Michigan's Medicaid State Plan provisions for mental health clinic services providers; or

2. At a minimum, possess a bachelor's degree in a human services field and function under the supervision of a QMRP or a QMHP.

TN No. N/A

Supersedes

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State of MICHIGAN

Case Management Services

Reserved

TN NO.: 16-0014      Approval Date:         JAN 24, 2017         Effective Date: 10-01-2016
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TN No.: 92-24

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Case Management Services

Reserved

TN NO.: 16-0014      Approval Date:   JAN 24, 2017      Effective Date: 10-01-2016

Supersedes
TN No.: 92-24

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Case Management Services

Reserved

TN NO.: 16-0014      Approval Date: JAN 24, 2017      Effective Date: 10-01-2016

Supersedes
TN No.: 92-24

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CASE MANAGEMENT SERVICES

A. Target Group:

See attached targeted group C.

B. Areas of State in which services will be provided:

[ ] Entire State

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide.

C. Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[ ] Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services

Assessment; care/services plan development; linking/coordinatoin of services; reassessment/follow-up; monitoring of services. (See Definition of Services for targeted group A.)

E. Qualification of Providers:

See attached.

____________________________________________________________________________

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CASE MANAGEMENT SERVICES

A. TARGET GROUP:

Targeted Group C: This targeted group consists of persons who are:

1. At least 60 years old and disabled, or at least 65 years old, and
2. Medically eligible for Medicaid-covered nursing home services, and
3. Seeking admission to, or at risk of entering, such a facility, and
4. Documented as having multiple, complex and diverse services needs and a lack of capacity and support systems to address those needs without case management.

Persons in this targeted group may reside in their own homes, the home of another, or a supervised living arrangement.

E. QUALIFICATION OF PROVIDERS

Providers: Case management provider organizations must be certified by the single State agency as meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management services including:
   a. Comprehensive client assessment
   b. Comprehensive care/service plan development
   c. Linking/coordination of services
   d. Monitoring and follow-up of services
   e. Reassessment of the client's status and needs

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

3. Demonstrated experienced with the target population.

4. A sufficient number of staff to meet the case management service needs of the target populations.
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5. An administrative capacity to insure quality of services in accordance with State and federal requirements.

6. A financial management capacity and system that provides documentation of services and costs.

7. Capacity to document and maintain individual case records in accordance with State and federal requirements.

Qualifications of Case Managers: A case manager team leader must be certified as a Registered Nurse (R.N.), or licensed to practice as a professional nurse in the State of Michigan. Social workers may be case managers if they possess a bachelor's degree in a human services field or experience as social workers, and receive approved case management training.

Supersedes

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CASE MANAGEMENT SERVICES

A. Target Group:

See attached targeted group D.

B. Areas of State in which services will be provided:

☐ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services

Assessment; care/services plan development; linking/coordination of services; reassessment/follow-up; monitoring of services. (See Definition of Services for targeted group A.)

E. Qualification of Providers:

See attached.

TN No. 92-84 Approval Date 8-6-92 Effective Date 07-01-92

Supersedes

TN No. 86-05

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CASE MANAGEMENT SERVICES

A. TARGET GROUP:

Targeted Group D: This targeted group consists of persons who are:

1. Aged 0-21 with a Michigan Department of Public Health, Division of Children's Special Health Care Services (CSHCS) medically eligible diagnosis, or

2. SSI-Disabled Children's Program clients age 0-16, or

3. Aged 21 and over with either cystic fibrosis or coagulation defects.

E. QUALIFICATION OF PROVIDERS:

Providers: Case management provider organizations must be certified by the single State agency as meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management services including:
   a. Comprehensive client assessment
   b. Comprehensive care/service plan development
   c. Linking/coordination of services
   d. Monitoring and follow-up of services
   e. Reassessment of the client's status and needs

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

3. Demonstrated experienced with the target population.

4. A sufficient number of staff to meet the case management service needs of the target populations.

5. An administrative capacity to insure quality of services in accordance with State and Federal requirements.

6. A financial management capacity and system that provides documentation of services and costs.

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Supersedes

TN No. 92-24
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CASE MANAGEMENT SERVICES

7. Capacity to document and maintain individual case records in accordance with State and federal requirements.

Qualifications of Case Managers:

1. Licensed to practice as a registered professional nurse in the State of Michigan and be employed as a Public Health nurse at the entry level or above by a local health department, or

2. Able to demonstrate to MDPH that comparable qualifications are met.

TN No. 93-24 Approval Date 06-92 Effective Date 07-01-92

Supersedes

TN No. 86-5

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
A. Target Group

See attached targeted group E

B. Areas of State in which services will be provided:

☐ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide.

C. Comparability of Services

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services

Assessment; care/services plan development; linking/coordination of services; reassessment/follow-up; monitoring of services. (See Definition of Services for targeted group A)

E. Qualifications of Providers

See attached

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Supersedes
TN No. N/A

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A. Target Group

**Targeted group E:**

1. Individuals under 21 years of age and determined by an individualized educational program committee or a hearing officer to have a characteristic or set of characteristics pursuant to the Michigan Administrative Rules for Special Education 340.1703 to 430.1715, or

2. Individuals from birth through age two who are experiencing developmental delay or have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay as defined in the P.L. 102-119, Part H, Michigan Interagency Agreement for Eligible Infants and Toddlers and their Families.

3. Individuals not in the target group include:
   - Persons who, as shown by an assessment, require mental health case management. These persons have a primary diagnosis of either mental illness or developmental disability and a documented need for access to the continuum of mental health services offered by a Medicaid-enrolled mental health clinic services provider, or
   - Persons who are age 0-21 with a Michigan Department of Health and Human Services, Division of Children’s Special Health Care Services medically eligible diagnosis, or
   - Persons who are SS-disabled Children’s Program clients age 0-16.
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CASE MANAGEMENT SERVICES

E. Qualifications of Providers

Providers: Case Management provider organizations must be certified by the single state agency as follows:

1.) to provide special rehabilitation services as prescribed by professionals acting within their scope of practice as defined by state law; and
2.) to provide special rehabilitation services in the least restrictive environment; and
3.) to comply with the provisions for quality assurance specified in Attachment 3.1-A, 13.d.(6).C of the state plan; and
4.) to maintain and submit all records and reports to ensure compliance with the Michigan Revised Administrative Rules for Special Education.

Qualifications of Case Managers:

Registered nurse with a valid Michigan license, or

Baccalaureate degree with a major in a specific special education area or have earned credit in course work equivalent to that required for a major, or

Three years personal experience in the direct care of a child with special needs, or

Demonstrated knowledge and understanding about:

1.) Infants and toddlers who are eligible under IDEA; and
2.) Part H of the IDEA and the regulations; and
3.) The nature and scope of services covered under IDEA, systems of payments for services, and other pertinent information; and
4.) Providing direct care of a child with special needs; and
5.) Providing culturally competent services within the culture of the community being served.

Supersedes
TN No. N/A

TN No. 94-28 Approval Date 11-1-84 Effective Date 07/01/94

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)): **Targeted Group F**: The target group is any new or existing Medicaid beneficiary covered under the Flint Michigan Section 1115 Demonstration (Project No. 11W 00302/5). This includes any pregnant women or children up to age 21 with a household income up to and including 400 percent of the FPL who have been served by the Flint water system during the specified time period. Eligibility also applies to any child born to a pregnant woman served by the Flint water system during the specified time period. Once eligibility has been established for a child, the child will remain eligible until age 21 as long as other eligibility requirements are met. An individual was served by the Flint water system if he or she consumed water drawn from the Flint water system and: 1) resided in a dwelling connected to this system; 2) had employment at a location served by this system; or, 3) received child care or education at a location connected to this system.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to ______________ [insert a number; not to exceed 180] consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

___ Entire State

X Only in the following geographic areas: The areas served by the Flint water system that are covered under the Flint Michigan Section 1115 Demonstration (Project No. 11W 00302/5).

Comparability of services (§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual’s needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
State Plan under Title XIX of the Social Security Act
State of Michigan

TARGETED CASE MANAGEMENT SERVICES

It is expected that face-to-face assessments are performed annually, however the frequency should be based on the needs and circumstances of the individual and/or family.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual’s authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual’s care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
  
  Monitoring must be face-to-face and is limited to 5 visits per year unless additional visits are justified based on the needs and circumstances of the individual and/or family.

_x__Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual’s needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual’s needs.

(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)); The State will provide TCM services through Designated Provider Organization (DPO). A DPO is any provider who has been approved by the State (in coordination with

TN# 16-0004 Approval Date MAY 9, 2016 Effective Date:05/09/2016

Supersedes TN# New Page

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
TARGETED CASE MANAGEMENT SERVICES

community leaders and stakeholders in the impacted area) and meets the following qualifications:

- Is currently enrolled as a Michigan Medicaid Provider;
- Can demonstrate the capacity to provide all core elements of TCM, including comprehensive assessment and care plan management, as well as linking, coordination and long-term monitoring of services;
- Has a sufficient number of staff to meet the service needs of the target population and the administrative capacity to ensure the provision of quality services in accordance with State and Federal requirements;
- Has experience in the coordination and linkage of community services; and
- Has the willingness and capabilities to coordinate with the individual’s Medicaid Health Plan, as applicable.

Freedom of choice has been waived pursuant to the authority approved under the Flint Michigan Section 1115 Demonstration (Project No. 11W 00302/5).

DPO Staff Qualifications
The case manager must meet one of the following criteria:

- Licensure as a Registered Nurse by the Michigan Department of Licensing and Regulatory Affairs and at least one year of experience providing community health, pediatric or maternal or infant health nursing services; or
- Licensure as a Social Worker by the Michigan Department of Licensing and Regulatory Affairs and at least one year of experience providing social work services to families.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services]

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual’s access to other services under the plan.

TN# 16-0004 Approval Date MAY 9, 2016 Effective Date:05/09/2016

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TARGETED CASE MANAGEMENT SERVICES

- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency’s authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Only face-to-face case management assessments and monitoring services are reimbursable.

TN# 16-0004 Approval Date MAY 9, 2016 Effective Date:05/09/2016
Supersedes TN# New Page
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

CASE MANAGEMENT SERVICES

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services

2. Eligible recipients will have free choice of the provider of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TN No. 98-24 Approval Date 8-6-92 Effective Date 07-01-92

Supersedes

TN No. 86-5

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the optional categorically needy eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

Please see page 1a of Supplement 2, ATTACHMENT 3.1-A

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II – Rates and Payments)
I. Eligibility

B. The applicable institutional eligibility groups the State has elected to cover, identified by statutory and/or regulatory reference.

<table>
<thead>
<tr>
<th>Eligibility Groups</th>
<th>Statutory and/or Regulatory Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>A special income level equal to 300% of the SSI Federal benefit.</td>
<td>42 CFR 435.236</td>
</tr>
<tr>
<td></td>
<td>42 CFR 435.17</td>
</tr>
<tr>
<td>Medically needy without spend down in States which also provide Medicaid to recipients of SSI.</td>
<td>42 CFR 435.320</td>
</tr>
<tr>
<td></td>
<td>42 CFR 435.322</td>
</tr>
<tr>
<td></td>
<td>42 CFR 435.324</td>
</tr>
<tr>
<td>Aged and disabled who have income at 100% of the Federal Poverty Level (FPL.)</td>
<td>Social Security Act</td>
</tr>
<tr>
<td></td>
<td>Section 1902 (m)1902(r)(2.)</td>
</tr>
</tbody>
</table>
C. The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. X SSI State: The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

   (a). Sec. 435.726 – States which do not use more restrictive eligibility requirements than SSI.

   1. Allowances for the needs of the:

      (A) Individual (check one)

      1. The following standard included under the State plan (check one):

         (a) SSI
         (b) Medically Needy
         (c) The special income level for the institutionalized
         (d) Percent of the federal poverty level: ___%
         (e) Other (specify):

      2. X The following dollar amount: $300% of Federal Benefit Rate

      Note: If this amount changes, this item will be revised

      3. The following formula is used to determine the needs allowance:

         

         Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

   (B) Spouse only (check one):

      1. SSI Standard
      2. Optional State Supplement Standard
      3. Medically Needy Income Standard
State of Michigan  
PACE State Plan Amendment Pre-Print  

PACE Services (continued):  

(B) Spouse only (continued)  

4. The following dollar amount $  
   Note: If this amount changes, this item will be revised.  

5. The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.  

6. The amount is determined using the following formula:  
   
7. Not applicable (N/A)  

(B) Family (check one):  

1. ___ AFDC need standard  
2. ___ Medically needy income standard  

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.  

3. ___ The following dollar amount: $  
   Note: If this amount changes, this item will be revised.  

4. ___ The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.  

5. ___ The amount is determined using the following formula:  
   
6. ___ Other:  

7. ___ Not applicable (N/A)  

(2). Medical and remedial care expensed in 42 CFR 435.726  

Regular Post Eligibility  

2. ___ 209 (b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts for the PACE enrollee income.  

(a) 42 CFR 435.735 – States using more restrictive requirements than SSI.  

1. ___ Allowances for the needs of the  
   (A) Individual (check one):  

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Approval Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>00-11</td>
<td></td>
<td>10/01/00</td>
</tr>
</tbody>
</table>

Supersedes  
TN No. N/A – new page  

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State of Michigan  
PACE State Plan Amendment Pre-Print

PACE Services (Allowances for the needs of the individual - continued):

1. The following standard included under the State Plan (check one):
   (a) SSI
   (b) Medically Needy
   (c) The special income level for the institutionalized
   (d) Percent of the Federal Poverty Level: %
   (e) Other (specify): 

2. The following dollar amount $ 
   Note: If this amount changes, this item will be revised.

3. The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):
   1. The following standard under 42 CFR 435.121:

   2. The Medically needy income standard

   3. The following dollar amount $ 
   Note: If this amount changes, this item will be revised.

   4. The following percentage of the following standard that is not greater than the standards above: % of standard.

   5. The amount is determined using the following formula:

   6. Not applicable (N/A)

(C) Family (check one):
   1. AFDC need standard
   2. Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

   3. The following dollar amount: $ 
   Note: If this amount changes, this item will be revised.

TN No. 00-11  
Approval Date 6-3-2007  
Effective Date 10/01/00

Supersedes  
TN No. N/A – new page
State of Michigan  
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PACE Services (Allowances for the needs of the family - continued):

4. ___ The following percentage of the following standard that is not greater than the standards above: ______% of ________ standard.

5. ___ The amount is determined using the following formula:

6. ___ Other

7. ___ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735

Spousal Post Eligibility

3. ___ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual’s contribution toward the cost of PACE services if it determines the individual’s eligibility under section 1924 of the Act. There shall be deducted from the individual’s monthly income a personal needs allowance (as specified below), and a community spouse’s allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:

1. Individual (check one):

   (A) ___ The following standard included under the State plan (check one):
   1. ___ SSI
   2. ___ Medically Needy
   3. ___ The special income level for the institutionalized
   4. ___ Percent of the Federal Poverty Level: _________% 
   5. ___ Other (specify): __________________________

   (B) ___ The following dollar amount: $________
   Note: If this amount changes, this item will be revised.

   (C) ___ The following formula is used to determine the needs allowance:

If this amount is different than the amount used for the individual’s maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual’s maintenance needs in the community:

Supersedes

TN No. 00-11 Approval Date 10-3-2001 Effective Date 10/01/00

Supersedes
TN No. N/A - new page
II. Rates and Payments

A. The State assures CMS that the capitated rates including any incentive payment will be less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. The State submits a detailed description of the amount would otherwise paid (AWOP) in the Actuarial Notes provided as part of the annual rate certification review. Please refer to supplement 2 attachment 3.1-A page 7a for a description of the rate setting methodology specific to Michigan.

1. X Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State’s cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. ___ Other (please describe)

B. X The rates were set in a reasonable and predictable manner. A letter from an actuarial consulting firm under contract with the State and supporting the rates shall be submitted with the proposed rates for every rebasing year and may be submitted with the rates for other years at the State's discretion. The Medicaid portion of the PACE rates will be rebased at least every fourth year by selecting a time period where costs and eligibility data have been stable and computing the costs of persons who have met the nursing home level of care, including individuals who utilize the MI Choice Home and Community Based Services Waiver for the Elderly and Disabled. Costs are analyzed in seven provider type categories: nursing facility, home and community based waiver, inpatient hospital facility, outpatient hospital facility, physician services, ancillary services, and pharmacy. These cost components are computed using Medicaid claims and eligibility data stored on the Michigan data warehouse.

Costs are then aggregated into per member per month costs and updated for inflation and other trends to bring them into the proposed payment period using adjustment factors. Rates are discounted at least five percent from the projected costs for the eligible PACE population. In the analysis for the rebasing years and the years subsequent to rebasing computations, base rates are updated using trend factors for each provider type cost category. Global Insight Skilled Nursing Home Market Basket, without capital, is utilized to trend the nursing facility cost category. State Medicaid actuarial trend projections are used for the remaining provider categories within the designated geographic areas defined below. These trend factors may then be adjusted to account for the projected effects of policy changes unanticipated by the Global Insight national industry trend or implemented after the base time period used in estimating the Medicaid Actuarial trends.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Program of All-Inclusive Care for the Elderly (PACE)

Michigan will calculate rates annually for each of the following regions.

<table>
<thead>
<tr>
<th>REGION</th>
<th>COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Wayne</td>
</tr>
<tr>
<td>2</td>
<td>Oakland</td>
</tr>
<tr>
<td>3</td>
<td>Lapeer, Macomb, Saint Clair, Sanilac</td>
</tr>
<tr>
<td>4</td>
<td>Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw</td>
</tr>
<tr>
<td>5</td>
<td>Barry, Clinton, Eaton, Gratiot, Ingham, Ionia, Shiawassee</td>
</tr>
<tr>
<td>6</td>
<td>Arenac, Bay, Genesee, Huron, Midland Saginaw, Tuscola</td>
</tr>
<tr>
<td>7</td>
<td>Berrien, Branch, Calhoun, Cass, Kalamazoo, Saint Joseph, Van Buren</td>
</tr>
<tr>
<td>8</td>
<td>Kent</td>
</tr>
<tr>
<td>9</td>
<td>Allegan, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Ottawa</td>
</tr>
<tr>
<td>10</td>
<td>Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Clare, Crawford, Emmet, Gladwin, Grand Traverse, Iosco, Isabella, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Osceola, Oscoda, Otsego, Presque Isle, Roscommon, Wexford</td>
</tr>
<tr>
<td>11</td>
<td>Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft</td>
</tr>
</tbody>
</table>

PACE organizations will receive an incentive bonus or penalty that will be administered after the end of the rate year once the PACE organization’s monthly enrollment reaches 150 participants by the first month of the proposed rate year. This adjustment is designed to minimize the number of voluntary disenrollments the PACE organization experiences. This adjustment will be based on the region’s average skilled nursing care costs and the estimated number of fee-for-service skilled nursing care days the PACE organization avoids by maintaining an attractive provider network and overall program. Voluntary disenrollment rates of less than 5% will entitle the PACE organization to a bonus while rates higher than 5% will result in a monetary penalty.

Should a catastrophic event occur, the voluntary disenrollment penalty will be suspended. The State will notify CMS of the suspension and define the nature of the catastrophic event. These events are defined as floods, nuclear accident, wild fire, etc. This list is meant to be expository and not definitive in nature.

Supersedes

04-11

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Program of All-Inclusive Care for the Elderly (PACE)

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment: For both State Medicaid Agencies and State Administering Agencies, the State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month. In cases where the State Medicaid Agency is separate from the State Administering Agency, the State Medicaid Agency assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the two agencies.
STATE OF MICHIGAN
PACE State Plan Amendment Pre-Print
Enrollment and Disenrollment (cont)

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Supersedes
TN No.: 00-11
STATE OF MICHIGAN
PACE State Plan Amendment Pre-Print

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TN NO.: 18-0002 Approval Date: May 31, 2018 Effective Date: 1/01/18

Supersedes
TN No.: 00-11

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

**Requirements Relating to Covered Outpatient Drugs**

*For the Categorically and Medically Needy*

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Provision(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935(d)(1)</td>
<td>Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.</td>
</tr>
</tbody>
</table>

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TN NO.: 05-19

Approval Date: **FEB 24 2006**

Effective Date: 1/1/2006

Supersedes TN No.: N/A new page

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of MICHIGAN

Requirements Relating to Covered Outpatient Drugs
For the Categorically and Medically Needy

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Provision(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1927(d)(2) and 1935(d)(2)</td>
<td>1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D</td>
</tr>
</tbody>
</table>

☒ The following excluded drugs are covered:

☐ (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)
☐ (b) agents when used to promote fertility (see specific drug categories below)
☐ (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
☐ (d) agents when used for the symptomatic relief cough and colds (see specific categories below)
☒ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific categories below)
☒ (f) nonprescription drugs (see specific categories below)
☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)
☒ (h) barbiturates

Effective January 1, 2013 – except for dual eligible individuals as Medicare Part D will cover all indications.

☒ (i) benzodiazepines

Effective January 1, 2013 – except for dual eligible individuals as Medicare Part D will cover all indications.

Specific category of drugs:

- Vitamin and mineral products (except prenatal vitamins and fluoride) prescribed by a physician to treat a specific diagnosed deficiency.
- Select over-the-counter (OTC) “drugs” limited to analgesic/antipyretics, antihistamines, dermatological, family planning, gastrointestinal, ophthalmic, otic, smoking cessation, and vaginal antifungals.

☐ No excluded drugs are covered

TN NO.: 14-012
Approval Date: AUG 1, 2014
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of MICHIGAN

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All groups

PREFACE to Attachment 3.1-B

The following statement applies to all services provided, as listed on the following pages of this Attachment:

Items or services that are determined to be experimental or investigational are not covered benefits. Such determinations will be made by the Medical Services Administration, based on qualified medical advice that the items or services have not been generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are being used or are to be used. This advice will originate from established sources such as Medicare, National Institutes of Health, Food and Drug Administration (FDA), the AMA's Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc. The determinations are not judgments that a physician's choice is inappropriate or that a patient does not need treatment.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of: MICHIGAN

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
(to the Medically Needy)

WE MAKE NO DIFFERENTIATION BETWEEN CATEGORICALLY
AND MEDICALLY NEEDY. THEREFORE, ATTACHMENT 3.1-A
REFERENCES TO BOTH OF THESE CATEGORIES.

Eff. 04/01/89
The single State agency has signed agreements with State health agencies to assure that the quality of medical care provided under the Medical Assistance Program meets high standards. See Attachment 4.16-A for copies of such agreements.

In cooperation with the aforementioned health agencies, the single State agency provides for the following:

1. A system of standards which must be met by health facilities, institutions and agencies providing care under the Program.

2. Licensure based on the assurance that each institution in which Medical Assistance clients receive medical or remedial care meets the State and Federal standards for the provision of such care. This assurance includes approval by the appropriate health agency of the type of service and the level of care which each facility is authorized to provide.

3. On-site surveys and re-surveys of the health facilities, institutions and agencies providing care under the Program to assure that they meet State and Federal standards for the provision of medical or remedial care.

4. A program of medical audit which assures that services provided to clients under Title XIX are consistent with their medical needs and with the objectives and requirements of the Program, including utilization review.

5. A system of coordination between the Crippled Children and the Medical Assistance Programs to assure that children receive care appropriate to their medical or rehabilitative needs.

6. A health screening program which will promote high quality care, providing for the early detection and treatment of diseases or abnormalities in children.

In addition, the single State agency assures that:

1. All providers of medical or remedial care under the Medical Assistance Program, including medical practitioners, are licensed by the appropriate State agency in compliance with State licensing requirements.

2. All providers of medical or remedial care under the Program have signed agreements with the single State agency, assuring that services will be rendered in compliance with Federal requirements under Title XIX.

3. Standards for reimbursement under the Program are related to the quality of care provided. For example, reimbursement rates to medical practitioners are graduated to differentiate between the services of general practitioners and those of specialists.

4. The services of medical consultants and of professional medical associations are utilized to the fullest extent to encourage the provision of adequate medical care, wherever needed.

TN No.: new
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods of Providing Transportation
for the Categorically and Medically Needy

In addition to ambulance benefits covered under the Medical Assistance Program, provision is made for assuring other essential medical transportation to and from providers of service of recipients not receiving transportation under the brokerage program, by the following methods:

a) For all eligible beneficiaries, transportation expenses related to the beneficiary’s use of medical services are paid if not otherwise available without cost to the client. Transportation costs for all Medicaid covered services are allowable for this purpose. A medical transportation payment requires an initial verification of need for the trip by the beneficiary’s treating physician.

b) For applicants or beneficiaries requiring medical examinations to determine factors of eligibility, i.e., employability, incapacity or disability, transportation related to receiving the medical examination is paid as a part of the administrative cost of the program.

c) For applicants or beneficiaries requiring a medical examination to meet the particular needs of children for protective services, child care services or foster care services, transportation related to receiving the necessary medical examination is paid as an administrative cost.

d) For beneficiaries released from mental institutions, transportation is arranged through relatives and friends, if feasible, or conveyors, when necessary, and paid as a part of administrative costs.

e) Volunteers of the DHS volunteer services program to provide transportation for many beneficiaries in need of such service, and are paid as administrative costs.

f) For all eligible beneficiaries, the DHS worker is required, when appropriate, to enlist the aid of relatives and friends for the purpose of helping the beneficiary obtain needed care, including meeting the beneficiary’s needs for transportation initially and on an ongoing basis. Workers are also permitted, if necessary and practical, to transport clients as part of program administrative costs.

g) For all medically needy eligible beneficiaries, the application of available income provides for income in excess of that needed for maintenance, be applied to the costs of necessary medical transportation as well as other necessary medical or remedial care.

h) An eligible beneficiary’s transportation expenses to and from EPSDT screening sites, and to and from initial referrals made by the screening site for diagnosis and treatment, are included as administrative costs of the Title XIX Program. The Michigan Department of Community Health (MDCH) has an agreement with the Michigan Department of Human Services (DHS) which sets forth the responsibilities and assigned functions to be carried out by both departments for the administration and oversight of transportation services in order to insure compliance with the statutory and regulatory requirements of MDCH policies and Michigan’s approved state plan.

Transportation is an administrative service, except in the areas where Michigan has an approved brokerage program under 440.170(a)(4). Clients or the medical provider can request non-emergency transportation. The request goes to the local DHS office and the transportation service is screened and approved.

Attachment 3.1-D
Page 1

TN NO.: 10-10 Approval Date: DEC 16 2011 Effective Date: 10/01/2010

Supersedes
TN No.: 92-07

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods of Providing Transportation for the Categorically and Medically Needy

I) Transportation expenses to and from medical providers for ongoing medically necessary treatment are included as administrative costs of the Title XIX program.

j) Transportation expenses to and from medical providers for dual (Medicare/Medicaid) eligibles are included as administrative costs of the Title XIX program.

k) Related travel expenses, including meals, lodging, and an attendant, are reimbursed if necessary to obtain medical services, and are included as an administrative cost.

l) Transportation services are requested through county DHS offices. DHS screens requests and approves the least costly, most appropriate mode of transportation available to meet the beneficiary’s need, including, as appropriate, commercial, public, and not-for-profit providers and agencies.

TN NO.: 10-10 Approval Date: DEC 16 2011 Effective Date: 10/01/2010

Supersedes
TN No.: 92-07
STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Liver, heart, heart/lung, bone marrow, and pancreas transplants are reviewed on a case-by-case basis for coverage.

Each request for coverage is considered by a committee of physician experts, and is judged as to the appropriateness of the transplantation procedure for funding. The committee uses a list of patient selection criteria to assist in making this judgement. The criteria are maintained for all organ extrarenal transplants, and are periodically revised. These criteria are used as guidelines. No set of written criteria can completely anticipate all the possible circumstances that may be associated with each individual case. The criteria were developed by the Michigan Department of Public Health and are as follows:

I. Heart Transplant

A. Indications for heart transplant

1. Absolute indications
   a. NYHA Class IV cardiac disease, without surgically correctible mechanical defects and unresponsive to medical therapy.
   b. A fixed pulmonary vascular resistance below eight Wood units.
   c. A thorough understanding by the patient and family of the magnitude of the operation and its sequelae, including lifetime follow-up.
   d. Strong motivation by the patient to undergo the procedure.
   e. A reasonable expectation that the patient's quality of life will be improved.
   f. Medical assessment that the patient is a reasonable risk for operation and has a tolerance of immuno-suppressive therapy.
   g. Medical assessment that the patient has sufficient social stability to provide assurance that he or she will cooperate with the follow-up and the immuno-suppressive program.

2. Relative indications
   a. Not older than 55 years of age
STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

B. Contraindications to heart transplant

1. Absolute contraindications
   a. Active infection, including dental infection.
   b. Active peptic ulcer disease.
   c. Cancer, unless evidence indicates that there is a high probability that the cancer is cured.
   d. Substance abuse, including ethanol and narcotic addiction.
   e. Significant irreversible mental disorder.
   f. Severe generalized arteriosclerosis.
   g. Chronic bronchitis or severe chronic obstructive pulmonary disease (COPD).

2. Relative contraindications
   a. Insulin dependent diabetes.
   b. Recent pulmonary embolism.
   c. Morbid obesity.

II. Heart/lung transplant

A. Indications for heart/lung transplant

1. Absolute indications
   a. NYHA class IV cardiac disease, without surgically correctible mechanical defects and unresponsive to medical therapy, with secondary lung damage leading to a fixed pulmonary vascular resistance of at least eight Wood units.
   b. Severe terminal pulmonary disease unresponsive to all medical therapy, for example chronic emphysema, cystic fibrosis, pulmonary fibrosis, or congenital defects.
   c. A thorough understanding by the patient and family of the magnitude of the operation and its sequelae, including lifetime follow-up.
   d. Strong motivation by the patient to undergo the procedure.
   e. A reasonable expectation that the patient's quality of life will be improved.
   f. Medical assessment that the patient is a reasonable risk for operation and has a tolerance of immunosuppressive therapy.
   g. Medical assessment that the patient has sufficient social stability to provide assurance that he or she will cooperate with the follow-up and the immunosuppressive program.

2. Relative indications
   a. Not older than 40 years of age.
B. Contraindications to heart/lung transplant

1. Absolute contraindications
   a. Active infection, including dental infection.
   b. Active peptic ulcer disease.
   c. Cancer, unless evidence indicates that there is a high probability that the cancer is cured.
   d. Substance abuse, including ethanol and narcotic addiction.
   e. Significant irreversible mental disorder.
   f. Severe generalized arteriosclerosis.

2. Relative contraindications
   a. Insulin dependent diabetes.
   b. Morbid obesity.

III. Liver transplant

A. Indications for liver transplant

1. Absolute indications
   a. Irreversible chronic liver disease which has progressed to the point of significant interference with the patient's ability to work or quality of life, and for which no effective medical or surgical therapeutic alternative is available.
   b. A thorough understanding by the patient and family of the magnitude of the operation and its sequelae, including lifetime follow-up.
   c. Strong motivation by the patient to undergo the procedure.
   d. A reasonable expectation that the patient's quality of life will be improved.
   e. Medical assessment that the patient is a reasonable risk for operation and has a tolerance of immunosuppressive therapy.
   f. Medical assessment that the patient has sufficient social stability to provide assurance that he or she will cooperate with the follow-up and the immunosuppressive program.

2. Relative indications
   a. Not older than 50 years of age.
   b. Stable patient with history of a failed hepatic transplant.
   c. A specific liver disease state characterized by
      1) Albumin less than 2.0 gm/dl.
      2) Serum bilirubin greater than 15 mg/dl.
B. Specific disease states for liver transplant

1. Alcoholic cirrhosis if the patient has abstained for two years as documented by multidisciplinary institutional review.
2. Budd-Chiari syndrome.
4. Chronic active hepatitis (HBsAg negative).
5. Congenital hepatic fibrosis.
6. Cryptogenic cirrhosis.
7. Extrahepatic biliary atresia with or without prior portoenterostomy.
8. Hepatic adenomatosis.
9. Inborn errors of metabolism:
   a. Alpha-1-antitrypsin deficiency (ZZ phenotype).
   b. Byler's disease.
   c. Crigler-Najjar syndrome, Type I.
   d. Galactosemia.
   e. Glycogen storage disease, Type I and IV.
   f. Hemachromatosis.
   g. Protoporphyria.
   h. Sea blue histiocyte syndrome.
   i. Tryosinemia.
   j. Wilson's disease.
   k. Other rare diseases considered on a case-by-case basis.
11. Pediatric hepatoblastoma and other primary hepatic tumors of low grade malignancy.
12. Portal hypertension requiring a porto decompressive procedure concomitant with end-stage liver disease.
13. Post-hepatic cirrhosis.
14. Primary biliary cirrhosis.
15. Sclerosing cholangitis.
17. Subacute hepatic necrosis.

C. Contraindicators to liver transplant

1. Absolute contraindications
   a. Active infection, including dental infection.
   b. Active peptic ulcer disease.
   c. Anasarca.
   d. Cancer, unless evidence indicates that there is a high probability that the cancer is cured; pediatric hepatoblastoma is an exception.
   e. Hepatitis B surface and e antigen positivity.
   f. Portal vein thrombosis.
   g. Severe generalized arteriosclerosis.
   h. Severe irreversible coagulopathy.
   i. Severe life-limiting associated extrahepatic disease.
   j. Substance abuse, including ethanol and narcotic addiction.
   k. Significant irreversible mental disorder.
2. Relative contraindications
   a. Hepatitis B surface antigen positivity without e antigen positivity.
   b. Insulin dependent diabetes mellitus.
   c. Intrahepatic or biliary sepsis.
   d. Morbid obesity.

IV. Pancreatic transplant

A. Indications for pancreatic transplant
   1. Absolute indications
      a. Irreversible severe diabetes mellitus which has progressed to
         the point of significant interference with the patient's
         ability to work or quality of life, and for which no effective
         medical or surgical therapeutic alternative is available.
      b. A thorough understanding by the patient and family of the
         magnitude of the operation and its sequelae, including lifetime
         follow-up.
      c. Strong motivation by the patient to undergo the procedure.
      d. A reasonable expectation that the patient's quality of life
         will be improved.
      e. Medical assessment that the patient is a reasonable risk for
         operation and has a tolerance of immunosuppressive therapy.
      f. Medical assessment that the patient has sufficient social
         stability to provide assurance that he or she will cooperate
         with the follow-up and the immunosuppressive program.
   2. Relative indications
      a. Between 5 years and 50 years of age.
      c. Inability to obtain a reasonable control of blood sugar with
         conventional treatment.

B. Specific disease states for pancreatic transplant
   1. Type I insulin-dependent diabetes.
   2. Insulin dependent diabetes secondary to traumatic or surgical
      removal of pancreas.
C. Contraindications to pancreatic transplant

1. Absolute contraindications
   a. Active infection, including dental infection.
   b. Active peptic ulcer disease.
   c. Cancer, unless evidence indicates that there is a high probability that the cancer is cured.
   d. Severe uncorrectable coronary artery disease.
   e. Substance abuse, including ethanol and narcotic addiction.
   f. Significant irreversible mental disorder.

2. Relative contraindications
   a. Morbid obesity.

V. Bone marrow transplant

A. Indications for bone marrow transplant

1. Absolute indications
   a. Specific bone marrow disease states, with a performance status of 2 or less on the ECOG scale.
   b. A thorough understanding by the patient and family of the magnitude of the operation and its sequelae, including lifetime follow-up.
   c. Strong motivation by the patient to undergo the procedure.
   d. A reasonable expectation that the patient's quality of life will be improved.
   e. Medical assessment that the patient is a reasonable risk for operation and has a tolerance of immunosuppressive therapy.
   f. Medical assessment that the patient has sufficient social stability to provide assurance that he or she will cooperate with the follow-up and the immunosuppressive program.

2. Relative indications
   a. Not older than 50 years of age for allogeneic BMT.
   b. Not older than 65 years of age for autologous BMT.

B. Specific disease states for bone marrow transplant

1. Leukemia: acute lymphocytic and non-lymphocytic leukemia, chronic myelogenous leukemia (in chronic or transformed stage).
2. Severe aplastic anemia.
3. Immune deficiency syndromes.
5. Fanconi's anemia.
6. Lymphoma (high-risk group or in relapse).
8. Neuroblastoma (stage IV).
9. Congenital severe hemolytic anemias (pyruvate kinase deficiency or thalassemia major).
11. Myelodysplastic syndrome (with severe pancytopenia).

C. Contraindications to bone marrow transplant

1. Absolute contraindications
   a. Any major irreversible organ damage.
   b. Active infection, including dental infection.
   c. Active peptic ulcer disease.
   d. Substance abuse, including ethanol and narcotic addiction.
   e. Significant irreversible mental disorder.

2. Relative contraindications
   a. Morbid obesity.
The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. □ Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes □ No □

2. □ Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes □ No □

3. □ All individuals eligible under the State's approved title XIX plan.

4. □ Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

   Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. All individuals eligible under this Title XIX plan.

3.
SECTION 4: General Program Administration
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

STATE STANDARDS FOR INSTITUTIONS

A. HOSPITALS

All hospitals providing services under the Title XIX Program, including hospitals for mental diseases, must meet the requirements of 20 CFR, Chapter III, Part 405, Subpart J.

B. NURSING CARE FACILITIES

All nursing care facilities providing services under the Title XIX Program must meet the requirements of the Michigan administrative rules governing nursing homes, which include the standards listed below. Facilities which must meet the standards listed include skilled and basic nursing homes, hospital long-term-care units, county medical care facilities and state homes and training schools for treatment of the mentally retarded.

State Administration

- licensure and certification
- inspections and investigations
- compliance with other laws and local ordinances

Administrative Management of Homes

- governing bodies and administrators
- admission policies
- employees' health
- acute and/or communicable diseases or accidents
- patient deaths
- visitors and religious ministrations

Patient Care

- written policy, maintained by the home, governing patient care
- oxygen administration
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

STATE STANDARDS FOR INSTITUTIONS

- blood and blood substitute administration
- tuberculosis tests

**Physician Services**
- medical direction of patients by a physician
- medical examinations
- medical visits
- treatment according to a physician's order
- utilization review plans

**Nursing Services**
- nursing personnel
- nursing work periods
- personal care and services
- equipment and facilities
- restorative services

**Food Services**
- meeting nutritional needs of patients
- meals and special diets
- menus
- meal and food records

**Pharmaceutical Services**
- medication kits
- dispensing, storage and administration of medications
- response to medication errors or drug reactions
- stop orders governing use of dangerous drugs
- disposal and release of medications

Other Services

- diagnostic services
- dental services
- medical social services
- diversional activities

Records

- record keeping
- patient clinical records
- patient registers
- accident records and incident reports
- employee records and work schedules

Buildings and Grounds

- building plans and specifications
- building exteriors
- entrances for physically handicapped
- interior construction
- public and personnel areas
- patient rooms
- isolation rooms
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of MICHIGAN

STATE STANDARDS FOR INSTITUTIONS

- nursing stations
- nursing care units
- toilet and bathing facilities
- water supply systems
- waste disposal
- heating
- laundry and linens
- kitchen and dietary areas
- insect and vermin control
- general maintenance and storage
- examination and treatment rooms
- miscellaneous requirements, including sanitary standards

Emergency Procedures
- disaster plans

Child Care Homes and Child Care Units
- requirement for compliance with skilled nursing facility standards
- admission policies in child care homes or units
- physicians' services
- nursing services
- patient care policies
- food services
- infant formulas and water solutions
- patient activities and rehabilitation

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

STATE STANDARDS FOR INSTITUTIONS

*educational activities
*physical environment
*hospital transfer agreements

Nursing Facilities for Care of Mentally Retarded Patients
*patient capacity and admissions in nursing facilities for care of mentally retarded patients
*specialized physician services
*specialized nursing services
*other specialized services

Nursing Facilities for Care of Mentally Ill Patients
*patient capacity and admissions in nursing facilities for care of mentally ill patients
*specialized physician services
*specialized nursing services
*other specialized services

In addition, all skilled nursing facilities must meet the requirements of 20 CFR, Chapter III. Part 405, Subpart K.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

COOPERATIVE ARRANGEMENTS WITH STATE HEALTH AND STATE VOCATIONAL REHABILITATION AGENCIES AND WITH TITLE V GRANTEES

I. MICHIGAN DEPARTMENT OF PUBLIC HEALTH
   Agreement, effective December 26, 1980

II. MICHIGAN DEPARTMENT OF MENTAL HEALTH
    Agreement, effective September 22, 1977

III. MICHIGAN DEPARTMENT OF EDUCATION, BUREAU OF REHABILITATION
    Interim agreement, effective September 30, 1980

IV. MICHIGAN DEPARTMENT OF PUBLIC HEALTH, AND MICHIGAN DEPARTMENT OF STATE POLICE, FIRE MARSHAL DIVISION
    Agreement, effective May 24, 1979

Rev. 01/01/81
Pursuant to Act 280, Public Acts of Michigan of 1939, as amended, a Medical Assistance Program has been implemented in the State of Michigan as authorized by the federal Social Security Act, as amended.

In order to fully comply with the provisions of the above legislation, with reference to appropriate and related federal requirements and with the mandates of Executive Order No. 1965-29 dated December 9, 1965 and subsequent attachments thereto, this contract is entered into by the Michigan Department of Social Services, hereinafter referred to as "Social Services" and the Michigan Department of Public Health hereinafter referred to as "Public Health".

ARTICLE I

It is the intent and purpose of the parties hereto, by entering into this contract: to promote high quality health care and services for recipients under the Medical Assistance Program; to comply with state and federal statues, regulations and guidelines requiring the proper expenditure of public funds for the administration of a Medical Assistance Program and certification of health care providers; to provide a mechanism for prior authorization of selected services; to assure that the services provided under Title XIX and Title V are consistent with the needs of recipients and the two programs' objectives and requirements.

ARTICLE II

The Directors of Social Services and Public Health shall designate from their staffs appropriate liaison persons whose responsibilities shall include regular and periodic communication about the programs and operations described in this contract. Overall liaison responsibilities shall be vested in the Director of Medical Services Administration, Social Services, and the Chiefs of the Bureau of Health Care Administration, and the Bureau of Personal Health Services, Public Health. These persons may delegate liaison responsibilities for programs or operations specified in the sections of Article III, below.

The liaison persons shall be responsible for the joint planning of relationships between the two agencies. They shall oversee the investigation of any problems that arise from the operation of this contract. They shall cause to be undertaken annually a review of the effectiveness of the working relationships defined in this contract, and shall initiate jointly any amendments to this contract.

ARTICLE III

The broad fundamentals of responsibilities and duties of the parties to this contract are subject to the terms and conditions contained in the sections below.
A. Budget Review and Comment

This section provides for Social Services review of, and the opportunity for comment on, Public Health's Proposed budget request as it pertains to the functions covered by this contract.

PUBLIC HEALTH WILL:

Forward to Social Services copies of the Public Health annual budget request and any program revision requests insofar as those requests pertain to the functions covered by this contract.

The copied portions of the budget request will be forwarded to Social Services upon completion but no later than the date that Public Health's budget request is transmitted to the Department of Management and Budget.

SOCIAL SERVICES WILL:

Comment on Public Health's budget request and program revision requests to Public Health and Management and Budget.

B. Certification of Medical Assistance Providers

In order to promote high quality of health care and services for recipients of Michigan's Medical Assistance Program, to assure the proper expenditure of public funds for health care and services provided said recipients and to conform with applicable state/federal requirements, this section provides a mechanism for certification of health facilities, institutions, agencies and other providers of medical service by Public Health to Social Services. The certification activity is contractually delegated to the Bureau of Health Care Administration, Public Health. The reports are used by the Medical Services Administration, Social Services, to assure proper payment of claims submitted by certified providers.

Section B pertains to providers of medical service which require certification as a basis for participation under Michigan's Medical Assistance Program administered by Social Services. Such certification will indicate that certified providers meet applicable state and federal standards for participation in the Medical Assistance Program.

Public Health will certify the following providers to Social Services and others as may be required from time to time as identified in Addenda to this section. Such certification does not mean that services provided by

Rev. 1/01/81
are incorporated as covered services under Michigan's State Plan for Medical Assistance.

1. Hospitals, including public and private psychiatric hospitals and psychiatric units of general hospitals.
2. Nursing homes.
3. County medical care facilities.
4. Hospital long-term care units.
5. Nursing care units in state MI/MR institutions.
6. Home health agencies.
7. Laboratories.
8. Ambulance services.
10. Physical therapy clinics and physical therapy practitioners.
11. HMOs.

PUBLIC HEALTH WILL:

1. At appropriate intervals as prescribed by state and federal regulations, conduct on-site surveys, re-surveys and other necessary examinations of the providers identified above applying to or already participating as providers of service under the state’s Medical Assistance Program, for purposes of determining their compliance with program requirements for certification as providers.

2. Certify and recertify to Social Services, in accordance with federal regulations and the Michigan Public Health Code, those providers which meet applicable federal and state statutes and regulations. The methodology of survey, evaluation and certification will also comply with applicable statutes, regulations and the provisions of this section and be subject to review and comment by Social Services.

3. Notify Social Services and the individual provider within 5 working days of a certification determination and 30 calendar days prior to the expiration or automatic cancellation date of a time limited certification. Such notifications shall be made by a document process mutually agreed upon by both departments and shall include information sufficient enough in detail as to allow Social Services to carry out appropriate provider agreement action as mandated by federal regulations. This document process shall also allow for extensions of existing certifications as provided for in federal regulations.

4. Annually provide to Social Services a complete listing of all certifications in effect on January 1 of that year.

5. Determine and authorize any waiver of provider requirements granted, the conditions of the waiver and the time period such waiver will be in effect.

Vernice Davis Anthony, Director  
Michigan Department of Public Health

Gerald H. Miller, Director  
Michigan Department of Social Services

Date  

Date

TN No. 91-33 Approval Date 1-23-92 Effective Date 10-01-91

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6. Maintain on file for three years all information and reports used in determining a provider's compliance with certification requirements. Such reports will include copies of the findings of those making on-site inspections, documentation of deficiencies and copies of official notices of waiver of any requirements.

7. Provide an appeal procedure for use when the provider is in disagreement with the evaluation of its compliance with certification requirements.

8. Delineate and approve the scope of services to be provided by health facilities, institutions and agencies as follows:
   a. With the assistance of appropriate professional organizations and agencies, develop standards and criteria for the provision of services by hospitals, nursing homes, medical care facilities, agencies, laboratories and other health facilities, institutions and agencies certified to provide care and services under the Medical Assistance Program.
   b. With the assistance of physician staffs and boards of trustees, as well as specialty consultants and local health officers as indicated, apply those standards and criteria to health facilities, institutions and agencies desiring to become providers of services under the Medical Assistance Program and other programs administered by Social Services.
   c. Certification shall include delineation and approval of the type of services and level of care, where applicable, which each facility or agency shall be authorized to provide under the Medical Assistance Program.

9. Provide to Social Services upon request and on a timely basis all reports necessary to meet federal reporting requirements.

10. Maintain data reporting procedures for determining expenditures in which federal financial participation is available.

SOCIAL SERVICES WILL:

1. Utilize as one of the determinants for provider enrollment, disenrollment and payment purposes the certification of providers or denial of such certifications made by Public Health to assure that reimbursement is made for health care and services rendered by providers meeting minimum accepted standards including the fire safety inspection.

2. Exercise ultimate authority to enroll or disenroll provider facilities and agencies in the Medical Assistance Program.

C. Prior Authorization, Medical Review and Independent Professional Review (MR/IPR)

This section provides for interdepartmental and multidisciplinary professional review and evaluation of the health status and care needs of eligible or potentially eligible Medical Assistance clients prior to and periodically following admission to skilled nursing and intermediate care facilities except those facilities for which MR/IPR has been contracted to the Michigan Department of Mental Health (MDMH) to perform for Social Services. In addition, an evaluation shall be made of the appropriateness of care provided by the facility to the client, the facility's adequacy in meeting the client's current care needs and the necessity and desirability of the client's continued placement in the facility.
The program shall be designed and operated to conform to requirements for MR/IPR set forth in federal regulations. Scheduling will involve consultation with local office staff of both agencies.

PUBLIC HEALTH WILL, IN COOPERATION WITH AND WITH THE APPROVAL OF SOCIAL SERVICES:

1. Provide nurse personnel, and where appropriate, a physician to provide consultation to the team, to participate in the MP/IPR prior authorization, periodic and interval review and evaluation processes.

2. Provide a system for recommending the appropriate level of care to be prior authorized for eligible or potentially eligible recipients! admitted to, or seeking admission to, certified skilled nursing or intermediate care facilities except those facilities for which MR/IPR is performed by MDMH.
   a. Specify, in agreement with Social Services, the medical information and documentation to be received as part of the application for prior authorization.
   b. Evaluate medical information and documentation received as part of application for prior authorization. Recommend to Social Services the level of care determination made for the individual client's needs. This determination serves as the medical justification for payment at that level of care.
   c. Notify Social Services, the facilities to which the client is or is about to be admitted, local health departments, and others as appropriate regarding the prior authorization of level-of-care recommendation.
   d. Within 5 working days of the recommendation, distribute the level-of-care recommendation to specified parties.

3. Provide a system of periodic and, as required, interval review and evaluation of Medical Assistance clients in skilled nursing and intermediate care facilities. Such reviews shall be performed at least annually in each facility with the schedule monitored by Social Services to insure compliance with federal regulations as well as Social Services' participation. The review and evaluation, conducted by a nurse and other appropriate personnel, shall include:
   a. Personal contact and observation of each client and a review of each client's plan of care and appropriate associated medical records.
   b. Consultation, when indicated, with the responsible attending physician and the utilization review committee chairperson or designated agent, in skilled facilities, and at the conclusion of each review a team exit conference with the facility administrator and other appropriate staff.
   c. Forwarding of facility reports to Social Services within 15 days after the end of the month in which the annual reviews were conducted.
   d. Contribution to the annual facility review reports by Public Health and Social Services inspection team members. These reports shall be transmitted to Social Services within 15 days of the close of the month in which the review was done.

4. Semi-annually consult with, and obtain continuing approval from, Social Services.
Services with respect to the functioning of the program.

5. Provide Social Services with reports necessary to fulfill federal reporting requirements within time frames established by the two departments.

6. Provide Social Services with statistical reports on MR/IPR as may be required under Social Services responsibilities.

7. Maintain necessary Medical Assistance Program files to ensure appropriate continuity of program responsibility. Immediate access to files will be afforded to both Public Health and Social Services.

8. Provide professional testimony for administrative hearings and in cases of litigation on all disputed level-of-care determinations.

9. At the request of Social Services participate in meetings, including those with Professional Standards Review Organizations, or entrance and exit interviews with federal agencies, when discussion involves the MR/IPR program.

SOCIAL SERVICES WILL:

1. Participate in MR/IPR and provide social evaluations and assessment of alternatives to facility care for clients during the prior authorization, and annual inspection and evaluation process.

2. Assist clients and their families in locating necessary community resources and appropriate placements to allow for the implementation of alternate care plans recommended by MR/IPR personnel.

3. Forward a copy of each annual facility inspection report filed by the interdisciplinary team leader to the facility and its functioning utilization review committee.

4. Take appropriate action on recommendations submitted by MR/IPR personnel.

5. Conduct administrative hearings to resolve formal appeals of disputed level-of-care determinations.

6. Participate in periodic program evaluations with Public Health as described in point 4 of the responsibilities of Public Health.

7. Maintain necessary files to ensure appropriate continuity of program responsibility. Immediate access to files will be afforded to both Public Health and Social Services.

8. Advise Public Health of meetings, including those with Professional Standards Review Organizations, or entrance and exit interviews with federal agencies, when discussion involves the MR/IPR program.

D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

In order to promote a comprehensive, preventive health care system for children eligible for services under Michigan's Medical Assistance Program (Medicaid), to assure the proper expenditure of public funds for health care and services provided said recipients, and to conform with applicable state and federal requirements, this section provides for a program of early and periodic screening, diagnosis and treatment (EPSDT) for eligible Medicaid recipients under age 21.

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to ascertain physical and developmental abnormalities, and to treat, correct or ameliorate abnormalities and chronic conditions found.

EPSDT is defined herein to include, at a minimum, the following services mandated by federal regulation:

1. informing eligible recipients of the availability of EPSDT services;
2. health screening according to an established periodicity schedule;
3. diagnosis and referral services;
4. identification, informing, and referring of recipients eligible for Title V services;
5. treatment for defects and conditions discovered, including services not otherwise available to other Medicaid recipients;
6. transportation, upon request, to and from screening, diagnostic, and treatment sites; and
7. documentation of the administrative process and clinical data resulting from these efforts.

Screening components, periodicity schedules, professional performance standards and review procedures, administrative procedures, and manuals will be developed by Public Health in mutual agreement with Social Services. Review procedures will be implemented in a manner consistent with the professional perspectives and responsibilities of the public health care system and in accordance with applicable federal and state statutes, rules and regulations.

Public Health will:

1. Screening, Referral, and Follow-up
   a. Develop screening content, procedures and standards:
      Professional health staff will develop and recommend content, frequency, and standards for screening services and evaluation data in cooperation with other medical, dental, and health representatives as appropriate. Content and standards will include, but need not be limited to, all services required by federal regulations; additional services may be provided at the option of screening providers with prior approval of Social Services. Frequency of screenings will be based on a periodicity schedule developed to provide screening intervals appropriate to age and stage of development. Special consideration will be given to steps required to make services available to handicapped individuals.
   b. Assure the availability of screening services:
      The availability of screening services on a statewide basis and the delivery of services at the local level will be accomplished through contracts and subcontracts approved by Social Services. Each such (sub)contract is to be reviewed and renegotiated annually and must specify the responsibilities, staff and other resources, and a detailed budget conforming with section C, below. Public Health will forward a copy of the signed contract to Social Services. Screening sites may...
be located at local health department clinics. Designated staff will have responsibility for day-to-day operation of the screening functions, including administrative and clinical performance. Periodically, the operation of clinics statewide will be evaluated and monitored by Public Health staff through the analysis of reports, data and on-site visits as needed. Reports of significant negative findings, together with recommended corrective action, will be forwarded by Public Health central office to Social Services within 60 days of the completion of each such analysis.

The screening clinic will provide local Social Services with a schedule of available screening times at least one month in advance for use by Social Services in scheduling client appointment times and preparing daily screening schedules for the clinic. Clinic staff will notify Social Services, within one working day, of an individual's failure to keep an appointment by completing and returning the daily screening schedule.

c. Assure that the established services are provided and recorded:

1) Screening procedures will be performed by specially trained clinic teams, which are staffed according to formulas designed to assure adequate screening.

2) Results of each client's screening and any referral information will be recorded on a screening summary form, agreed to by Social Services, which will be sent to central office within a designated period of time after completion of the screening. Data from the summary will be placed on computer file after evaluation and an analysis by central office staff; Social Services generates the reports for use by Public Health central office and local health department staff in follow-up and monitoring activities.

3) Clinic staff will: a) screen clients; b) interpret results to families; c) assist in completing health history forms, when necessary; d) offer assistance to families in locating and selecting appropriate medical resources and arranging appointments as necessary; e) offer assistance in utilizing medical resources effectively; and f) identify those clients eligible for Title V services, referring them as appropriate.

4) Clients will be referred by the clinic to medical/health providers for further evaluation and treatment when indicated by screening results. Referral information (including the provider type and provider ID number of the provider to whom referral is made) and date of appointment will be recorded on the client's screening summary, prior to the form's submission to central office. Such referral data will be placed on computer file and periodically matched with the Social Services medicaid claims file to verify that treatment has been initiated. If no match is made, indicating treatment has not been initiated, a non-treatment report will be generated by Social Services and sent to the screening clinic for follow-up.

5) Upon receipt of a non-treatment report, clinic staff will follow-up with clients so referred to them and will prepare an outcome report identifying an outcome for each referral client. Follow-up will be prepared. October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
also occur whenever a client chooses to make his/her own appointment.

2. Outreach, Training and Transportation

a. Contract with local health departments or other health care delivery organizations for the provision of outreach and scheduling services with approval of Social Services. Such contracts are to be reviewed and renegotiated annually with outreach staffing allocated according to the formula in 3.d.2) below.

b. Forward to Social Services proposals for outreach services at the local level with Public Health's recommendations for approval, rejection, or conditions of acceptance.

c. Monitor outreach activities performed by local health departments and other health care organizations and report any significant negative findings and recommendations for corrective action, to Social Services.

d. Provide training programs for, and the monitoring of, screening and outreach teams as needed.

e. Offer assistance to families in arranging transportation for referrals. If transportation assistance is requested, clinic staff will inform outreach workers by forwarding a referral-for-services form; outreach workers then arrange transportation.

3. Fiscal Control, Documentation and Reporting

a. Develop and implement budget proposal format and procedures which assure:

1) Adequate detail to reflect the previous, current, and projected years' costs by agreed-to line items;
2) Narrative explanation of each projected increase or decrease;
3) Provision of a rationale for any budgetary increases; and
4) Availability of work papers upon request.

b. Submit all local contract proposals and significant budget amendments to Social Services, allowing a one month lead time for approval. Annual budget requests and any program revision requests shall be developed in cooperation with Social Services to facilitate consistency between the two department's budgets. All local EPSDT contracts shall be coincident in duration and termination date with the state fiscal year.

c. Promulgate a formula agreed to be Social Services, for staffing patterns, to local health department clinics and other health-care providers involved in screening, outreach and transportation services. The standard formula follows:

1) Clinic staff: One (1) clerk for every 4,000 contracted screening appointments, One (1) nurse for every 4,000 contracted screening appointments, One (1) technician for every 2,000 contracted screening appointments, One (1) budgeted nurse position for every 8,000 contracted screening and appointments for follow-up, One (1) clinic aide for every 4,000 contracted screening appointments (or more...
where previously approved) and sufficient staff for back-up to work a minimum of 4 hours per month to maintain skills. When contracted screening appointments total less than 4,000 per contract, staffing levels will be a percentage of the formula, as agreed by Social Services.

2) Outreach staff (when performed by Public Health): For every 1,000 contracted screening appointments at a given site, one outreach coordinator; for every additional 1,000 contracted screening appointments, one Public Health field representative; for every 4,000 contracted screening appointments, one full-time transporter and one full-time clerk.

e. Reimburse local contractors for actual costs incurred in fulfilling EPSDT (sub)contracts, such as reimbursement not to exceed the amount of the local contract or the state EPSDT appropriation.

f. Develop and implement methods for the maintenance of financial records in accordance with currently accepted accounting principles. For each of the first three quarters of the year, report expenditures data, in the aggregate, to Social Services.

g. During the last quarter of the fiscal year, report expenditure data, by (sub)contract and in the aggregate, monthly to Social Services. Comparison of expenditures to approved budgets will be shown on these reports. If expenditures appear to be exceeding approved budgets for the fiscal year, corrective action must be recommended for Social Services consideration.

h. Provide Social Services with monthly information on screening results, including: clients screened, clients referred for diagnosis and treatment, and other information regarding screening and outcome required for effective program management, federal reporting requirements, and other written documentation which may be found necessary by either agency at the central or local level.

i. Require that overscheduling, at a rate of at least 25% over capacity, be allowed in clinics where average attendance is less than 80% of optimum capacity.

4. Program Coordination

Designate a staff member to serve as EPSDT coordinator and liaison with Social Services.

5. Other Program Operations

Provide whatever assistance is necessary to Social Services, through outreach and scheduling activities and data collection, to ensure that federal requirements are met with regard to the informing of clients, completion of screenings within established time limitations, and identification of clients eligible for services under Title V programs.

SOCIAL SERVICES WILL:

Local staff will perform activities related to client contact (e.g., eligibility, outreach, and scheduling) and access to screening/referral services, and

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training while central office staff will carry out functions related to planning and management, computer systems and budget.

1. Eligibility Determination and Outreach

Assure that the following services are provided at the local level, by outreach workers or other local office staff:

a. Eligibility determination: Workers will determine eligibility of individuals for the Medical Assistance Program, see that eligibility status is entered and updated on central computer files, and assist clinic staffs or providers with eligibility questions.

b. Informing and outreach:

1) Social Services will consider Public Health proposals for outreach services, using the following criteria: a) completeness and rationale of the proposal, b) cost effectiveness, c) adherence to the established staffing formula, d) local Social Services effectiveness and position on the proposal, and e) other pertinent factors.

2) Outreach staff will inform those eligible for medical assistance of the availability of EPSDT services and encourage/facilitate participation. On a monthly basis, computer generated informing letters will be sent to clients appropriate for screening; a list of these clients will be sent to local offices for locally initiated contact. As clients call the local office in response to the letter, workers will discuss the program, answer their questions and schedule screening appointments. Workers will contact those clients who do not respond to the letter. Face-to-face contact per written procedures will be made on all new or re-opened cases. Special procedures will be used for informing blind, deaf or illiterate clients.

c. Scheduling: Using a screening time schedule provided by the clinic, workers will schedule screening appointments for clients or reschedule as necessary. With the exception of a relatively small number of walk-ins, all clients who wish to be screened will be scheduled for a specific time at a specific clinic. Clients will be assisted in completing health history forms prior to the clinic visit. Daily screening schedules, listing individual appointments, will be prepared and sent to screening clinics five working days in advance; such listing will also provide clinic staff with client information necessary for completing screening summaries. For all clients who are appropriate for screening but are not screened for any reason, workers will prepare a Refusal Notice (EPSDT), identifying reasons for nonparticipation and date of refusal, to be placed on file for future reference and follow-up. When advised by screening clinics of missed appointments, workers will contact clients to determine reasons and seek to eliminate barriers to participation, and reschedule if appropriate.

d. Supportive services: To facilitate attendance at screening appointments, workers will offer and arrange transportation for clients as needed; on referrals from local health departments/clinics, provisions will be made for transportation, child care or other supportive services to facilitate diagnostic and treatment appointments.
2. Information Services

a. Maintain a computerized reporting and monitoring system, to ensure all clients are systematically and periodically contacted regarding EPSDT, and to furnish to local offices:

1) A listing of eligible clients, distributed monthly, providing a master list of clients eligible for screening or rescreening.

2) Case summary report, distributed monthly, also listing eligible clients, to facilitate documentation of local office activities in attempting to screen clients. The form will be completed for all families contacted and retained as permanent record of a family's program experience.

3) Outreach case management report, distributed monthly, to identify the number of clients forwarded to local offices as appropriate for screening, and the outcomes. Clients due for screening must either be screened or their nonparticipation must be documented on a Refusal Notice.

4) Other lists and reports needed to effectively perform outreach, scheduling and follow-up activities, and to meet federal requirements for reporting, documentation, and maintenance of complete client records.

b. Provide accurate lists of clients due for screening to local health departments or other organizations performing outreach functions.

c. Provide to Public Health a list of enrolled Medical Assistance providers by county and such additional information as may be required and agreed upon, to implement, maintain and evaluate the screening program.

d. Maintain a record of expenditures for the diagnosis and treatment portion of the program to document client participation in the program and the accruing costs.

3. Contracts and Budget

a. Central office Social Services will review all local health department contract proposals within one month, with input from local Social Services offices; agree on number of appointments to be made available, by county, as well as the anticipated contract costs, by health district and state total. Approvals of screenings and budgets shall be within the limits of authorized funding. Numbers of target screenings will be predicated on program goals, past experience, available funds and local Social Services recommendation.

b. Provide funds to Public Health equal to the actual costs of rendering services under this agreement, such costs to include all state and local costs necessary to staff, equip and operate screening clinics, provide outreach services in selected areas, provide related activities and administer the screening program. Such funds are to be paid at periodic intervals on a mutually agreed to schedule, and are not to exceed amounts appropriated for EPSDT services.
4. Program Coordination

Designate a staff member to serve as EPSDT coordinator and liaison with Public Health and with the Division of Family Services, Social Services.

5. Auxiliary Services

a. At both central office and local levels, develop publicity for the program to increase client participation and facilitate clients' access to health care by assuring availability of medical/dental resources through adequate provider participation and arrangement of other services as needed.

b. Provide training for outreach necessary in the program, when outreach functions are performed by local departments of social services; and, as appropriate, coordinate efforts with Public Health in outreach training.

E. Medical Assistance and the Crippled Children Program

This section provides for casefinding and case management of crippled children eligible for Medical Assistance. It also provides for additional certification of certain facilities for the care of children eligible for Medical Assistance and delegation of the Title V fiscal intermediary responsibility.

The crippled children program is a state/federal funded program administered by Public Health, Bureau of Personal Health Services, Division of Services to Crippled Children (DSCC). The crippled children program is authorized by the Michigan Public Health Code (Act 368 of the Public Acts of 1978, as amended) to serve single or married individuals "under 21 years of age whose activity is or may become so restricted by disease or deformity as to reduce the individual's normal capacity for education and self-support". Cooperation between the Medical Assistance Program and the Crippled Children Program is required for effective delivery of services to those individuals eligible for both programs.

PUBLIC HEALTH WILL:

1. Determine which children in, or eligible for, the Medical Assistance Program qualify as crippled children under legislative mandate and Public Health's rules and procedures.

2. Provide case management including approval of physicians, hospitals and other providers for the provision of services, to those determined to be eligible for Crippled Children Program benefits. This management will be provided by physicians, nurses, and other health professionals in the central and regional offices that serve crippled children.

3. Utilize the same method of payment for services rendered to crippled children (including rates of reimbursement) used by Social Services to pay for services rendered to Medical Assistance recipients.

4. Provide to Social Services, on a timely basis, all information relating to eligibility, authorization and other information as required, which would enable invoices for services rendered to be processed for prompt payment.

5. Certify to Social Services hospitals and nursing-care facilities approved for the inpatient care of children eligible for Medical Assistance benefits.

6. Certify to Social Services the speech and hearing centers approved for...
the evaluation of recipients suspected of being hard of hearing.

7. Prior authorize those selected services for Social Services program recipients which may from time to time be mutually agreed upon.

8. Provide to Social Services, on a timely basis, all reports necessary to fulfill federal reporting requirements.

9. Designate appropriate personnel to work on a Public Health/Social Services task force to examine issues of reimbursement, claims processing, cost-accounting, and systems development.

SOCIAL SERVICES WILL:

1. Determine the financial eligibility of children for whom application has been made for Medical Assistance and who are or have been determined medically eligible for assistance under the Crippled Children Program.

2. Serve as the fiscal intermediary, and make payments for covered services authorized by Public Health for eligible Crippled Children Program recipients, and bring to the attention of Public Health for resolution, before payment, invoices for services that appear to be inconsistent with program requirements.

3. Provide Public Health with the opportunity to review modifications of standards used to authorize payments so that the standards may be justified or revised jointly before implementation.

4. Provide data processing support to maintain computer systems relative to eligibility, government and management reporting for Crippled Children Program activities as mutually agreed upon.

5. Provide reimbursement to Public Health for the cost of covered services provided in the Crippled Children Program's diagnostic clinics to individuals eligible for Medical Assistance in accordance with mutually agreed upon procedures.

6. Provide reimbursement to Public Health by interaccounting for the cost of medical management and prior authorization of services provided to children eligible for Medical Assistance.

7. Provide Public Health, on a timely basis, all reports necessary to fulfill federal reporting requirements.

8. Review with Public Health, in advance, all initial and final cost settlements for hospitals, which affect Crippled Children Program expenditures.

9. Review with Public Health, in advance, all gross adjustments as may be mutually agreed upon, which affect Crippled Children Program expenditures.

10. Designate appropriate personnel to work on a Public Health/Social Services task force to examine issues of reimbursement, claims processing, cost-accounting, and systems development.

F. Medical Assistance and Title V Projects

The purpose of this section is to provide for cooperative arrangements.
between the program of projects administered by Public Health (Title V grantee) and the Medical Assistance Program. The program of projects carried out under Title V of the Social Security Act include:

Maternity and Infant Care
-- initial assessment and plan of care for duration of pregnancy
-- post partum care
-- nursing services
-- nutrition services

Intensive Infant Care

Health of Children and Youth

Family Planning

Dental Health of Children and Youth

These projects have as their purpose the reduction of infant mortality and morbidity and the reduction of the incidence of mental retardation and other handicapping conditions.

PUBLIC HEALTH WILL:

1. Promote cooperative program planning and monitoring efforts at the state and local levels.

2. Identify individuals in need of preventive, diagnostic, treatment and medical care and services.

3. Identify and refer to Social Services individuals who may be eligible for Medical Assistance Program benefits.

4. Provide or arrange for health care and services mandated by the program of projects incorporating appropriate diagnostic, preventive, prenatal, delivery and postnatal services, surgical and specialized perinatal services to the high-risk obstetrical patient and neonate including long-term development assessment; family planning counseling and medical services; medical and dental care for children and youth including screening, diagnosis, preventive services, treatment, correction of defects and aftercare.

5. In accordance with mutually agreed upon procedures, request from Social Services reimbursement for the cost of covered Medical Assistance care and services provided by Title V projects to individuals eligible for Medical Assistance.

6. Establish, maintain standards and guidelines for quality of health care rendered by Title V projects.

7. Certify to Social Services public providers of family planning services.

8. Designate hospitals, physicians, and transportation providers for eligibility for the newborn intensive care program.

9. Designate appropriate personnel to work on a Public Health/Social Services task force to examine issues of coordination, policy develop-

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ment, quality assurance, and reporting and evaluation.

SOCIAL SERVICES WILL:

1. Promote cooperative planning at the state and local levels.
2. Determine the financial eligibility of individuals for whom application has been made for Medical Assistance.
3. Identify and refer individuals in need of health care and services available by and through Title V projects to Public Health.
4. Establish the scope of services and reimbursement levels available under the State Plan for Medical Assistance.
5. Reimburse, as first payor, the cost of care and services furnished by or through the Title V grantee to individuals eligible for Medical Assistance.
6. Designate appropriate personnel to work on a Public Health/Social Services task force to examine issues of coordination, policy development, quality assurance, and reporting and evaluation.

G. Trust Fund Procedures

This section provides a procedure for verification of compliance of trust fund records pursuant to Act 368 of the Public Acts of 1978, as amended, Sections 21321 and 21721.

SOCIAL SERVICES WILL:

1. Audit the patient trust funds on a continuing basis, concurrent with the financial audit of each Michigan nursing home.
2. At the conclusion of the audit, direct a written statement indicating evidence of compliance or non-compliance to Public Health.

PUBLIC HEALTH WILL:

2. Support Social Services' budget request for the cost of the above audit functions.

ARTICLE IV

Assigned functions will be carried out by Public Health and Social Services in full compliance with Michigan's approved State Plan for Medical Assistance and the statutory and regulatory requirements of the Department of Health and Human Services. The respective responsibilities of Public Health and Social Services detailed in Sections A through G above are not meant to exclude any other delegations of function that are mutually agreed to and within the scope of this contract. Each section of this contract will be reviewed at least annually and, in the absence of revision, will be noted with the date of the review.

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It is understood and agreed that the parties shall have the right to examine all physical records originated or prepared pursuant to this contract, including working papers, reports, charts and any other documentation arising out of this contractual relationship. Said records shall be made available for review by the parties upon reasonable notice. The parties shall, for three years, maintain all pertinent data, information, and reports. Any exchange or release of medical or eligibility information relating to recipients affected by this agreement shall be in accordance with state and federal confidentiality guidelines. It is also agreed by Public Health that it will assign appropriate professional health personnel when indicated to coordinate with financial auditors where questions regarding medical service to Medical Assistance recipients are identified.

ARTICLE V

In the performance of the functions, Public Health is not authorized and may not change, disapprove or delay action on any administrative decision of Social Services or otherwise substitute its judgment for that of Social Services as to the application of policies, rules and regulations promulgated or otherwise initiated by Social Services.

It is further agreed and understood between the parties that, in recognizing the ultimate authority of Social Services as the single State agency for those matters falling within that authority, Social Services shall solicit recommendations from Public Health in the development and implementation of Medical Assistance Program policies and procedures. However, decisions of Social Services within its authority shall be final and binding on all parties hereto.

ARTICLE VI

Term, Extension, and Termination: This contract supersedes any prior agreement between the parties and shall continue in effect for a period of one year from the date hereof. It shall remain effective for successive periods of one year each thereafter unless during any such period, this contract shall be cancelled in accordance with the terms contained herein. This contract may be terminated, when either party requests termination, by giving 90 days written notice to the other party of its intention to terminate.

ARTICLE VII

This instrument contains the entire contract between the parties and shall not be modified in any manner except by an instrument in writing executed by both parties. If any term or provision of this contract or the application thereof to any person or circumstances shall, to any extent, be invalid or unenforceable, the remainder of this contract, or the application of such term or provision to person or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby and each term and provision of this contract shall be valid and be enforced to the fullest extent permitted by law.
This addendum refers to the Section H of Article III of the contract between the Michigan Department of Social Services and the Michigan Department of Public Health for the provision of services under Michigan's Medical Assistance Program.

Section H - Certification of Diabetes Outpatient Education Programs

This section provides for the certification and recertification of Diabetes Outpatient Education Programs established for Medicaid recipients throughout the State of Michigan for FY 96 through FY 97.

PUBLIC HEALTH WILL:

1. Certify local health departments, publicly funded clinics and hospital outpatient programs eligible for reimbursement of diabetes outpatient education services.

2. Provide the Michigan Diabetes Outpatient Education Program Standards to certified programs.

3. Perform certification procedures, on-site visits, and recertification of eligible agencies, in a manner and at a frequency to be determined by Public Health.

4. Notify Social Services in writing of eligible agencies which have been certified and the date that status was obtained.

5. Notify Social Services in writing of any agency which, at time of recertification no longer meets the requirements for certification.

6. Respond to inquiries and/or conduct workshops for interested agencies regarding the certification or recertification process.

7. Provide the necessary matching state funds.

SOCIAL SERVICES WILL:

1. Add a specialty code to the provider's enrollment file when notified by public health of certification. If the provider is not currently enrolled with Medicaid, the enrollment application will be sent for completion.

2. Process provider claims.

Supersedes

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Approval Date 2-23-96 Effective Date 10-01-95

4. Respond to inquiries regarding billing and reimbursement.

5. Audit participating providers as indicated in the State Plan.

6. Create and generate reports on expenditures and utilization as requested by Public Health.

7. Approve and adopt program standards, revisions and certification procedures developed by Public Health.

8. Provide FFP funds by means of the regular quarterly flow-through process for FY 96 and FY 97 to certify and recertify eligible agencies for their diabetes outpatient education programs.

Gerald H. Miller, Director
Michigan Department of Social Services

DATE: 12-26-95

James K. Haveman Jr., Acting Director
Michigan Department of Public Health

DATE: 10-13-95

RECOMMENDED BY: Jean Chabut
Jean Chabut, Chief
Center for Health Promotion and Chronic Disease Prevention

DATE: 10-6-95

TN No. 96-02 Approval Date 2-28-96 Effective Date 10-01-95

Supersedes

TN No. 93-18
ADDENDUM K TO THE CONTRACT BETWEEN
THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES
AND
THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
(OCTOBER 1, 1992 - SEPTEMBER 30, 1994)

This addendum sets forth the responsibilities of the Michigan Department of Social Services (MDSS) and the Michigan Department of Public Health (MDPH) relative to the Maternal Support Services (MSS) program established on a statewide basis for Medicaid recipients. Public Health’s responsibility is to certify for Social Services the agencies that wish to become maternal support services providers and that meet program standards to insure thereby that recipients receive effective and quality service. Social Services’ responsibility under this agreement is to reimburse the costs which Public Health incurs to discharge its MSS responsibility and to support Public Health in carrying out its MSS contract.

The Maternal Support Services program was established November 1, 1987, as a preventive health interdisciplinary effort to improve the pregnancy outcomes of Medicaid eligible women, and accordingly to reduce the infant mortality rate occurring in Michigan. Effective January 1, 1993, the program will be extended to serve infants older than two months of age. The extension is referred to as Infant Support Services (ISS). The MSS/ISS program is an interdisciplinary effort which consists of professional community nursing, nutritional and psychosocial needs assessment and related services, combined with ancillary and transportation services. These services are targeted toward women and infants considered to be at psychosocial and/or nutritional risk by their prenatal care or primary care provider and referred for MSS and/or ISS. The women and infants are eligible for services under Michigan’s Medical Assistance Program (Medicaid).

A statewide quality assurance system is hereby developed and implemented for Maternal and Infant Support Services program. The objective of such a system is to assess and certify MSS and/or ISS provider-applicants on an ongoing basis, to assure that every certified provider understands program objectives and meets the standards of quality care.

Responsibilities:

PUBLIC HEALTH WILL:

1. Operate a certification process for provider applications submitted by interested agencies to MDSS or MDPH.

2. Upon review of the written application, notify MDSS in writing of interim certification status of agencies whose applications are deemed satisfactory, so MDSS can enroll them in the Medicaid program.

3. Contact these interim certified agencies to schedule and perform a site visit to verify that the agency is providing all services required by the MSS and/or ISS program in the manner described in the Medicaid Program Policy Manual.

4. Develop and maintain a site visit tool for certification/recertification of agencies.

5. Conduct a certification site visit with each of these agencies.

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6. Complete within thirty (30) calendar days the certification site visit report for each agency and forward a copy to MDSS.

7. Place the screened agency into one of three certification statuses: full (three years) certification, temporary (six months) certification or decertified. The "full" certification status will remain effective for three years, unless the agency is non-compliant with program policies and procedures. Reasons for decertification include an agency not maintaining qualified staff or not providing the full range of maternal and/or infant support services as needed.

9. Advise MDSS of an agency's decertification status within 15 calendar days to enable MDSS to take appropriate actions regarding the agency's Medicaid provider status.

10. Initiate and perform a second site visit to agencies placed on "temporary" status to assure a corrective action plan has been implemented and deficiencies are satisfactorily addressed. An agency which does not correct its deficiencies during its "temporary" period, may be placed by MOPH into "decertification" status.

11. Develop policy and procedures for granting staffing waivers to certified providers.

12. Review agency requests for waivers to program standard staffing qualifications, apply developed criteria, and notify applicant agency in writing within thirty (30) calendar days of the approval or denial of their requests. Forward a copy of waiver determination letter to MDSS.

13. Inform agencies, when appropriate, of the their right to appeal MDPH's certification determination.

14. Initiate within fifteen (15) calendar days after receipt of any appeal, an appeals process to reassess the agency's fitness as an MSS and/or ISS provider.

15. Inform the agency and MDSS of the outcomes of any appeals process/hearing.

16. Submit to MDSS's MSS and ISS liaison, quarterly reports compiling the status of MSS and ISS certified agencies including, by quarter and year-to-date, the number of provider applications received, approved, and the number of agencies recertified.

17. Meet periodically (at least quarterly) with MDSS liaison to provide an update of any certification inquiries or issues brought to attention by MSS and/or ISS providers.

18. Forward for response to the MDSS liaison, written or verbal provider inquiries regarding Medicaid policy or billing. Respond directly only to provider issues regarding MSS and ISS certification.

19. Maintain accurate fiscal records for all expenditures incurred in the implementation of this contract. Submit quarterly reports to MDSS Accounting and MSS and ISS liaison of applicable expenditures to carry out this contract. On an annual basis, forward to MDSS the cost of seven (7) MDPH FTEs and related cost required to execute this contract.

Supersedes

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
20. Provide access to authorized representatives of MDSS, the Auditor General, Federal Grantor agency, Comptroller General of the United States, Health Care Financing Administration, or any duly authorized representatives, to all documentation related to this agreement.

21. Designate a MDPH staff member to serve as a liaison with MDSS to coordinate interdepartmental MSS and ISS activities and issue resolutions.

22. Consult with MDSS staff liaison prior to publishing any MDPH communications that will have direct impact on the MSS program.

SOCIAL SERVICES WILL:

1. Assure that outreach services are provided at the local level, at a minimum as part of the recipient eligibility intake/application process.

2. Recruit new MSS and/or ISS providers and inform newly certified Medicaid providers of the MSS and ISS Program.

3. Develop and circulate publicity of the MSS and ISS program to increase client and provider participation and facilitate clients access to early prenatal care.

4. Enroll promptly into its Medical Assistance (Medicaid) Program all provider applicants who are certified by MDPH to be MSS and/or ISS providers.

5. Upon receipt of notification from MDPH of "decertification" status being given to an agency, take the appropriate actions to make the agency ineligible for reimbursement of further MSS and/or ISS.

6. Provide appropriate reimbursement to certified MSS and/or ISS agencies. Notify the MDPH staff liaison regarding changes in reimbursement rates.

7. Provide technical assistance and periodic training to all certified MSS and ISS providers and MDPH staff regarding program policies and billing procedures.

8. Notify MDPH if/when provider becomes ineligible to provide Medicaid services, so a decertification notice can be issued, and current MSS and ISS clients can be transferred to another certified MSS and/or ISS provider, to assure continuity of care.

9. Provide the MDPH liaison a quarterly report indicating program expenditures, by procedure code, for maternal and infant support services.

10. Provide federal Title XIX funds to MDPH to cover costs of rendering provider certification services under this agreement. Such funds, in combination with the non-federal funds, will cover the costs of seven (7) FTEs and related costs for necessary equipment, transportation, meetings, and materials.

11. Designate a staff member to serve as a liaison with MDPH to coordinate interdepartmental activities and issue resolutions.

TN No. 93-25 Approval Date 10-27-93 Effective Date 10-1-92

Supersedes

TN No. 91-39
12. Consult with MDPH liaison in advance on all proposed MDSS Bulletins containing policy information or changes which may impact upon the implementation of MSS and/or ISS.

<table>
<thead>
<tr>
<th>Vernice Davis Anthony, Director Michigan Department of Public Health</th>
<th>Gerald Miller, Director Michigan Department of Social Services</th>
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<td>Date: SEP 15 1993</td>
<td>Date: 9-30-93</td>
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TN No. 93-25
Approval Date 10-27-93
Effective Date 10-1-93

Supersedes
TN No. 91-39

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
ADDENDUM L TO THE CONTRACT BETWEEN
THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES
AND
THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
(October 1, 1992 - September 30, 1994)

This addendum sets forth the responsibilities of the Michigan Department of Social Services (MDSS) and
Michigan Department of Public Health (MDPH) relative to special activities designed to assist and serve
Medicaid eligible pregnant women, infants and children so the outcome of pregnancy will be positive and
infant deaths and morbidity thereby reduced. Recognizing that the Medicaid infant mortality rate is
unacceptably high and that the number of Medicaid eligible pregnant women is increasing due to recently
expanded state eligibility standards, the state is implementing special outreach and administrative
activities targeted for Medicaid eligible pregnant women and infants. The role of MDPH is to assist
MDSS in serving Medicaid recipients; the role of MDSS is to reimburse, and otherwise support, MDPH for
its Medicaid related activities.

Responsibilities:

PUBLIC HEALTH WILL:

1. Contract with local health departments and other agencies to outreach Medicaid eligible pregnant
   women to advise them of available prenatal care and other necessary health services, to
   encourage and coordinate their use of needed prenatal and postpartum health care services, to
   assist them in removing barriers to service, to assist them in locating service providers and in
   completing Medicaid recipient applications, where applicable. Outreach will include:
   - Maternal and Infant Health Advocacy Services
   - Public information/media activities aimed at Medicaid eligible pregnant women
   - Statewide hotline to direct Medicaid recipients to available care and otherwise to assist
     with problems which may impede timely receipt of needed medical services.

2. Outreach families of Medicaid eligible infants and children and assist them in becoming enrolled
   in the Medicaid Program.

3. Monitor at the community level Medicaid provider participation particularly relative to prenatal
   care and delivery services. Work with providers to encourage their participation in the Medicaid
   Program and, as necessary, work to assemble community resources sufficient to make available
   medical services for Medicaid eligibles.

4. Utilize the "Source of Payment" field on state birth certificates to determine the extent to which
   Medicaid eligibles are represented in the state's infant mortality statistics, perform related
   computer work and analyses. Continue data collection from local health departments on
   Prenatal Information Form (PIF) and Infant Information Form (IIF) systems to monitor service
   delivery to Medicaid eligible pregnant women and infants. On a quarterly basis, beginning from
   April 1, 1993, provide MDSS a report on data collected on both of the above activities.

5. Both the Departments of Public Health and Social Services recognize the value in sharing
   information to address the problem of infant mortality. Within that context, and within the
   constraints of Federal and state confidentiality requirements, the Departments will work together
   to resolve the issue of sharing of Medicaid birth data with the Department of Public Health, and
   will make maximum efforts to share information for the mutual resolution of this problem.

TN No. 26 Approval Date 10-29-93 Effective Date 10-1-92
Supersedes
TN No. 38
Addendum L for FY 92-94
Page 2

6. Target health education and advocacy activities to pregnant women and infants living in migrant camps.

7. Protect the confidentiality of Social Services recipient information according to generally accepted professional standards and in accordance with federal regulations at 42 CFR 431.300-307.

8. Provide MDSS with related program reports and statistics as mutually agreed upon, include a report due April 1, 1993, which describes and summarizes outreach activities of the maternal and infant health advocates and migrant teams/workers.

9. Maintain accurate fiscal records for all expenditures incurred in the implementation of this agreement.

10. Submit quarterly reports of applicable expenditures to MDSS. These shall include the number of state FTE's and expenditures of both the state and local health departments for staff and related support costs to carry out the activities of this agreement.

11. Provide access to authorized representatives of Social Services, the Auditor General, Health Care Financing Administration, Comptroller General of the United States, or any duly authorized representative, to all documentation related to this agreement in accordance with federal regulations at 42 CFR 431.300-307.

12. Designate a staff member to serve as liaison with MDSS to coordinate related interdepartmental activities.

13. Provide local health agencies with program consultation, administrative support and assistance with quality assurance issues.

14. Expenditures under this agreement shall be limited to the GF-GP appropriations for this purpose in the Department of Public Health budget. For FY 1993, that amount is $3,190,000 GR-GP. Any enacted appropriations, enacted supplementals or approved appropriations transfers for this purpose will automatically be incorporated into this agreement.

15. Assist MDSS in developing capacity for substance abuse treatment services for pregnant women and provide consultation to local agencies to develop effective referral and service relationships with substance abuse treatment programs.

SOCIAL SERVICES WILL:

1. Assist MDPH in discharging the Public Health responsibilities detailed above.

2. Work cooperatively to maximize Public Health's assistance with the Medicaid application process. Close coordination of activities will be especially necessary at the local level.

3. Set Medicaid fee screens at 115 percent for selected prenatal care and delivery procedure codes for services provided by Title V agencies, pursuant to Medicaid Regulations at 431.615(c)(4). The affected codes are: 59410, 59420, 59515, X4850, X4853, X4854, X4855.

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TN No. 25.26 Approval Date 10-22-93 Effective Date 10-1-92
Supersedes
TN No. 91-38
4. Designate a staff member to serve as liaison with MDPH to coordinate related interdepartmental activities and to resolve issues which arise.

5. Consult with MDPH relative to Medicaid infant mortality reduction initiatives, policies and programs.

6. Consult with MDPH. in advance, on all proposed policies which may affect MDSS infant mortality reduction initiatives.

7. Provide MDPH the Title XIX matching funds for actual costs incurred in discharging the administrative duties detailed above, as mutually agreed to.

8. Provide a minimum of two training sessions at two locations for local health agencies on processing MICH-Care applications.

Vernice Davis Anthony, Director
Michigan Department of Public Health

Gerald H. Miller, Director
Michigan Department of Social Services

Date: SEP 1 5 1993

Effective Date: 10-1-93

Attachment 4.16-A
Page A-30

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
ADDENDUM M TO THE CONTRACT BETWEEN
THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES
AND
THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
(July 1, 1995-DECEMBER 31, 1996)

This addendum sets forth the responsibilities of the Michigan Department of Social Services (MDSS) and the Michigan Department of Public Health (MDPH) relative to the Medicaid managed care ombudsman program established statewide for Medicaid enrollees. The general purpose of ombudsman services is to assist Medicaid enrollees in understanding, electing, and using the managed care system. Under the terms of this agreement, MDPH's responsibility is to contract with, and oversee, qualified agencies that wish to provide ombudsman services and that meet MDPH-established program standards. In so doing, MDPH thereby assists MDSS in administering the Medicaid Program. Social Services' responsibility is to provide oversight of the ombudsman service as appropriate for a single State agency and to reimburse the mutually agreed-to, federally matchable Title XIX costs which Public Health incurs to discharge the terms of this agreement and to otherwise support Public Health in meeting the responsibilities identified below.

The more detailed purpose of the ombudsman program is to assist recipients in

- choosing a Medicaid managed care program,
- understanding how the various Medicaid managed care programs work,
- accessing services through their managed care system,
- knowing how/when to use their primary care providers and how/when to use emergency room services,
- understanding the value of preventive services, such as EPSDT and immunizations,
- accessing preventive services within, or through, the managed care system,
- recognizing the value of other Medicaid services such as dental services and how to access them,
- resolving problems/needs relative to Medicaid managed care enrollment by assisting the recipient to call the Managed Care Recipient Hotline 1-800-642-3195,
- overcoming the barriers of special needs (e.g. language, culture, illiteracy) to access health care, and
- obtaining Medicaid services specifically for children with special health care needs and pregnant women.

Supersedes
TN No. N/A

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Responsibilities:

PUBLIC HEALTH WILL:

1. Draft and forward to MDSS, for approval, the qualifying standards that agencies must meet in order to provide ombudsman services. The standards must include the requirement that contracted agencies and staff will keep recipients' Medicaid related information confidential.

2. Select and forward to MDSS, for approval, the names of any and all agencies that Public Health considers qualified to provide ombudsman services.

3. Notify MDSS in writing of the applicants placed under contract so MDSS can verify that MDPH has contracted with MDSS approved agencies and can inform local DSS offices of agencies providing service.

4. Manage contracts, including payment of any and all appropriate charges resulting from the contract.

5. Confer with the managed care ombudsman contractors for the purpose of reviewing progress and providing necessary guidance to the contractors in solving problems which may arise.

6. Provide access to authorized representatives of MDSS, the Auditor General, Federal Grantor agency, Comptroller General of the United States, Health Care Financing Administration, or any duly authorized representatives, to all documentation related to this agreement.

7. Designate a MDPH staff member to serve as a liaison with MDSS to coordinate interdepartmental managed care and managed care ombudsman activities.

8. Consult with, and obtain approval of, the MDSS staff liaison prior to publishing any MDPH communications that have direct impact on Medicaid managed care plans. In general, materials having a direct impact on Medicaid managed care plans will be issued by MDSS.

9. Provide MDSS with semi-annual and annual reports documenting project activities, encounters, successes, and issues. Such reports are to be provided within 90 days of the end of the reporting period.

10. Provide all state funds used to support ombudsman services and bill MDSS on a quarterly basis for the federal portion of MDSS agreed-to costs incurred under this program.

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
11. Maintain relevant program and fiscal records.

SOCIAL SERVICES WILL:

1. Provide required overall monitoring and oversight of ombudsman services as required of the single State agency.

2. Review and approve MDPH proposed qualifying standards that agencies must meet in order to provide ombudsman services, including the requirement that contracted agencies and staff must keep recipients’ Medicaid related information confidential.

3. Review and approve MDPH’s recommendations of agencies qualified to provide ombudsman services. Advise MDPH of approvals.

4. Inform local DSS offices as to what agencies are providing ombudsman services and also inform Medicaid managed care providers about the ombudsman program.

5. Develop and circulate publications about Medicaid managed care programs that increase client and provider participation and facilitate recipient access to a Medicaid managed care plan.

6. Provide technical assistance and periodic training to Wayne State University regarding how managed care programs function; Wayne State University will in turn provide direct managed care training to the ombudsmen.

7. Provide the MDPH liaison with a monthly list of managed care providers for use by the local ombudsmen in helping recipients to choose a managed care provider.

8. Designate a staff member to serve as a liaison with MDPH to coordinate interdepartmental activities and seek resolution of issues.

9. Bill HCFA on a quarterly basis for the federal portion of agreed-to costs incurred under this program and pay MDPH the federal funds so collected.

Date: 7/28/95

Date: 10-3-95

Gerald H. Miller, Director
Michigan Department of Social Services
ADDENDUM N TO THE CONTRACT BETWEEN
THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES ADMINISTRATION
AND
THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
CENTER FOR SUBSTANCE ABUSE SERVICES

This agreement is by and between the Michigan Department of Social Services, Medical Services Administration (hereafter referred to as the DSS) and the Michigan Department of Public Health, Center for Substance Abuse Services (hereafter referred to as the MDPH/CSAS).

WITNESSETH THAT: WHEREAS the DSS has implemented coverage of selected substance abuse treatment services to Medicaid eligible recipients and the DSS and MDPH/CSAS had agreed to continue coverage of some alcoholism treatment and drug dependency services in freestanding facilities to Medicaid eligible recipients using State funds and, the MDPH/CSAS has agreed to identify qualified programs, administer prior authorization as defined by DSS, and supply technical assistance; and

WHEREAS, the DSS has the authority to implement such coverage for Medicaid eligible recipients and in accordance with policies established by DSS.

NOW, THEREFORE, in consideration of the above and in consideration of the promises and mutual covenants hereinafter contained, the parties hereto agree as follows:

A. PURPOSE AND OBJECTIVES OF SUBSTANCE ABUSE TREATMENT SERVICES COVERAGE

The purpose of this coverage is to improve access to substance abuse treatment services for Medicaid eligible recipients.

The objectives are as follows:

1. To provide payment for substance abuse treatment services to qualified MDPH/CSAS approved substance abuse treatment services providers for individual, group, and intensive outpatient counseling and methadone treatment services for Medicaid eligible recipients including those whose health care is covered through a Health Maintenance Organization plan for the period October 1, 1991 through September 30, 1992.

2. To develop the awareness and involvement of Medicaid eligible recipients in substance abuse treatment services.

3. To evaluate the effectiveness and success of the Medicaid substance abuse treatment services program coverage and where appropriate implement further changes.
B: RESPONSIBILITIES OF DSS

DSS shall:

1. Enroll substance abuse treatment services providers qualified by MDPH/CSAS as Medicaid providers.

2. Process all claims for enrolled substance abuse treatment services providers for Medicaid eligible recipients receiving services from the providers.

3. Reimburse the enrolled participating substance abuse treatment services providers in accordance with the rate provisions established by DSS in conjunction with MDPH/CSAS.

4. Assist MDPH/CSAS in the evaluation of this coverage by placing at its disposal all available information pertinent to the program including previous reports and any other data relative to the program as generated by the Medicaid Management Information System (MMIS).

5. Examine and approve, on a timely basis, all studies, reports, and other documents presented by MDPH/CSAS.

6. Give prompt written notice to MDPH/CSAS whenever DSS observes or otherwise becomes aware of any change in the coverage.

7. Give prompt notice to MDPH/CSAS whenever DSS is aware of an ownership or address change of a substance abuse services provider.

8. Continue to work with the Health Care Financing Administration to obtain and maximize all available federal financial participation for substance abuse treatment services.

9. Prepare reports of non-Title XIX expenditures and report to MDPH/CSAS on a monthly basis.

10. Monitor expenditures and with approval of MDPH/CSAS implement coverage changes as appropriate.

11. Hear final appeals of any prior authorization denials made by MDPH/CSAS local coordinating agencies or their designated agents in accordance with DSS established and approved criteria and processes.

12. Reimburse MDPH/CSAS for the federal match portion of the administrative costs incurred by local coordinating agencies for prior authorization of intensive services per the MDPH/CSAS quarterly billing to DSS during the period October 1, 1991 through September 30, 1992.

13. Audit substance abuse treatment services providers for compliance with all Medicaid federal and state rules and regulations.
14. Provide technical assistance and invoice billing training for all participating providers.

15. Provide MDPH/CSAS with all necessary prior authorization forms and provider enrollment forms.

C. RESPONSIBILITIES OF MDPH/CSAS

MDPH/CSAS shall:

1. Establish substance abuse treatment program qualification criteria in cooperation with and as approved by the DSS and review provider qualification applications to determine those qualifying programs.

2. Notify DSS of those substance abuse treatment services providers qualified to participate with the services each program is qualified to render, and to provide these qualified programs with the necessary DSS provider enrollment forms.

3. Promptly notify DSS whenever they are aware of any change in the qualification of an enrolled Medicaid substance abuse treatment services provider.

4. Contribute 100% of the state share for individual, group and intensive outpatient counseling and methadone treatment services for dates of service from October 1, 1991 through September 30, 1992.

5. Create an account and cost centers to record substance abuse treatment services and prior authorization expenditures. Prepare reports for DSS within 15 days of the end of the quarter for purposes of obtaining federal matching funds.

6. On behalf of the DSS, perform prior authorization through the MDPH/CSAS local coordinating agencies.

7. Evaluate the prior authorization process and recommend changes.

8. Prepare and submit statistical reports in accordance with DSS requirements.

9. Administer the prior authorization process in accordance with DSS established and approved criteria and processes through the local coordinating agencies. Final appeals of any denials will be heard by the DSS.
10. Reimburse the local coordinating agencies directly for prior authorization costs and submit a billing for federal match to DSS within 15 days of the end of the quarter.

11. Evaluate and report on the effectiveness of the Medicaid substance abuse treatment services program coverage for successful recipient outcomes.

D. AGREEMENT DURATION

This Agreement shall be for the period October 1, 1991, through September 30, 1992.

E. BUDGET AND PAYMENT

DSS shall process and reimburse all coverage associated claims through the existing automated billing system with the expenditures charged to the MDPH/CSAS account number 110-35-3468. MDPH/CSAS liability for the acceptable cost for eligible services provided to Medicaid eligible recipients will be limited to the general fund/general purpose funds required for the state match. The DSS will claim the appropriate federal matching funds for covered services, and transfer the revenue to MDPH/CSAS on not less than a quarterly basis.

F. SCOPE OF SERVICES PROVIDED

All substance abuse treatment services provided to Medicaid eligible recipients under this coverage shall be limited as listed below.

- Outpatient: Limit of 45 hours of any combination of individual, and/or group counseling per continuous 12-month period per Medicaid eligible recipient.

- Intensive Outpatient: Limit of 40 days (or partial days) of intensive outpatient counseling per continuous twelve month period per Medicaid eligible recipient. Additionally, intensive outpatient counseling services require prior authorization.

- Methadone Maintenance: Methadone maintenance services and medications as necessary per physician order and within state and federal regulations.

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G. GENERAL PROVISIONS

1. DSS Funds - Termination

DSS payment of funds for purposes of this Agreement is subject to and conditional upon the availability of funds for such purposes. No commitment is made by DSS to continue to expand such activities. DSS may terminate this Agreement in accordance with the provisions of the cancellation clause (Clause G-10) upon, written notice to MDPH/CSAS at any time prior to completion of this Agreement if, in the opinion of DSS, such funds are restricted.

2. Cost Documentation

MDPH/CSAS agrees to maintain financial records, documents, and other accounting procedures and practices that reflect all direct costs expended in the performance of this Agreement. Further, the accounting system shall provide for specific identification of all sources of funds, all contracts/subcontracts, purchase orders, accounts payable, and cash disbursements.

3. Review and Monitoring Reports

MDPH/CSAS and DSS shall attempt to comply with all program and fiscal review reporting procedures as are or may hereinafter be established by either department.

4. Examination and Maintenance of Records

MDPH/CSAS agrees to permit DSS, or any of its identified agents, access to the facilities being utilized, at any reasonable time to observe operations. MDPH/CSAS further agrees to retain all financial records or other documents relevant to the Agreement for three years after final payment, or until completion of the Single Audit Act requirements and any persons duly authorized by DSS shall have full access to and the right to examine any of said materials during said period. If an audit is initiated prior to the expiration of the three year period, and extends past that period, all documents must be maintained until completion in accordance with the Single Audit Act. DSS shall provide findings and recommendations of audits to MDPH/CSAS. DSS will adjust future payments or final payment if the findings of an audit indicate over- or underpayment to MDPH/CSAS in the period prior to the audit. MDPH/CSAS agrees that if it ceases business operations, the records will be maintained as DSS may direct.

5. Compliance with Civil Rights, Other Laws

MDPH/CSAS shall comply with all published rules, regulations, directives, and orders of the Michigan Civil Rights Act of 1955, as amended, being MCLA 423.304 and 423.304a. MDPH/CSAS further shall comply with provisions of Title VI of the Civil Rights Act of 1964, and any amendments.
thereto. MDPH/CSAS shall also comply with the provisions of the
Handicapped Civil Rights Act of 1976, being Public Act 220, and the
Rehabilitation Act of 1973, being Section 504 of Public law 93-112.
Further MDPH/CSAS agrees to comply with all other Federal, State, and
local laws, regulations, and standards, and any amendments thereto, as
they may apply to MDPH/CSAS.

6. Recipient Rights System

MDPH/CSAS and DSS shall have a system of hearings under which
applicants, or recipients, or an individual acting on behalf of an applicant
or recipient may appeal denial, reduction or termination of a service.

7. Confidentiality

The use or disclosure of information concerning services, applicants, or
recipients obtained in connection with the performance of this Agreement
shall be restricted to purposes directly connected with the administration
of the program implemented by this Agreement; and the Administrative
Rules for Substance Abuse Services in Michigan.

8. Contracts

Substance abuse treatment services providers shall enter into a Medicaid
provider agreement with DSS for the Medicaid substance abuse
treatment services program. This agreement is not contingent on a
contract with MDPH/CSAS.

9. Liability

MDPH/CSAS shall indemnify, save, and hold harmless DSS against any
and all expense, and liability of any kind which the MDPH/CSAS may
sustain, incur, or be required to pay arising out of this Agreement;
provided, however, that the provisions of this paragraph shall not apply
to liabilities or expenses caused by or resulting from the acts or
omissions of DSS or any of its officers or employees. Further, in the
event MDPH/CSAS becomes involved in or is threatened with litigation,
MDPH/CSAS shall immediately notify DSS and DSS may enter into such
litigation to protect the interests of DSS as they may appear.

10. Cancellation of Agreement

If, in the opinion of DSS, MDPH/CSAS fails to comply with the conditions
of this Agreement or to fulfill its responsibilities as indicated in the
Agreement, or DSS determines that the methods and techniques being
utilized in accomplishing the goal are not acceptable or compatible with
DSS policies, DSS reserves the right to cancel this Agreement by giving
sixty days notice to MDPH/CSAS. MDPH/CSAS may terminate this
Agreement upon sixty days written notice to DSS at any time prior to the
completion of the Agreement period if DSS fails to comply with the
conditions of this Agreement.
11. Closeout

When this Agreement is concluded or terminated, MDPH/CSAS shall provide DSS, within ninety days after conclusion or termination, with all financial, performance and other reports required as a condition of the Agreement. DSS shall make adjustments to MDPH/CSAS for allowable costs not covered by previous interaccount billings. The final interaccount billing adjustment may be subject to an audit.

12. Continuing Responsibilities

Termination, conclusion, or cancellation of this Agreement shall not be construed so as to terminate the ongoing responsibilities of MDPH/CSAS contained in the Examination and Maintenance of Records and Closeout Paragraphs included in this Agreement.

13. Agreement Inclusiveness/Amendment

This Agreement contains all the terms and conditions agreed upon by the parties. No other understanding, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto. MDPH/CSAS agrees, upon request by DSS and recipient of the proposed amendment, to amend this Agreement if and when required in the opinion of DSS, due to revision of federal or state laws or regulations. If MDPH/CSAS refuses to sign such amendment within fifteen days after receipt, this Agreement shall terminate upon such refusal. This Agreement may otherwise be amended only by the written consent of all the parties hereto.
IN WITNESS THEREOF, the DSS and MDPH/CSAS have caused this Agreement to be executed by their respective officers duly authorized to do so.

Dated at Lansing__________, Michigan  

MICHIGAN DEPARTMENT OF  
PUBLIC HEALTH

This 4th day of Sept., 1992

Witness:__________________________

Vernice Davis Anthony  
Director

Dated at Lansing__________, Michigan  

MICHIGAN DEPARTMENT OF  
SOCIAL SERVICES

This_____ day of______, 1992

Witness:__________________________

Gerald H. Miller,  
Director

TN No. 90-28 Approval Date 11-8-93 Effective Date 10-15-90

Supersedes  
TN No. N/A

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AGREEMENT BETWEEN
THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES AND
THE MICHIGAN DEPARTMENT OF MENTAL HEALTH

Pursuant to Act 280, Public Acts of Michigan of 1939, as amended, a Medical Assistance Program has been implemented in the State of Michigan as authorized by Title XIX of the federal Social Security Act, as amended.

In order to comply fully with the provisions of the above legislation with reference to appropriate and related federal requirements, this agreement is entered into by the Michigan Department of Social Services, hereinafter referred to as "Social Services," and the Michigan Department of Mental Health, hereinafter referred to as "Mental Health."

ARTICLE I

It is the intent and purpose of the parties hereto, by entering into this agreement, to promote high quality of health care and services for recipients of Michigan's Medical Assistance Program, to assure the proper expenditure of public funds for health care services provided said recipients, and to conform with applicable state and federal requirements. The extent of responsibilities and duties of the parties to this agreement are subject to the terms and conditions contained in the specific schedules attached hereto.

ARTICLE II

Assigned functions will be carried out by Mental Health and Social Services in full compliance with Michigan's approved State Plan for Medical Assistance and the statutory and regulatory requirements of the U.S. Department of Health and Human Services. The respective responsibilities of Mental Health and Social Services are detailed in the attached schedules. This agreement and attached schedules may be amended from time to time as dictated under Article I. All such amendments will be attached and once signed and dated by the directors of the two departments, are hereby incorporated as part of this agreement.

It is understood and agreed that the parties shall have the right to examine all physical records originated or prepared pursuant to this agreement, including working papers, reports, charts, and any other documentation arising out of this agreement. Said records shall be made available for review by the parties upon reasonable notice. The parties shall, for six years from the date of preparation/production, maintain all pertinent data, information, and reports.
ARTICLE III

In the performance of the functions, Mental Health is not authorized and may not change, disapprove, or delay action on any administrative decision of Social Services or otherwise substitute its judgment for that of Social Services as to the application of policies, rules, and regulations promulgated or otherwise initiated by Social Services.

It is further agreed and understood between the parties that, in recognizing the ultimate authority of Social Services as the single State agency for administration of the Medical Assistance Program, Social Services shall solicit recommendations from Mental Health in the development and implementation of policies and procedures for the Medical Assistance Program coverage of mental health services. However, decisions of Social Services within its authority shall be final and binding on all parties to this agreement.

ARTICLE IV

It is agreed that each party to this agreement shall provide the other with data necessary to carry out its responsibilities under this agreement. It is also agreed by Mental Health that it will assign appropriate professional mental health personnel, when indicated, to coordinate with financial auditors when questions regarding mental health services to Medical Assistance recipients are identified.

ARTICLE V

It is agreed that each party will consult and cooperate on budget issues. This will include interagency accounting transfers of federal funds for Medicaid-enrolled State facilities operated by the Department of Mental Health for those services requiring Social Services and Mental Health transfer of federal funds and any administrative services whose costs are determined by a federally-approved allocation plan.

ARTICLE VI

This agreement supersedes any prior agreement between the parties and shall continue in effect until or unless the two parties mutually agree to amend or terminate it. Any change in the agreement requires at least thirty (30) days prior written notice by either party.

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ARTICLE VII

This instrument, including the schedules, contains the entire agreement between the parties and shall not be modified in any manner except by an instrument in writing executed by the parties. If any term or provision of this agreement or application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this agreement, or the application of such term or provision to such person or circumstance other than those to which it is held invalid or unenforceable, shall not be affected thereby; and each term and provision of this agreement shall be valid and be enforced to the fullest extent permitted by law.

ARTICLE VIII

Responsibility for responding to inquiries and coordination of this agreement shall rest with the Entitlements Division, Bureau of Program Development, Quality Assurance for the Department of Mental Health and the Bureau of Program Policy, Medical Services Administration for the Department of Social Services.

C. Patrick Babcock, Director
Michigan Department of Social Services

Date

7/18/89

Thomas D. Watkins, Jr., Director
Michigan Department of Mental Health

Date

1/5/90
SCHEDULE A
SURVEILLANCE, UTILIZATION, AND REVIEW

Schedule A provides a mechanism for a program of surveillance, utilization, and professional performance review of care and service rendered to Medical Assistance recipients.

Surveillance, utilization, and professional performance review are defined herein to include: authorization of health care, including psychiatric services as well as services provided to persons with developmental disabilities, prior to their provision; determination of the appropriateness of treatment and care rendered; Inspection of Care review at facilities which provide services to persons with mental illness and to persons with developmental disabilities; and consultation with providers of care related to these activities.

General surveillance, utilization, and professional performance review procedures and manuals will be developed by Mental Health and submitted to Social Services for review and approval. Review procedures will be implemented in a manner consistent with the professional perspectives and responsibilities of the Michigan mental health system, and in accordance with applicable federal and state statutes and regulations. The review procedures will provide, as necessary, for the evaluation of services in relation to the needs of the clients, the appropriateness of the setting, the medical necessity of the services, benefits, and scope of service.

A. In carrying out these review activities, Mental Health will:

1. Develop review guidelines, procedures, and protocols which shall conform with applicable federal and state standards and regulations. These guidelines, procedures, and protocols shall apply to public, as well as private, Medical Assistance providers of services and include the following:

a. Public Psychiatric Hospitals.
b. Private Psychiatric Hospitals.
c. Psychiatric Units of Private and Public General Hospitals.
d. Specialized Nursing Facilities which provide services for persons with Developmental Disabilities.
e. Specialized Nursing Facilities which provide services for persons with Mental Illness.
f. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) including homes which provide Alternative Intermediate Services (AIS) for persons with Developmental Disabilities.
g. Mental Health Clinic Services Providers.
Mental Health shall also:

h. Home and Community-Based Waiver, including Model Waiver, Program Services Providers.

i. Omnibus Budget Reconciliation Act (OBRA) of 1987 defined responsibilities.

j. Community Supported Living Arrangements services providers.

2. Certify, consistent with the guidelines, procedures, and protocols developed in Section 1:

a. Providers of Medical Assistance Mental Health Clinic services.

b. Specific sites for the delivery of Medical Assistance Mental Health Clinic services and, with the exclusion of birth homes, sites for the delivery of Home and Community-Based Waiver Program services.

c. Eligibility of individuals, as well as providers, of Home and Community-Based Waiver Program services.

d. Psychiatric partial hospitalization programs if so authorized by Social Services.

e. Eligibility of individuals, as well as providers, of Community Supported Living Arrangements services.

3. Assume responsibility for ensuring the availability of qualified health professionals to carry out the surveillance, utilization, and professional performance review of services for the items stipulated in Section 1 above.

4. Provide consultation to Social Services, when so requested, for the development of general surveillance, utilization, and professional performance review procedures.

5. Provide field consultation services as it determines necessary and appropriate to maintain contact with Medical Assistance Program providers of mental health services.

6. Provide, with the approval of Social Services, a system of recipient enrollment for, or prior authorization of, medical eligibility for Medical Assistance. The system shall pertain to:

a. Continued inpatient psychiatric treatment for Medical Assistance clients in psychiatric hospitals operated by Mental Health.
Mental Health shall also:

b. Continued psychiatric partial hospitalization treatment for Medical Assistance clients provided under the auspices of private providers.

c. Care and services for Medical Assistance clients in specialized nursing facilities for persons with developmental disabilities.

d. Care and services for Medical Assistance clients in specialized nursing facilities for persons with mental illness.

e. Care and services for Medical Assistance clients provided by providers certified to participate in the ICF/MR program, including AIS/MR.

f. Care and services for Medical Assistance clients provided through the Home and Community-Based Waiver and Model Waiver Programs.

g. Services and supports for Medical Assistance consumers provided through Community Supported Living Arrangement programs.

h. Conduct of eligibility reviews utilizing health and psychiatric care guidelines, procedures, and protocols developed in accordance with Section 1 of this agreement.

i. Specification of the information and documentation to be reviewed as part of the application for prior authorization.

j. Determination of the extent of required documentation, with the approval of Social Services.

k. Notification of the facility/unit/provider/program and Social Services of the prior authorization determination within time constraints established by Social Services.

7. Establish and maintain a regular system of Inspections of Care (IOCs) for the following providers of Medical Assistance services:

-- Intermediate Care Facilities for the Mentally Retarded (ICF/MR) including AIS/MR;

-- Institutions for Mental Disease (IMD);

-- Specialized Nursing Homes which provide services to persons with mental illness or developmental disabilities.
Mental Health shall also:

a. These Inspections of Care shall be conducted within applicable federal and state regulations.

b. In the conduct of these Inspections of Care, Mental Health shall also consult, when indicated, with the responsible physician and treatment personnel, with the utilization review committee chairperson or designated agent, with the administrator and/or other appropriate staff within the program.

c. A report for each provider shall be submitted by Mental Health to Social Services in a timely manner on completion of the annual review, covering observations, conclusions, and the recommendations of the Inspection of Care teams regarding the treatment, care, or other services found within the programs as revealed by case reviews or other knowledge acquired during visits to the program.

d. Mental Health shall make available qualified mental health personnel to provide consultation to Social Services personnel performing the Inspection of Care in facilities and programs other than the provider types listed in Section 1 of this agreement, on the request of the aforementioned Social Services personnel.

e. At stipulated intervals, provide Social Services with reports necessary to fulfill federal reporting requirements.

f. Maintain data reporting procedures for determining expenditures in which federal financial participation is available.

B. Social Services will:

1. Act as the central point for all financial audits and investigations including processing of referrals in a timely manner. In carrying out this responsibility, Social Services will:

a. Record, coordinate, and investigate referrals of possible fraud, abuse, or misutilization.

b. Request further Inspections of Care from Mental Health, as indicated.

c. Provide Mental Health with status reports on financial audits, investigations, or reviews upon request and in a timely manner.

2. Confer, negotiate, finalize, and execute all cost-settlement agreements with providers with representation from Mental Health when involving a medical audit.

Attachment 4.16-A
Page B-7
Social Services shall also:

3. Initiate litigation, when indicated.

4. Develop and promulgate program policy on covered services, limitations, procedures, and public disclosure, consistent with state and federal statutes and regulations.

5. Provide consultation to Mental Health, when so requested, for the development of general surveillance, utilization, and professional performance review procedures.

6. Review and take appropriate action upon recommendations made by Mental Health within the context of this agreement and report such actions to Mental Health in a timely manner.

7. As part of its program responsibilities:
   a. Take appropriate action on the recommendations of the Inspection of Care teams.
   b. Assist individuals receiving services and their families to locate and implement alternate care plans when recommended by the Inspection of Care team.

8. Provide the necessary data to ensure that Mental Health is able to carry out its responsibilities under this agreement and to meet the state's responsibilities under applicable statutes and regulations.

The provision of this Schedule shall be modified, within the terms of the basic agreement, as alternate methods of surveillance, utilization, and professional performance review are developed and/or mandated by state or federal regulations or statutes. This Schedule shall remain in effect until or unless the two parties mutually agree to modify or terminate it.
SCHEDULE B
PERSONAL CARE SERVICES

Schedule B deals with reimbursement for personal care services covered by the Medical Assistance Program for clients receiving such services under terms of contracts with Mental Health and/or community mental health services boards under agreement with Mental Health.

Pending final development and implementation of a mutually acceptable common payment and claim system for all services provided to individuals in community living facilities, child care agencies, and family foster care homes under contract with, or operated by Mental Health and/or community mental health services boards, Mental Health and Social Services hereby agree to the following division of responsibilities for billing and preparation of claims for federal financial participation, for assurance of compliance with standards and certifications required for billing, and for documentation of such compliance.

A. For services provided under contract with Mental Health, Mental Health will be responsible for:

1. Assuring that the services billed to the Medical Assistance Program conform to the definition and purpose of personal care services as specified by Social Services.

2. Verifying that the contracting agency responsible for providing such services has met the appropriate operating, management, and physical plant standards required by Mental Health and Social Services for operation and licensure.

3. Assuring that each client for whom a claim is processed has an appropriate plan of care ordered by a physician, developed by a case manager after an assessment of the client's needs, and supervised by a registered nurse who conducts at least an annual review.

4. Assuring that the client for whom a claim is made is eligible for Medical Assistance.

5. Producing the detailed billing and maintaining the historical file of personal care charges by client.

6. Assuring that the original documentation of personal care services provided is in accordance with the client plan of care, and the verification of compliance with licensing and operational standards is maintained for subsequent audit.

7. Producing and transmitting quarterly to Social Services the data required by Social Services to claim federal financial participation for personal care services.

8. Preparing and transmitting to Social Services claims for federal financial participation in the cost of administrative services provided by Mental Health for personal care services. These costs will be determined in accordance with cost distribution procedures approved by Social Services.
B. For services provided by or under contract with the community mental health services boards, Mental Health will be responsible for:

1. Processing claims prepared by those community mental health services boards which agree to comply with the personal care standards and procedures for federal financial participation indicated as in Section A above for Mental Health.

2. Distribution of federal funds received to community mental health services boards when authorized by legislative appropriations.

C. Social Services will be responsible for:

1. Preparation of the claim for federal financial participation.

2. Making services or facilities available to permit verification by Mental Health, and the participating responsible mental health agencies, of client eligibility for Medical Assistance as required by Social Services.

3. Vouchering federal revenues to mental health appropriation deduct accounts as and when authorized by the legislative appropriations for Mental Health and Social Services.

4. Conducting periodic reviews to determine that Mental Health responsibilities under Sections A and B above are fulfilled.

*This schedule became effective October 1, 1982, and will remain in effect unless modified or canceled by mutual consent of both parties.

This agreement may be modified in writing by mutual consent of both parties at any time.
SCHEDULE C
CASE MANAGEMENT SERVICES

Schedule C deals with reimbursement for case management services covered by the Medical Assistance Program for clients receiving such services under terms of contracts with Mental Health and/or community mental health services boards under agreement with Mental Health.

Mental Health and Social Services hereby agree to the following division of responsibilities for billing and preparation of claims for federal financial participation, for assurance of compliance with standards and certifications required for billing, and for documentation of such compliance.

A. For services provided by or under contract with Mental Health, Mental Health will be responsible for:

1. Assuring that the services billed to the Medical Assistance Program conform to the definition and purpose of mental health case management services as specified by Social Services.

2. Verifying that the agency responsible for providing such services has met the appropriate operating, management, and service standards required by Mental Health and Social Services, including enrollment as a mental health clinic services provider.

3. Assuring that each client for whom a claim is processed has an appropriate plan of care developed by a qualified case manager after an assessment of the client's needs, and receives case management services monthly by the case manager.

4. Assuring that the client for whom a claim is made is eligible for Medical Assistance.

5. Producing the detailed billing and maintaining the historical file of case management services by client.

6. Assuring that the original documentation of case management services provided, client plan of care, and verification of compliance with applicable standards is maintained for subsequent audit.

7. Preparing and transmitting to Social Services claims for federal financial participation in the cost of administrative services provided by Mental Health for case management services. These costs will be determined in accordance with cost distribution procedures approved by Social Services.
B. Social Services will be responsible for:

1. Preparation of the claim for federal financial participation.

2. Vouchering federal revenues accruing from Mental Health case management services provided by DMH-operated mental health clinic services providers (i.e., State regional centers, psychiatric hospitals, and State community living services agencies) to Mental Health appropriation deduct accounts as and when authorized by the legislative appropriations for Mental Health and Social Services.

3. Making services or facilities available to permit verification by Mental Health, and the participating responsible mental health agencies, of client eligibility for Medical Assistance as required by Social Services.

4. Conducting periodic reviews to determine that Mental Health responsibilities under Section A above are fulfilled.

This Schedule became effective April 8, 1986, and will remain in effect unless modified or canceled by mutual consent of both parties.
SCHEDULE D
HOME AND COMMUNITY-BASED WAIVER SERVICES

Schedule D deals with reimbursement for home and community-based waiver services covered by the Medical Assistance Program for clients receiving such services under terms of contracts with Mental Health and/or community mental health services boards under agreement with Mental Health.

With regard to Federal Health Care Financing Administration (HCFA) approved home and community-based waiver (HCBW), including Model waiver services provided to eligible individuals, Mental Health and Social Services hereby agree to the following division of responsibilities for billing and preparation of claims for federal financial participation, for assurance of compliance with standards and certifications required for billing, and for documentation of such compliance.

A. For services provided directly by or under contract with Mental Health and/or community mental health services boards, Mental Health will be responsible for:

1. Assuring that the services billed to the Medical Assistance Program conform to the definition and purpose of HCBW services as specified in the HCFA-approved home and community-based services waiver program applications.

2. Verifying that the contracting agency responsible for providing such services has met the appropriate operating, management, and physical plant standards required by Mental Health, Social Services, and/or HCFA for operation and licensure.

3. Assuring that each client for whom a claim is processed meets federal ICF/MR eligibility criteria, and has an appropriate plan of care which is ordered by a physician, developed by the client's interdisciplinary team and case manager after an assessment of the client's needs, and monitored regularly.

4. Assuring that the client for whom a claim is made is eligible for Medical Assistance.

5. Producing the detailed billing and maintaining the historical file of HCBW service charges by client.

6. Assuring that the original documentation of all home and community-based services provided in accordance with the client plan of care, and the verification of compliance with licensing and operational standards is maintained for subsequent audit.

7. Assuring that the independent audits/assessments required under HCFA's HCBW final rules are conducted in conformance with audit and assessment requirements specified in the final rules.

8. Preparing and transmitting to Social Services claims for federal financial participation in the cost of administrative services provided by Mental Health for HCBW services. These costs will be determined in accordance with cost distribution procedures approved by Social Services.
B. Social Services will be responsible for:

1. Preparing the claims for federal financial participation.

2. Making services or facilities available to permit verification by Mental Health, and the participating responsible mental health agencies, of client eligibility for Medical Assistance as required by Social Services.

3. Vouchering federal revenues accruing from Home and Community-Based Waiver Serviced provided by DMH-operated mental health clinic services providers (i.e., State regional centers for persons with developmental disabilities and State community living services agencies) to mental health appropriation deduct accounts as and when authorized by the legislative appropriations for Mental Health and Social Services.

4. Conducting periodic reviews to determine that Mental Health responsibilities under Section A above are fulfilled.

5. Providing necessary reports for Health Care Financing Administration.

This Schedule became effective October 1, 1987, and will remain in effect as long as Mental Health administers home and community-based waivers or unless modified or canceled by mutual consent of both parties.
SCHEDULE E
COMMUNITY SUPPORTED LIVING ARRANGEMENTS

Schedule E deals with reimbursement for community supported living arrangements covered by the Medical Assistance program for consumers receiving such services under terms of contracts with Medicaid-enrolled mental health clinics under agreement with Mental Health.

With regard to the Health Care Financing Administration (HCFA) approved amendment authorizing community supported living arrangements (CSLA) services provided to eligible individuals, Mental Health and Social Services hereby agree to the following division of responsibilities for billing and preparation of claims for federal financial participation, for assurance of compliance with standards and certifications required for billing, and for documentation of such compliance.

A. For services provided under contract with community mental health services boards, Mental Health will be responsible for:

1. Assuring that the services billed to the Medical Assistance Program conform to the definition and purpose of CSLA services as specified in the HCFA-approved community supported living arrangements amendment application.

2. Verifying that the contracting agency responsible for providing such services has met the appropriate operating, management, and physical plant standards required by Mental Health, Social Services, and/or HCFA for operation and licensure.

3. Assuring that each consumer for whom a claim is processed meets the federal definition of developmental disability as defined in the CSLA legislation, and has an individual support plan which is developed by the consumer, his/her individual support planning team, and the qualified human service professional after an assessment of the consumer's needs, and monitored on a regular basis.

4. Assuring that the consumer for whom a claim is made is eligible for Medical Assistance.

5. Producing the detailed billing and maintaining the historical file of CSLA service charges by the consumer.

6. Assuring that the original documentation of all CSLA services provided in accordance with the consumer's individual support plan, and the verification of compliance with licensing and operational standards is maintained for subsequent audit.

7. Preparing and transmitting to Social Services information for federal financial participation in the cost of administrative services provided by Mental Health for CSLA services. These costs will be determined in accordance with cost distribution procedures approved by Social Services.
B. Social Services will be responsible for:

1. Preparing the claims for federal financial participation.

2. Making services available to permit verification by Mental Health, and the participating enrolled mental health clinics, of consumer eligibility for Medical Assistance as required by Social Services.

3. Conducting periodic reviews to determine that Mental Health responsibilities under Section A above are fulfilled.

4. Providing necessary reports for the HCFA.

This schedule becomes effective October 1, 1991, and remains in effect as long as Mental Health administers the CSLA amendment or unless modified or cancelled by mutual consent of both parties.

Gerald H. Miller, Director
Michigan Department of Social Services

Date 12-17-92

James K. Haveman, Jr., Director
Michigan Department of Mental Health

Date 12-15-92
Joint Working Agreement Between The

MICHIGAN DEPARTMENT OF SOCIAL SERVICES

and

THE MICHIGAN DEPARTMENT OF EDUCATION, REHABILITATION SERVICES

Part I: Purpose, Objectives, and Mutual Responsibilities

Part II: Functions of Operational Oversight Committee

Part III: Working Arrangements Between Rehabilitation Services and Social Services Program Offices

Section A: Agreement Between Medical Services Administration and Rehabilitation Services

Rev. 10/01/80
PART I

JOINT WORKING AGREEMENT BETWEEN THE
MICHIGAN DEPARTMENT OF SOCIAL SERVICES
AND THE
MICHIGAN DEPARTMENT OF EDUCATION, REHABILITATION SERVICES

Purpose

The purpose of this agreement is to facilitate the coordination of benefits and services provided to handicapped individuals by the Michigan Department of Social Services and the Michigan Department of Education, Rehabilitation Services, hereafter referred to as DSS and Rehabilitation Services, respectively. The parties join together under the mandate of the PL 95-602, the Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978, and federal regulations at 42 CFR, Part 431 and 45 CFR, Parts 1361, 1362, 1363. This agreement is structured into three parts: The first includes the purpose, objectives, and mutual responsibilities of the two parties; the second part describes the functioning of an Operational Oversight Committee, and the third part includes more detailed working relationships between Rehabilitation Services and different program areas within DSS, including the Medical Services Administration (MSA), Office of Adult and Family Community Services (OAFCS), the Office of Income Assistance (OIA), and the Office of Employment Development Services (OEDS).

Part I of this agreement includes a description of the common goals of the two agencies, a delineation of the specific services to be provided by each agency, a mechanism for a working relationship between the two parties and a procedure by which problems, either in the working agreement or of individual service delivery, may be resolved.

Objectives

The broad objectives of this agreement are:

1. To improve self-sufficiency and self-support of handicapped persons;
2. To assure that through cooperative efforts handicapped persons are referred to and obtain appropriate services of each agency;
3. To promote common administrative and budgetary direction;
4. To assure joint planning for staff development in training efforts;
5. To assure the coordination of planning, funding, program development, and evaluation of program efforts;
6. To establish annual objectives and develop plans of action to support the broad objectives set forth in this agreement;
7. To establish an oversight committee made up of representatives of DSS and Rehabilitation Services to monitor and evaluate the operation of this agreement and procedures developed as a result of this agreement, and to recommend changes in program planning and administration within each agency;
8. To assure the annual review of the agreed upon local and oversight action plans for purposes of future planning efforts;
9. To establish and demonstrate new and innovative approaches intended to enhance services to mutual clientele.

Rev. 10/01/80
Joint Responsibilities

1. Appointment of a lead representative from the Central Office of each agency, who will be responsible for carrying out the administrative implications of this agreement as described in Part II, the Oversight action.

2. Representation on the Operational Oversight Committee as described in Part II of this agreement.

3. Development of annual action plans to implement this agreement.

4. Joint review, evaluation, and, when necessary, modification of any policies or procedures which implement this agreement.

5. Encouragement of the development of new local agreements and the continuation of existing local agreements.

6. Designation of liaison staff from all appropriate operating units throughout the state from both agencies and, where appropriate, designation of joint operational activity.

7. Exchange of necessary data and information, with due consideration for client's confidentiality and rights of due process.

8. Joint review of any contracts which arise as a result of this agreement.

9. Development of joint budget requests when such requests are desirable to facilitate the delivery of services described in this agreement and to achieve optimum cost effectiveness through a reduction in the duplication of services.

DSS Responsibilities

1. Provision of specific supportive services as described in Part III of this agreement.

2. Development of policies which maximize the resources of Rehabilitation Services in serving handicapped clients of DSS.

Rehabilitation Services Responsibilities

1. Provision of a full range of rehabilitation services described in Part III of this agreement to all eligible Rehabilitation Services clients.

2. Development of rehabilitation services which maximize the state's receipt of federal financial participation.

3. Assumption of primary responsibility for case management in all accepted cases which have been referred by DSS.

STATE OF MICHIGAN
DEPARTMENT OF SOCIAL SERVICES
Dr. John T. Dempsey, Director
6/10/80

STATE OF MICHIGAN - DEPARTMENT OF EDUCATION, REHABILITATION SERVICES
Peter P. Griswold, State Director of Rehabilitation
6/10/80

Rev. 10/01/80
PART II

Functions of Operational Oversight Committee - Agreement Oversight

To implement the objectives described in the general agreement between DSS and Rehabilitation Services, a lead representative from the Central Office of each agency will be appointed and be responsible for carrying out the administrative implications of this agreement. These two lead representatives will co-chair an Operational Oversight Committee which will include, at a minimum, a representative from each agency's field services office and from MSA.

The Operational Oversight Committee will be responsible for establishing annual service objectives and the policies and procedures affecting the agreement. The Committee is also responsible for planning the delivery of services and for monitoring and evaluating the implementation of the agreement.

1. General Policies and Procedures

Annual state objectives, general policies and procedures will be developed by appropriately designated staff from both agencies. The Operational Oversight committee is to review and recommend approval of policies and procedures thus developed. The policies and procedures will include a method of referral between the two agencies, an agreement concerning the specific areas of service delivery responsibilities of each agency and a requirement for designated liaison people assigned from all appropriate operating units throughout the state from both agencies. The objectives and procedures affected by this agreement are to be reviewed whenever either agency initiates a request for review, but not less than annually.

2. Local Agreements

Local agreements between DSS and Rehabilitation Services, while not required, are encouraged. Where local agreements exist, they may be accomplished through formal agreements between local operating units of both agencies or, as appropriate, between geographic administrative units representing several counties. It is recommended that local agreements include local program objectives addressed to specific needs which shall be designed to help achieve the general priorities established by each state agency. The local agreements should specify the particular client groups in need and the resources which are available or which can be developed to meet these needs. The local agreements should clearly delineate the respective service delivery responsibilities of both agencies. Local directors of both agencies are also encouraged to assure primary responsibility for coordinating the local activities of the two agencies, including the delivery of services. Copies of all local agreements must be forwarded to the Operational Oversight Committee to enable the evaluation of local activities and as resources for the development of other local agreements.

3. Policy/Procedural Interpretation

Questions on policies and procedures which arise in the operation of local responsibilities are to be answered by the managers of field services in each agency, with appropriate consultation and input from affected program offices. Formalization of policies and procedures shall result in the issuance of information memoranda, manual materials, and other formal communications to affected operating units.

ST.PLAN-4.16-A/Sec.C; Kuerbitz; 9/28/88  Rev. 10/01/80
4. **Staff Development**

The Operational Oversight Committee annually shall review results of operations and identify areas where staff training and development would improve delivery of services of each agency. Although an annual review of training needs is required, this issue may be explored whenever needs become evident. Staff development units of each agency will conduct training as recommended by the Operational Oversight Committee if such training also meets any additional criteria for approval existent within DSS and Rehabilitation Services.

5. **Reports and Evaluation**

The Operational Oversight Committee will establish an annual statement of objectives for service based on each agency's priorities for service and funding. At least semi-annually, the Operational Oversight Committee will review and evaluate each agency's progress toward these objectives and report its findings to appropriate administrative staff of each agency. Minimally, the objectives will contain data statements obtained from existing field reports on the population in need of service, target population to be referred for rehabilitation, and progress toward rehabilitation. The report will also contain statements related to special areas of concentrated efforts, such as joint-funded demonstration projects, and special projects to serve broad categories of individuals.

Where local agreements are made between DSS and Rehabilitation Services, a statement as to local DSS population in need of rehabilitation, agreed-upon referral rates, and expected outcomes will be included.

A compilation of the activities related to any existing local agreements will be prepared by the lead representatives of the Central Offices of both agencies and reviewed by the Operational Oversight Committee and recommendations for changes will be made.

At least annually, the Operational Oversight Committee will prepare and evaluate outcomes of joint services and cooperative relationships and may recommend future program direction for the administration of each agency as a result.
PART III

Section A: Agreement Between Medical Services Administration and Rehabilitation Services

Purpose:

The purpose of this section is to establish an administrative and policy framework for the greater coordination of benefits and services between Rehabilitation Services (RS) and the Medical Services Administration (MSA). By describing the planned working relationships between the two parties, the agreement is designed to obtain the greatest amount of services to handicapped individuals. A foundation will thus be established for improved program operations.

Manual Objectives:

The two parties wish to assure that the approximately 10,000 recipients mutually eligible for the programs offered by each agency receive medical assistance appropriate to their needs.

The RS will take into their system 7000 new assistance recipients who are medicaid eligible and are referred by local DSS offices.

Further, MSA will continue as payor of first resort for medically-related rehabilitation services when the recipient is eligible for both programs. This presupposes that all nongovernmental sources, such as benefits from existing insurance policies, have been exhausted.

Services Provided by Each Party:

RS works with eligible individuals to prepare them for gainful occupation and/or independent living. The following services are available at all RS offices, as appropriate for individual needs:

1. Medical and psychological evaluation.
2. Vocational counseling and guidance.
3. Physical restoration and corrective surgery.
4. Artificial limbs, hearing aids, braces, and other appliances.
5. Training for a job.
6. Maintenance and transportation.
7. Tools, equipment, licenses, or initial stock and supplies.
8. Job placement and follow-up.

MSA administers the Medical Assistance Program which provides health care services to eligible individuals who do not have the financial resources to obtain them. Among the services available, subject to specific restrictions, are: physician, hospital, and laboratory services, prescribed pharmaceuticals; dental, vision, and hearing services; medical supplies; prosthetic and orthotic devices; speech, physical, and occupational therapies.

Referrals:

In addition to the objective of referring recipients during the next fiscal year, operational manuals for both agencies will contain reciprocal referral procedures which direct local staff.

ST.PLAN-4.16-A/Sec.C; Kuerbitz; 9/28/88

Rev. 10/01/80
Reimbursement Arrangements:

RS and MSA will develop statewide policy and procedures to bring their respective reimbursement schedules for providers of medical services and durable medical equipment into compatibility wherever possible. In addition, they will develop methods for information exchange on reimbursement issues:

- RS and MSA will develop policy and procedures for sharing costs of expensive, prior authorized, durable medical equipment for those recipients eligible for both programs.

- RS and MSA will establish methods of identifying mutual program recipients and exchanging data on all services delivered and payments made on behalf of these dually enrolled recipients.

- For dually enrolled recipients, reimbursement will be made according to procedures published in medical assistance manuals issued to providers enrolled in the medical assistance program. For exceptional cases, rates may be negotiated on an individual basis.

Reports:

RS and MSA will seek methods for reducing paper processing and overlapping services, records, and other medical information for those recipients referred from one program to the other. Full consideration will be given to current laws and regulations regarding confidentiality.

RS and MSA will draw on their recipient records systems to identify recipients who may be eligible for both programs. Any recipients identified in this manner will be included in expanded outreach and referral activities by the two agencies.

Monitoring and Liaison:

The specific activities outlined in this section shall be monitored by the Operational Oversight Committee described in Part II, as scheduled by that committee. The liaison persons from each agency shall sit on that committee.

STATE OF MICHIGAN
DEPARTMENT OF SOCIAL SERVICES

Dr. John T. Dempsey, Director

Date 9/30/80

STATE OF MICHIGAN - DEPARTMENT OF EDUCATION, REHABILITATION SERVICES

Peter P. Griswold, State Director of Rehabilitation

Date 9/30/80

Rev. 10/01/80
FIRE SAFETY INSPECTION AGREEMENT
BETWEEN
THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES
THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH
THE MICHIGAN DEPARTMENT OF STATE POLICY-FIRE MARSHAL DIVISION

This agreement provides for those aspects of fire safety inspection, above and beyond licensing requirements, which are required for certification of health care facilities who desire to participate as a provider in the titles XVIII and/or XIX Medicare/Medicaid programs. The following health care facilities are included: nursing homes, county medical care facilities and/or other facilities designated by the Michigan Department of Public Health. It is understood that all activities carried out under this agreement will be in accord with the applicable Federal/State statutes and regulations.

A. The Michigan Department of State Police - Fire Marshal Division will:

1. Conduct, at appropriate intervals, onsite surveys and resurveys of the above facilities applying to participate or participating as providers of care under the State's Medical Assistance Program and carry out such other activities as may be necessary to determine a facility's compliance with pertinent Federal and State requirements for payment as a provider.

2. Complete the required survey report forms utilizing the Life Safety Codes as required by Federal regulations, and transmit it according to a predetermined schedule to the Department of Public Health for incorporation in the certification action.

3. Request and obtain from individual facilities, when indicated, a plan of correction for each deficiency noted in the course of the facility survey or resurvey and listed on the survey report form. Completed plans of correction are to be attached to the survey report form transmitted to the Department of Public Health.

4. Transmit completed Federal waiver forms with justification and recommendations as indicated to the Department of Public Health for review and/or approval.

5. Secure or conduct training for Fire Marshal Division personnel to insure uniform and proper application of the requirements dictated by this agreement.

6. Maintain a file for a period of at least three years on all information and reports used in determining a facility's compliance with fire safety standards. These files shall be available for review by the appropriate Federal and State agencies.

Rev. 11/01/80
7. Develop methods and procedures acceptable to the Department of Health and Human Services and the Department of Social Services for determining and substantiating the expenditures made by the Department of State Police - Fire Marshal Division in which Federal financial participation is requested.

8. Submit for payment to all concerned parties, within 30 days of ending of the preceding month, summary of expenses incurred pursuant to this agreement.

9. Conduct, or cause to be conducted, investigations of all fires in facilities covered by this agreement.

B. The Michigan Department of Public Health will:

1. Utilize the required survey report forms, plans of correction obtained from individual facilities, and waiver recommendations and justifications in completing its evaluation of individual facilities and developing certification actions.

2. Provide necessary coordination with the Department of State Police, Fire Marshal Division to assure the timely completion of fire safety surveys and evaluations as well as the timely completion and submission of survey report forms and other documents as indicated.

3. Provide the required forms to the Department of State Police, Fire Marshal Division, to complete the necessary fire safety inspections.

4. By inter-departmental billing between the Department of Public Health and the Department of State Police, Fire Marshal Division, reimburse those expenses for the services which are incurred by the Department of State Police in the performance of the survey duties related to the Title XVIII Medicare program.

C. The Michigan Department of Social Services will:

1. Utilize the Michigan Department of Public Health's certification, including the fire safety evaluation, as one of the determinants for provider enrollment and payment purposes.

2. Exercise ultimate authority to enroll provider facilities in the Medicaid Program.

3. By inter-departmental billing between the Department of State Police, Fire Marshal Division and Department of Social Services reimburse in full the actual expenses for the services which are incurred by the Department of State Police in the performance of the survey duties related to the Title XIX Medicaid program.

Rev. 11/01/80
D. Each department will designate a liaison to carry out periodic review and joint planning relative to this agreement.

E. The Michigan Department of State Police will develop an annual budget detail worksheet for the program and submit to the Michigan Department of Public Health and the Michigan Department of Social Services for prior review and acceptance. The percentage of costs to be allocated between the Michigan Department of Public Health and the Michigan Department of Social Services shall be jointly agreed prior to implementation of the annual program budget.

This agreement will supplant all prior agreements and will expire September 30, 1983. Further, this agreement may be terminated or amended only by the unanimous and written consent of all parties listed herein.

John I. Dempsey, Director
Michigan Department of Social Services

Maurice S. Reizen, M.D., Director
Michigan Department of Public Health

Gerald L. Hough, Colonel, Director
Michigan Department of State Police

10/20/80

10-1-80

9-15-80
AGREEMENT
BETWEEN THE
MICHIGAN OFFICE OF SERVICES TO THE AGING
AND THE
MICHIGAN DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES ADMINISTRATION

The Office of Services to the Aging (hereafter referred to as OSA) and the Department of Social Services, Medical Services Administration (hereafter referred to as DSS) by entering into this agreement intend:

- to promote quality targeted case management (TCM) services for high risk elderly clients on the verge of entering a nursing home;
- to promote quality home and community based waiver services for elderly and disabled (HCBS/ED) clients who are nursing home eligible;
- to assure the proper expenditure and accountability of public funds for health care services provided to these Medicaid clients; and
- to comply with state and federal statutes, regulations, and guidelines pertaining to TCM and HCBS/ED waiver services.

Legal authority for these programs is found in Act 280, Public Acts of Michigan of 1939, as amended, and Title XIX of the federal Social Security Act, as amended. This agreement will serve to delineate the relationship and responsibilities between DSS and OSA in the administration of Medicaid reimbursable activities for TCM services and HCBS/ED waiver services. (Responsibilities of OSA and DSS in the administration of Medicaid reimbursable activities are delineated for TCM services in Schedule B and HCBS/ED waiver services in Schedule C.)

The responsibility for periodic review and joint planning, maintaining liaison between parties affected by this agreement, and for jointly evaluating policies implemented through this agreement is vested in the Program Development Division of OSA and the Bureau of Program Policy of MSA, DSS.

This agreement is effective January 1, 1993, and will automatically renew each year unless OSA and DSS agree to modify or terminate it. This agreement may be modified in writing by mutual consent of both parties at any time.

MICHIGAN DEPARTMENT OF SOCIAL SERVICES

Gerald Miller, Director

Date

MICHIGAN OFFICE OF SERVICES TO THE AGING

Diane K. Braunstein, Director

Date

TN No. 93-05 Approval Date 10-18-94 Effective Date 1-1-93

Supersedes

TN No. 89-22

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Schedule A

DEFINITIONS

The following definitions are used in conjunction with this agreement.

1. AAA - Area Agency on Aging

2. Administrative Agent - The entity to whom DSS delegates day to day responsibility for TCM and HCBS/ED program operations, in this instance, OSA.

3. Care Plan - An individual written plan of care developed by qualified individuals for each client under the HCBS/ED waiver. This plan of care describes the medical and other services (regardless of funding sources) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency.

4. CM - Care Management. (See TCM).

5. CTS - Client Tracking System. Used by OSA and AAAs to monitor HCBS/ED waiver clients and their services.

6. DMB - Department of Management and Budget.

7. DPH - Department of Public Health.

8. DSS - Department of Social Services.


10. HCBS/ED - Home and Community Based Services for the Elderly and Disabled.

11. HCFA - Health Care Financing Administration.

12. Medicaid - The federal/state program established to ensure that essential health care services are made available to those who otherwise could not afford them.

13. MSA - Medical Services Administration. The entity within the Department of Social Services responsible for administering the Medicaid Program.

14. Organized Health Care Delivery System (OHCDS). A public or private organization for delivering health services as identified in 42 CFR 447.10(b).

15. OSA - Office of Services to the Aging.

16. Personal Care - Assistance that is provided to a person who needs help in performing his/her own activities of daily living (eating, bathing, transferring, etc.) or instrumental activities of daily living (shopping, errands, light housekeeping, meal preparation, etc.).
17. TCM - Targeted Case Management. Those services that will assist Medicaid-eligible persons in gaining access to needed medical, social, educational and other services. Core elements of case management include assessment; service plan development; linking/coordination of services; reassessment/follow-up; and monitoring of services.

18. Waiver Services - Those services, authorized by HCFA, that are not regular Medicaid State Plan coverages but may receive ffp under the HCBS/ED waiver.
GENERAL PROVISIONS

This agreement discusses the relationship established between OSA and DSS for the purpose of providing targeted case management to the elderly and disabled. This agreement also recognizes activities directly performed by OSA as well as the activities of the AAAs who have contractual ties to OSA and who perform targeted case management-related activities as Medicaid providers.

SECTION I: DSS RESPONSIBILITIES

DSS will:

1. Assure that TCM claims meet DSS policies and guidelines; prepare and submit claims for federal financial participation (ffp).
2. Make information available to OSA to permit verification of client Medicaid eligibility and provider Medicaid enrollment prior to bill preparation and submission of claims.
3. Verify that the individual for whom a claim is made is eligible for Medicaid.
4. Conduct periodic reviews as necessary to determine that OSA responsibilities under this agreement are fulfilled.
5. Generate a remittance advice to providers, with a copy to OSA, indicating the status of claims received by DSS. Reimbursement for TCM is made pursuant to the arrangements described in the Michigan Medicaid State Plan, Attachment 4.19-B, Item 9, "Case Management Services".
6. Monitor TCM claims to prevent duplication of services.

SECTION II: OSA RESPONSIBILITIES

OSA will:

1. Assure that TCM providers conform to DSS approved case management criteria through annual certification reviews of each provider agency.
2. Assure that each Medicaid client has an appropriate care plan developed by a qualified case manager after an assessment of the client's needs.
3. Provide written TCM billing documentation to DSS in a format specified by DSS.
4. Maintain the historical file of TCM services, by client.
5. Assure that case record documentation of TCM is maintained for six years for the purpose of subsequent audit.
Schedule B
TARGETED CASE MANAGEMENT

6. Provide guidance to, and encourage collaboration between, local agencies providing case management.

7. Assure client freedom of choice in the selection of a case manager.

8. Adhere to standards of confidentiality, as defined in 42 CFR 431 and State law, regarding client information and assure the same of the AAAs. Client information may be shared ONLY as necessary for the administration of Medicaid reimbursable activities.

9. Assure that the provider agency adheres to the following:
   a. TCM should be provided in accordance with a care plan;
   b. TCM services shall meet program criteria approved by DSS;
   c. clients should be involved in the TCM process and their rights respected;
   d. standards of confidentiality, as defined in 42 CFR 431 and State law, regarding client information. Client information may be shared ONLY as necessary for the administration of Medicaid reimbursable activities;
   e. TCM shall be documented to OSA in a format specified by OSA;
   f. appropriate records shall be maintained for six years for the purpose of subsequent audit;
   g. cooperation shall be provided to financial and programmatic audits by OSA.

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
GENERAL PROVISIONS

This agreement describes the relationship established between OSA and DSS for the purposes of administering various activities related to the HCBS waiver and related State Plan personal care services. (Personal care for waiver clients must meet existing criteria as indicated in 3.1A 23 (f) of the Michigan State Plan as well as the criteria indicated in the approved waiver plan. For this schedule, reference to waiver services includes personal care services.) This agreement also recognizes the operational responsibilities of OSA, as well as the responsibilities of the AAAs who perform waiver activities directly as organized health care delivery systems (OHCDS).

SECTION I: DSS RESPONSIBILITIES

DSS, as the single State Medicaid agency is ultimately responsible for ensuring that the terms and conditions of the HCBS/ED waiver are met.

DSS will:

1. Provide necessary client information to the Office of Services to the Aging, as the administrator of this waiver, and the AAAs as needed.

2. Assure cooperation between OSA and the Department of Public Health (DPH) with respect to the determination of the client's medical eligibility for nursing home care through the use of the R-19, Request for Prior Authorization of Medical Eligibility for Reimbursement for Skilled Nursing or Intermediate Care.

3. Review determinations of medical eligibility and determine financial eligibility for individuals who make an application for Medicaid benefits.


5. Arrange for and provide funding for evaluation activities, including an independent assessment of the HCBS/ED waiver, if required.

6. Determine an annual amount to be targeted for HCBS/ED waiver services and obtain HCFA approval regarding administrative funds for the HCBS/ED waiver.

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Schedule C
HOME AND COMMUNITY BASED SERVICES
ELDERLY AND DISABLED WAIVER
(AND PERSONAL CARE)

7. Process claims for HCBS/ED waiver services through the Medicaid Management Information System. The claims will be subject to all appropriate Medicaid policies and will assure:
   a. that clients are Medicaid eligible;
   b. that waiver services are not claimed for clients while they are institutionalized; and
   c. that waiver services are not claimed for the cost of room and board, except for approved out-of-home respite services.

8. Provide OSA and AAAs with remittance advices identifying the status of waiver and related personal care services claims received by DSS;

9. Prepare and submit to HCFA the required quarterly and annual reports for service expenditures.

10. Prepare and submit to HCFA ffp claims for waiver administration and services.

11. Assure financial accountability:
   a. conduct periodic program and fiscal audits of OSA to review compliance with the terms and conditions of the HCBS/ED waiver;
   b. ensure that financial documentation kept by DSS for waiver services is maintained for six years for purposes of subsequent audit.

12. Provide OSA with non-waiver Medicaid expenditure data on all waiver recipients for purposes of evaluating waiver costs during any waiver year.

13. Cooperate and collaborate with OSA and the AAAs to review the overall waiver progress, address project issues and concerns, and evaluate project performance.

SECTION II: OSA RESPONSIBILITIES

OSA, as the administrative agent for waiver operations, is responsible for the day to day operation of the HCBS/ED waiver.

OSA will:

1. Ensure that all AAAs operate in compliance with DSS approved requirements for an OHCDS through annual certification reviews of each OHCDS entity.

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2. Ensure that each AAA's performance of activities complies with the HCBS/ED waiver plan as approved by HCFA, OSA administrative standards, the terms and conditions of this agreement, Department of Management and Budget administrative rules, DSS policies and guidelines, and OSA/DSS waiver policy and procedures.
   a. provide AAAs with written notification when waiver requirements are not met;
   b. recommend corrective action, as necessary;
   c. ensure that corrective action procedures are implemented in a timely manner.

3. Verify that AAAs providing administrative case management under the waiver meet the same operating, management, and CM Performance Criteria as specified in Schedule B, Targeted Case Management, of this agreement, with the exception of Section II, item 7.

4. Maintain a state waiver client register and individual client files of all waiver services on the OSA Client Tracking System (CTS);

5. Compile billing data, and submit to DSS at least quarterly, as required by DSS specifications and format.

6. Provide DSS with expenditure reports for OSA's costs and each AAA's costs in a format, and on a schedule, specified by DSS.
   a. compile waiver data as required and submit to DSS in a timely manner;
   b. generate ad hoc waiver reports from the CTS as needed by DSS and OSA for purposes of evaluating waiver performance and program expenditures.

7. Ensure that financial documentation for waiver services is maintained by AAAs for purposes of subsequent audit;
   a. maintain documentation to fully disclose the extent of waiver services provided for a period of six years for the purpose of subsequent audit;
   b. provide these records upon request to DSS, HCFA, or any other agency with authority to audit.

8. Perform fiscal assessments of the AAAs using DSS approved policies and standards.

9. Using the CTS, monitor projected vs actual expenditures for waiver services to determine cost-effectiveness per the approved waiver plan.
10. Ensure that waiver costs are below the cost of nursing home care by evaluating expenditure rates on the CTS.

11. Adhere to standards of confidentiality, as defined in 42 CFR 432 and State law, regarding client information and assure the same of the AAAs. Client information may be shared ONLY as necessary for the administration of Medicaid reimbursable activities.

12. Cooperate with evaluation activities, including the independent assessment if required under HCFA's Home and Community Based Services rules.

13. Cooperate and collaborate with DSS and the AAAs to review the overall waiver progress, address project issues and concerns, and evaluate project performance.

SECTION III: AAA RESPONSIBILITIES

For purposes of this waiver, AAAs under contract with OSA will function as organized health care delivery systems (OHCDS) and will carry out their OHCDS responsibilities in compliance with DSS-approved requirements for operation of an OHCDS. In their capacity as OHCDS, AAAs will:

1. Enroll eligible clients in the waiver;
   a. conduct waiver assessments (pre-admission screenings);
   b. complete the R-19 forms for evaluations and annual re-evaluations;
   c. inform Medicaid clients of all available waiver service alternatives;
   d. provide waiver recipients with choice of institutional or home and community based care;
   e. respect the client's choice of service alternatives;
   f. explain the appeal process to each client, as appropriate;
   g. assist the client in completing the necessary forms for Medicaid eligibility determinations;
   h. adhere to standards of confidentiality, as defined in 42 CFR 431 and State law, regarding client information. Client information may be shared ONLY as necessary for the administration of Medicaid reimbursable activities.
2. Link clients to services;
   a. develop individual written care plans for waiver clients;
   b. establish frequency and duration of all waiver and related state plan services on client care plans;
   c. submit appropriate documentation to DSS for authorization of Medicaid State Plan covered durable medical equipment, and/or medical supplies. Remaining services will be covered by the waiver program;
   d. arrange waiver and related state plan services to be provided;
   e. assist the client in locating providers, if necessary.

3. Monitor service delivery and client status;
   a. provide case management according to DSS approved case management criteria;
   b. ensure that all services are provided as authorized in individual care plans;
   c. monitor and evaluate clients' health status;
   d. ensure that waiver services are not provided to institutionalized clients.

4. Contract with qualified entities to deliver HCBS/ED waiver services;
   a. ensure that entities meet and maintain all applicable service standards and waiver requirements;
   b. utilize contracts with such entities which meet the requirements of 42 CFR 434.6;
5. Reimburse contractors and/or subcontractors who are part of the OHCDS for waiver services furnished to individual clients as authorized in the client's care plan.
   a. provide billing instructions to contractors and/or subcontractors;
   b. prior to payment, verify that waiver services are provided according to the client care plan;
   c. ensure that all available third-party reimbursement resources are identified and utilized prior to authorizing expenditures for waiver services;
   d. on a monthly basis, prepare and submit service payment data to OSA, according to DSS approved specifications and format.

6. Track waiver service costs on CTS:
   a. maintain individual client files as required by OSA on all waiver clients for the purpose of tracking client demographics, service payment data, and client status;
   b. submit all CTS client files to OSA monthly;
   c. edit and update files as required by OSA.

7. Review contractor and/or subcontractor activity and billing claims through independent financial audits as required by DSS approved standards.

8. Maintain records; and
   a. ensure that all necessary records (e.g., care plans, R-19s, financial documentation) are maintained to disclose fully the extent of services provided for a period of six years for the purpose of subsequent audit;
   b. provide these records upon request to OSA, DSS, HCFA, or any other agency with authority to audit.

9. Cooperate and collaborate with DSS and OSA to review the overall waiver progress, address project issues and concerns, and evaluate project performance.
AGREEMENT BETWEEN
THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES AND
THE MICHIGAN DEPARTMENT OF EDUCATION

Pursuant to Act 280, Public Acts of Michigan of 1939, as amended, a Medical Assistance Program has been implemented in the State of Michigan as authorized by Title XIX of the federal Social Security Act, as amended.

In order to comply fully with the provisions of the above legislation with reference to appropriate and related federal requirements, this agreement is entered into by the Michigan Department of Social Services, hereinafter referred to as "Social Services," and the Michigan Department of Education, hereinafter referred to as "Education."

ARTICLE I

It is the intent and purpose of the parties hereto, by entering into this agreement, to promote high quality of health care and services for recipients of Michigan's Medical Assistance Program, to assure the proper expenditure of public funds for health care services provided said recipients, and to conform with applicable state and federal requirements. The extent of responsibilities and duties of the parties to this agreement are subject to the terms and conditions contained in the specific schedules attached hereto.

ARTICLE II

Assigned functions will be carried out by Education and Social Services in full compliance with Michigan's approved State Plan for Medical Assistance, provider manuals, enrollment agreements, and the statutory and regulatory requirements of the U.S. Department of Health and Human Services. The respective responsibilities of Education and Social Services are detailed in schedules, as amended from time to time, which will be attached and which, when signed and dated by the directors of the two departments, are hereby incorporated as part of this agreement.

It is understood and agreed that the parties shall have the right to examine all physical records originated or prepared pursuant to this agreement, including working papers, reports, charts, and any other documentation arising out of this agreement. Said records shall be made available for review by the parties upon reasonable notice. The parties shall, for six years from the date of origination, maintain all pertinent data, information, and reports.
ARTICLE III

In the performance of the functions, Education is not authorized and may not change, disapprove, or delay action on any administrative decision of Social Services or otherwise substitute its judgment for that of Social Services as to the application of policies, rules, and regulations promulgated or otherwise initiated by Social Services.

It is further agreed and understood between the parties that, in recognizing the ultimate authority of Social Services as the single State agency for administration of the Medical Assistance Program, Social Services shall solicit recommendation of policies and procedures for the Medical Assistance Program coverage of School Based Services. However, decisions of Social Services within its authority shall be final and binding on all parties to this agreement.

ARTICLE IV

It is agreed that each party to this agreement shall provide the other with data necessary to carry out its responsibilities under this agreement. It is also agreed that Education will assign appropriate professional personnel, when indicated, to coordinate with financial auditors when questions regarding School Based Services to Medical Assistance recipients are identified.

ARTICLE V

It is agreed that each party will consult and cooperate on budget issues. It is also agreed that the State portion of the total reimbursement for services rendered to Medical Assistance recipients will be the responsibility of the cooperating school districts. Social Services will reimburse the cooperating school districts for the federal portion of said reimbursement according to the medical assistance provider enrollment agreement and the provider manual for School Based Services.

The parties further agree that, whatever audits or financial management reviews may be deemed appropriate, such audits or reviews may be initiated in order to assure that local funds certified as being available are actually available, or that other Federal funds received at the local level are not supplanted as the State's share of the match.

ARTICLE VI

This agreement supersedes any prior agreement between the parties and shall continue in effect until or unless the two parties agree to modify or terminate it. Any change in the agreement requires at least thirty (30) days prior written notice by either party.
ARTICLE VII

This instrument, including the schedules, contains the entire agreement between the parties and shall not be modified in any manner except by an instrument in writing executed by the parties. If any term or provision of this agreement or application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this agreement, or the application of such term or provision to such person or circumstance other than those to which it is held invalid or unenforceable, shall not be affected thereby; and each term and provision of this agreement shall be valid and be enforced to the fullest extent permitted by law.

This agreement, and attached schedules, is effective August 1, 1993, and will remain in effect unless modified or canceled by mutual consent of both parties.

Gerald H. Miller, Director
Michigan Department of Social Services

Date 12/1/93

Robert E. Schiller, State Superintendent of Public Instruction
Michigan Department of Education

Date 12/1/93

TN No. 91-23 Approval Date 12-18-93 Effective Date 10-1-91
Supersedes
TN No. N/A
The following definitions are to be used with this agreement.

1. "Social Services" is the Michigan Department of Social Services, the single state agency responsible for the administration of the Medical Assistance Program.

2. "Education" is the Michigan Department of Education, the agency responsible for the administration of the special education program within the public school system.

3. "Cooperating School District" means a Medicaid enrolled provider of School Based Services that is also:
   (a) An intermediate school district, or a local school district as defined in Section 5 of Act 451 of 1976, as amended, and/or;
   (b) The Michigan School for the Deaf and/or the Michigan School for the Blind.

4. "Recipient" means a person receiving medical assistance, Social Security Income, or aid to families with dependent children.

5. "Child" or "Pupil" is any individual between the ages of 0 (zero) and 26 enrolled in school.

6. "School Based Services" means those medical, nursing, and related services provided to a child with a handicapping condition; requested in the IEP or IFSP; or as determined through coordination of services; and provided in the school setting.

7. "Physician" means any person licensed as a Medical Doctor or Doctor of Osteopathy to practice medicine in the State of Michigan.

8. "Professional Team" means the staff of at least three individuals representative of different professions or service areas that are relevant to the recipient's needs.
9. "Individual Education Plan (IEP) Related Services" or "Individual Family Service Plan (IFSP) Related Services" are:
   (a) Medically necessary diagnostic services.
   (b) Medically necessary health services, which means a health service that is consistent with the child's diagnosis or condition, and:
      (1) is recognized as the prevailing standard or current practice by the provider's peer group, and
      (2) is rendered in response to a life-threatening condition or pain; or to treat an injury, illness or infection; disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition.
   (c) provided in the school district in which the child/pupil is enrolled.
   (d) determined through the Individual Educational Planning Committee or Individual Family Service Planning Committee.
   (e) prescribed/provided by eligible licensed/certified providers.

10. "Medical Assistance" means any program for which the Medical Services Administration acts as the fiscal intermediary. This includes the Medical Assistance (Medicaid); State Medical Program; Children's Special Health Care Services; and Refugee and Repatriate Programs.
SCHEDULE B
SCHOOL BASED SERVICES

Schedule B is explanatory of the provision of, and reimbursement for, School Based Services covered by the Medical Assistance Program for recipients receiving such services under terms of the contract with Education and/or cooperating school districts under agreement with Education.

Education and Social Services agree, as specified in 42 CFR 431.615(d)(5)(vi) through (viii), to the following:
- Semiannually review and jointly plan for needed changes in this agreement,
- Designate staff as liaison between the respective departments,
- Conduct monthly or more frequent discussions by liaison staff to monitor the cooperative work by the departments contained in this agreement, and
- Solicit comments and jointly evaluate proposed changes in policies that affect the cooperative work by the departments.

Education and Social Services hereby agree to the following division of responsibilities for billing and preparation of claims for federal financial participation, for assurance of compliance with standards and certifications required for billing, and for documentation of such compliance.

A. Education will have an agreement with cooperating districts to provide assurances that the districts, in the provision of services under this agreement, will be responsible for:

1. Assuring that the services billed to the Medical Assistance Program conform to the definition and purpose of School Based Services as specified by Social Services.

2. Verifying that the cooperating school district responsible for providing such services, and specific sites for the delivery of services, have met the appropriate operating, management, and physical plant standards required by Education and Social Services for operation and certification.

3. Assuring that each recipient for whom a claim is processed for School Based Services, has an individual education plan for related services or an individual family service plan for related services, developed by the appropriate professional team, concurred with as necessary by the parents, and ordered and approved by a physician when required.

4. Assuring that the recipient for whom a claim is made is eligible for Medical Assistance.

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5. Producing the detailed billing and maintaining the historical file of School Based Services charges by recipient.

6. Assuring that the original documentation of School Based Services provided is in accordance with the recipient's individual education plan or individual family service plan, and the verification of compliance with licensing and operational standards is maintained for subsequent audit.

B. Education will be responsible for:

1. Providing consultation to Social Services, when so requested, for the development of general surveillance and utilization review procedures.

2. Providing field consultation services as it determines necessary and appropriate to maintain contact with Medical Assistance providers.

3. Assist Social Services to establish a process of quality assurance which includes the following elements:
   
i. Certification criteria for cooperating school districts providing School Based Services;
   
ii. Provider staff qualifications and validation of cooperating school district's listing of staff providing covered School Based Services to students;
   
iii. Content and format for site survey (s) to determine ability and readiness of an applicant agency to become a cooperating school district; and
   
iv. Policies and procedures to address cooperating school district noncompliance with certification criteria.

4. Monitoring cooperating school districts to determine that services rendered to Medical Assistance recipients meet requirements as specified in the policies and procedures for the Medical Assistance Program for School Based Services.

5. Conduct site surveys as needed and in cooperation with the Department of Education Monitoring Model to determine cooperating school districts' continued compliance with certification criteria;

6. Notify Social Services that a cooperating school district has met the certification criteria.

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Supersedes
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C. Social Services will be responsible for:

1. Preparing the claim for federal financial participation.

2. Making services or facilities available to permit verification by cooperating school districts of recipient eligibility for Medical Assistance as required by Social Services.

3. Enrolling with Medical Assistance those agencies who have received approval from Education.

4. Processing claims from the cooperating school districts for Medicaid reimbursement, in accordance with Medical Assistance policies.

5. Acting as the central control point for all Medicaid financial audits and investigations, including processing of referrals in a timely manner. In carrying out this responsibility, Social Services will:
   (a) record, coordinate, and investigate referrals of possible fraud, abuse or misutilization.
   (b) provide Education with status reports on financial audits, investigations, and reviews upon request in a timely manner.

6. Initiating litigation, when indicated.

7. Developing and promulgating program policy on covered services, limitations, procedures, and public disclosure, consistent with state and federal statutes and regulations.

8. Establish a process of quality assurance which includes the following elements:
   
   i. Certification criteria for cooperating school districts providing School Based Services;
   
   ii. Provider staff qualifications and validation of cooperating school district's listing of staff providing covered School Based Services to students;
   
   iii. Content and format for site survey (s) to determine ability and readiness of an applicant agency to become a cooperating school district; and
   
   iv. Policies and procedures to address cooperating school district noncompliance with certification criteria.
9. Reviewing and taking timely and appropriate action upon recommendation made by Education to Social Services.

10. Providing the necessary data to ensure that Education is able to carry out its responsibilities under this agreement and to meet the state's responsibilities under applicable statutes and regulations.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperative Agreements

JOINT OPERATING AGREEMENT
Between the

Michigan Department of Community Health
a Principal State Department

and the

State Office of Administrative Hearings and Rules
a Type I Agency

This agreement is entered into to implement Executive Order (E.O.) 2005-1 in a manner consistent with federal law. E.O. 2005-1 created the State Office of Administrative Hearings and Rules to consolidate rulemaking and administrative hearing functions within one Type I Agency, within the Department of Labor and Economic Growth.

WHEREAS, the Michigan Department of Community Health (MDCH) is a principal department of Michigan state government, as defined in MCL § 16.104, and is designated as the responsible Single State Agency (SSA) administering the Medicaid program in the state; and

WHEREAS, the State Office of Administrative Hearings and Rules (SOAHR), a Type I Agency (MCL § 15.103), was created by Governor Jennifer M. Granholm in E.O. 2005-1 and amended in E.O. 2005-26; and
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperative Agreements

WHEREAS, MDCH and SOAHR desire to jointly conduct operations to the extent necessary to assure MDCH control over Medicaid decisions and determinations under the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the premises and of the mutual agreements, representations, provisions and covenants herein, MDCH and SOAHR, intending to be legally bound, agree as follows:

I. SUMMARY OF THE AGREEMENT

The MDCH is responsible for administration of the federal Medicaid program, under Title XIX of the Social Security Act and rules promulgated under that authority. 42 U.S.C. 1396 et al. and 42 CFR Part 430 et al.

Title XIX requires states to complete and follow a State Plan, which includes certain required assurances. The state must "provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan." 42 U.S.C. 1396a(a)(5). The MDCH is designated as Michigan’s Single State Agency. (Michigan’s Medicaid State Plan, § 1.1(b), p. 3.)

The phrase “single state agency” (SSA), sometimes referred to as the Medicaid agency, has extensive meaning and brings about additional duties. Its ability to delegate its authority and control is limited by 42 CFR 431.10, which provides in part:

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Supersedes
TN No.: N/A new page
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperative Agreements

In order for an agency to qualify as the Medicaid agency—

(1) The agency must not delegate, to other than its own officials, authority to—
   (i) Exercise administrative discretion in the administration or supervision of the plan, or
   (ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

42 CFR 431.10(e).

This agreement makes clear the supervisory and oversight powers and responsibilities of the MDCH. In form and substance, the administrative law judges' decisions continue to be subject to the oversight, supervision, and authority of the Director of the MDCH.

II. DELEGATION TO ADMINISTRATIVE LAW JUDGES

Medicaid decision-making authority is narrowly drawn and subject to the following limitations:

(1) MDCH has delegated to SOAHR authority to issue decisions entitled "Decisions and Orders" (D & Os) for only certain case types. Administrative Law Examiners (ALEs) are authorized by MDCH to issue only Proposals for

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Decisions for Medicaid Provider appeals brought pursuant to the Social Welfare Act, 1939 PA 280, MCL 400.1 et seq., and 1979 AC R 400.3401 et seq.

(2) In all other cases referred to SOAHR by MDCH, ALEs are authorized to issue D&Os. D&Os will be issued by the ALEs in a timely manner and will be forwarded for review to those individuals within MDCH designated by MDCH by case type or case type grouping. MDCH will have the following periods of time to review the D&Os:

(a) Five (5) business days from the date of receipt of a D & O for appeals involving:

i. Waivers: Adult Benefit, Family Planning, Habilitation and Supports, Children's, MiChoice, and Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c).

ii. Other Cases: Hospital Admission denials, Nursing Home eligibility, OBRA/Preadmission Screening and Annual Resident Review (PASARR); Children's Special Health Care Services including prior authorization; Programs for All Inclusive Care to the Elderly (PACE), Substance Abuse Services, and all other appeals not specified in Section 11(1) or 11(2)(b).

(b) Three (3) business days from the date of receipt of a D & O for appeals involving: Breast and Cervical Cancer Prevention

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and Treatment, Beneficiary Monitoring Program, Medicaid client general issues, Disenrollment from Medicaid Managed Care, Family and Neighborhood Services, Home Help Services program, Medicare Buy-In, Exceptions from Medicaid Managed Care, Maternity Outpatient Medical Services, Medicaid Medical Services Billing, Office of Medical Affairs, Prior Authorization, Physical Disability Services, Pharmacy Benefits, Policy Exception, Managed Care Organization/Qualified Health Plan, Transportation reimbursement, Vision-glasses.

(3) Prior to the expiration of the review time periods specific in 2(a) and 2(b), MDCH must exercise one of the following options:

(a) If MDCH disagrees with the D & O, MDCH must
   i. Issue a Final Decision and Order resolving the case, or
   ii. Issue an Order Converting the Decision and Order to a Proposal for Decision requiring supplemental action by either the ALE or the parties.

(b) If MDCH agrees with the D & O, MDCH will take no action and the D & O shall become the final decision of MDCH as a matter of law, at the expiration of the review period.

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(4) ALEs are not authorized to issue D & Os in those cases in which the ALE believes MDCH policy to be out of conformity with case law, statute or promulgated regulation.

(5) ALEs are not authorized to make decisions, either through D & Os or Proposals for Decision, on constitutional grounds, overrule statutes, overrule promulgated regulation, or overrule or make exceptions to department policy.

(6) In cases where the ALE’s recommended remedy exceeds his or her delegated authority, the ALE will make a Recommended Policy Hearing Authority Decision to MDCH’s Director, and the Director will issue a Final Decision and Order. In these instances, the review time period specified in subsection II(2) shall not apply.

(7) If, following the expiration of D & O review period the D & O has become the final decision of MDCH, MDCH retains the authority pursuant to MCL 24.287 et seq. and 1979 AC R 400.901 et seq., to request a rehearing or reconsideration. The Administrative Law Manager (ALM) shall review all requests for rehearing or reconsideration and shall issue an order which grants or denies all requests for rehearing or reconsideration.

i. **Rehearing:** If the ALM grants rehearing, the case shall be returned to SOAHR for rehearing. The rehearing will be noticed and conducted by SOAHR in the same manner as the original hearing. Upon the close of the record, SOAHR will
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issue a Rehearing D & O that is subject to MDCH review pursuant to subsection II(2). If MDCH agrees with the Rehearing D & O, the Rehearing D & O shall become the final decision of MDCH as a matter of law, at the expiration of the review period.

ii. Reconsideration: If the ALM grants Reconsideration, the ALM shall issue a Reconsideration Order. If the ALM grants reconsideration, the decision may be modified without further proceedings unless the ALM determines there is a need for further testimony for the purposes of reconsideration. If the ALM determines that further testimony is required, additional hearing(s) shall be scheduled. The reconsideration hearing will be noticed and conducted by SOAHR in the same manner as the original hearing. Upon the close of the record, SOAHR will issue a Reconsideration D & O that is subject to MDCH review pursuant to subsection II(2). If MDCH agrees with the Reconsideration D & O, the Reconsideration D & O shall become the final decision of MDCH as a matter of law, at the expiration of the review period.

iii. Judicial Review: All D & Os, Orders Denying Rehearing or Reconsideration, Rehearing D & Os, and Reconsideration D & Os

Attachment 4.15-A
Page H-7

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OEs are subject to judicial review pursuant to MCL 24.301 et seq. and 1979 AC R 400.901 et seq.

III. TRAINING

In coordination with the SOAHR Executive Director, MDCH will provide training to ALEs assigned to their cases and, where applicable, will cooperate with the SOAHR Executive Director to secure all possible federal, state, and foundation training funds available.

IV. SPECIAL PROVISIONS

SOAHR will comply with:

- 42 USC 1396 et seq.;
- 42 CFR 400 et seq.;
- MCL 400.1 et seq.;
- All Medicaid Policy;
- 1979 AC, R 400.901 et seq.;
- 1979 AC, R 400.3401 et seq.; and
- MDCH Medicaid hearings policy as found at: http://www.michigan.gov/mdch/0,1607,7-132-2946_5093-16825-00.html

V. COMPLIANCE CONCLUSION

The MDCH is required to provide a hearing before the agency, when requested by a recipient or provider. By providing a dual relationship of responsibility and oversight and by vesting review authority in MDCH, the federal law requirements are met, while following E.O. 2005-1.

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TN No.: N/A new page
VI. PRIOR AGREEMENTS

Upon execution by both parties, revised Joint Operating Agreement replaces and
supersedes the Joint Operating Agreements executed by the parties on May 5, 2006

A. Edwin Durie  
Chief Deputy Director  
MDCH  

Date

Peter L. Plummer  
Executive Director  
SOAHR  

Date

Supersedes
TN No.: 06-07  
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Liens and Adjustments or Recoveries

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

   The State is not a TEFRA state. Determination of permanent institutionalization is not required or performed.

2. The following criteria are used for establishing that a permanently institutionalized individual’s son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

Because 42 CFR §433.36(f) is a provision required only if a State chooses to impose a lien against an individual’s real property prior to his or her death, and the State is not a TEFRA state, the State does not have nor need such criteria.

3. The State defines the terms below as follows:

   - **estate** – MCL 700.1104(b) "estate" includes the property of the decedent, trust, or other person whose affairs are subject to this act as the property is originally constituted and as it exists throughout the administration. ("as the property is originally constituted and as it exists throughout administration" describes an asset that has changed forms. As an example: an individual has real estate which is sold in parcels and the proceeds from the sale of the separate parcels are invested in cds. Even though the asset is no longer in its original form, it is still part of the estate when the estate is distributed.) Additionally, the state’s estate recovery statute (MCL 400.112h (a)) defines estate as ". . . All property and other assets included within an individual’s estate that is subject to probate administration. . ." If a decedent received (or is entitled to receive) benefits under a long-term care insurance policy and had assets or resources disregarded, pursuant to 42 USC 1396p(b)(4)(B) “estate” includes all real and personal property and other assets in which the decedent had any legal title or interest immediately before or at the time of death to the extent of that interest, including but not limited to, assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, transfer-on-death deed, payable on death contract, promissory note or other arrangement.

   - **Survivor** – an individual who is entitled to inherit from the decedent’s estate, who does not predecease the deceased beneficiary

   - **individual’s home** – any shelter used by an individual or spouse as a place of residence in which the individual has a home-ownership interest

   - **equity interest in the home** – any equitable right, title or interest in real property

   - **residing in the home for at least one or two years on a continuous basis** – occupancy of an individual’s home by a sibling, child or other survivor using the home as the principal place of residence

   - **discharge from the medical institution and return home** – the attending physician has signed an order for discharge from the nursing home, following which the individual has returned to reside in his or her own home, and

   - **lawfully residing** – use of the home of an individual residing in a nursing facility as a primary place of residence by a spouse, a minor, blind or disabled child, a sibling or other survivor. Such property must be the spouse’s, child’s, sibling’s or other survivor’s mailing address or legal address for driver’s licensure and/or voter registration.

TN NO.: __________ Approval Date: MAY 24, 2016 Effective Date: 01/01/2016

Supersedes
TN No.: 12-10

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Liens and Adjustments or Recoveries

- Surviving spouse – a person who is still married to the decedent. A person who is a party to a judgment of separate maintenance or a judgment of divorce is not a surviving spouse for purposes of this section.

4. The State defines undue hardship as follows:

An undue hardship may exist when (1) the estate subject to recovery is the primary income producing asset of the survivors (where such income is limited), including, but not limited to, a family farm or business; OR (2) the estate subject to recovery is a home of modest value.

There is a presumption that no hardship exists if the hardship resulted from estate planning methods under which assets were diverted in order to avoid estate recovery. The agency will not grant an undue hardship waiver if the granting of such waiver results in the payment of claims to other creditors with a lower priority standing.

Home of modest value is defined as a home valued at fifty percent (50%) or less of the average price of homes in the county where the homestead is located, as of the date of the beneficiary’s death.

For individuals who apply for but do not meet the definition of undue hardship as found in MCL §400.112g and provided above, the state will consider granting an exemption when a survivor who was residing in the deceased beneficiary’s home continuously for at least two years immediately before the beneficiary’s date of death, provided care that kept the deceased beneficiary out of an institution, even if the deceased beneficiary never entered an institution. This exemption will only be granted in circumstances where non-institutional long-term care services approved under the state plan were provided and only after the means test has been satisfied.

The State is following its own definition of undue hardship in accordance with mcl §400.112g(3)(e). When considering whether to grant an undue hardship waiver, a means test will be applied. West Virginia v. Thompson, 475 F.3d 204. An applicant will satisfy the means test only if both of the following are true:

- Total household income of the applicant is less than 200 percent of the poverty level for a household of the same size; and
- Total household resources of the applicant do not exceed $10,000.

Undue hardship waivers are temporary. Undue hardship waivers expire when the conditions which qualified an estate, or a portion of an estate, for a waiver no longer exist.

5. The following standards and procedures are used by the State for deferring or waiving estate recoveries when recovery would cause an undue hardship, or when recovery is not cost-effective.

Review of hardship waivers begins with the estate recovery caseworker. The caseworker reviews all incoming waiver applications and makes an initial recommendation to accept or deny and sends it to the estate recovery program manager.

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Liens and Adjustments or Recoveries

The Estate Recovery program manager’s responsibilities are:

- monitors state and federal laws and regulations pertaining to estate recovery
- conducts all initial hardship waiver reviews
- monitors progress of filed claims in probate
- assists caseworkers in sending notices of intent to file
- ensures adherence to applicable timeframes
- develops, tests, and implements TED, the Third Party Liability Electronic Database.
- approves all correspondence and informational materials
- coordinates with the Office of Legal Affairs and the Office of the Attorney General
- verifies information in recommendations received from the caseworker and in the waiver applications
- directs the activities of staff in pursuing recoveries
- evaluates methods for maximizing reimbursement from liable sources
- ensures adherence to state and federal laws and regulations
- approves or denies waiver applications

The caseworker will use the following criteria when making an initial undue hardship waiver recommendation:

- whether the estate is the primary income-producing asset of the survivors
- whether the estate is a home of modest value
- whether an actual hardship exists after application of the means test

TED is a module of the third party liability database that is used to process estate recovery cases.

6. The State defines cost-effective as follows:

Recovery is considered cost-effective when the potential recovery amount of the estate exceeds the cost of filing the claim or if the claim amount is above a $1,000 threshold.
7. The State uses the following collection procedures:

The State identifies deceased recipients subject to estate recovery via a match with the Medicaid recipient eligibility file using data from the National Social Security Death Index and State Vital Statistics, and claims paid with a discharge status code indicating death. The match is run weekly. Deceased recipients are also identified by obtaining referrals from local MDHHS offices, service providers, long-term care facilities, attorneys, personal representatives, family members of recipients, and possibly by monitoring newly opened probate court records for high-population counties in Michigan.

Under the Michigan Probate Code, a personal representative is required to publish notice to creditors to present their claims to the estate. The personal representative must send a copy of the published notice to all known creditors of the estate. A known creditor of the decedent is any creditor whose existence is reasonably ascertainable through an investigation of the decedent’s records for the 2 years prior to death. (MCL 700.3801(1)). The State will be a creditor ascertainable from review of the decedent’s past two years’ records; therefore, the State will be a known creditor and the personal representative will be required to send it notice of the probate estate.

The personal representative is also required, by state law to:

(1) within 91 days after appointment or other time specified by court rule, a personal representative, who is not a special personal representative or a successor to another representative who has previously discharged this duty, shall prepare an inventory of property owned by the decedent at the time of death, listing it with reasonable detail, and indicating as to each listed item, its fair market value as of the date of the decedent's death, and the type and amount of an encumbrance that may exist with reference to each listed item.

(2) the personal representative shall send a copy of the inventory to all presumptive distributees and to all other interested persons who request it, and may also file the original of the inventory with the court. The personal representative shall submit to the court on a timely basis information necessary to calculate the probate inventory fee. (MCL 700.3706)

The personal representative shall keep each presumptive distributee informed of the estate settlement. Until a beneficiary's share is fully distributed, the personal representative shall annually, and upon completion of the estate settlement, account to each beneficiary by supplying a statement of the activities of the estate and of the personal representative, specifying all receipts and disbursements and identifying property belonging to the estate. MCL 700.3703(4)

(D) that, during the course of administering the estate, the personal representative must provide all interested persons with all of the following:

(i) a copy of the petition for the personal representative’s appointment and a copy of the will, if any, with the notice.

(ii) a copy of the inventory.

(iii) a copy of the settlement petition or of the closing statement.

(iv) unless waived, a copy of the account, including, but not limited to, fiduciary fees and attorney fees charged to the estate (MCL 700.3705).
Within 30 days of learning of the death of a Medicaid recipient who is subject to estate recovery, MDHHS mails a Notice of Intent (NOI) to the last known address of the decedent if a claim will be pursued. If a valid address is not known, a letter will be sent to the facility where the decedent last resided to request a family contact. The NOI indicates that the state intends to file a claim against the estate in probate court to seek reimbursement for payments made by the Medicaid program (not to exceed the value of the estate).

The NOI also indicates that the State may defer recovery in the event that recovery would result in an undue hardship. The NOI provides the State's definition of an undue hardship along with a contact phone number and address to request an undue hardship application. The NOI also advises that an undue hardship application may be downloaded from the estate recovery website and gives the url. Lastly, the NOI states that adverse decisions may be appealed under the Administrative Procedures Act, (MCL 24.201-24.328) within 60 days of receiving notice of the State's final decision.

Upon confirmation that a case does not meet any statutory exemptions or hardship conditions and that probate has been opened, the State files a claim against the estate and pursues recovery. The State’s estate recovery claim is administered through the State Probate Court system and all claims are subject to review by the Probate Court. The Probate Court’s allowance or denial of the State’s claim is subject to the appellate review available to all other Probate Court decisions.

The State will petition a court pursuant to estates and protected individuals code, for distribution of estate assets upon determination that the personal representative has failed to distribute the proceeds of the estate in a timely manner (MCL §700.3415; 3807(1); 3951; 3952; 3953).

8. The State assures CMS that the full FMAP share of all recoveries will be credited timely to CMS via the CMS-64 report.

The State will provide CMS copies of the reports mandated by the Michigan Legislature. Such reports will be forwarded to CMS at the same time the reports are presented to the Legislature.
Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

No premiums are charged.

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

Not applicable to Michigan

*Description provided on attachment.

Supersedes Approval Date 04-14-92
Effective Date 10-01-91

HCFA ID: 7986E
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State/Territory: MICHIGAN

C. State or local funds under other programs are used to pay for premiums:
   ☐ Yes  ☐ No
   Not Applicable

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:
   Not Applicable

*Description provided on attachment.

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Approval Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
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<td>04-14-92</td>
<td>10-01-91</td>
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TN No. N/A

HCFA ID: 7986E

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State/Territory: MICHIGAN

Optional Sliding Scale Premiums Imposed on Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

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HCFA ID: 7986E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MICHIGAN

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

N/A

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

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Effective Date 10-01-91

HCFA ID: 7986E
It should be noted that States can select one or more options in imposing premiums.

**A. For groups of individuals with family income at or below 100 percent of the FPL:**

1. Premiums

   a. \(\_\_\_X\_\_/ \) No premiums will be imposed for individuals with family income at or below 100 percent of the FPL.

   \(\___\_/\) Other (specify the premium amounts by group and income level).

**B. For groups of individuals with family income above 100 percent but below 150 percent of the FPL:**

1. Premiums

   \(A\_X\) No premiums may be imposed for individuals with family income above 100 percent but below 150 percent of the FPL.
C. For groups of individuals with family income above 150 percent of the FPL:

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1. Premiums

   a. ___/ No premiums are imposed.
   b. X/ Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level).

<table>
<thead>
<tr>
<th>Group of Individuals</th>
<th>Premium</th>
<th>Method for Determining Family Income (including monthly or quarterly period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optional targeted low income children as described in</td>
<td>$10.00 per month per family</td>
<td>Modified Adjusted Gross Income (MAGI) method is applied when determining eligibility for this Medicaid expansion group</td>
</tr>
<tr>
<td>1902(a)(10)(A)(9ii)(XIV) and 42 CFR 435.229 who are under 19 years of age and whose income is between 160-212 per cent of the Federal Poverty Level.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Attach a schedule of the premium amounts for the various eligibility groups.

Not Applicable: The premium is set at $10.00 per month per family.

b. Limitation:
   - The total aggregate amount of premiums and cost sharing imposed for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.
c. No premiums shall be imposed for the following individuals:
   • Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
   • Pregnant women;
   • Any terminally ill individual receiving hospice care, as defined in section 1905(o);
   • Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual’s income required for personal needs; and
   • Women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.
   • An Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services is exempt from premiums.

   d. Enforcement
      1. ___ / Prepayment required for the following groups of individuals who are applying for Medicaid:
      2. X / Eligibility terminated after failure to pay for 60 days for the following groups of individuals who are receiving Medicaid: Optional targeted low income children as described in 1902(a)(10)(A)(9ii)(XIV) and 42 CFR 435.229 who are under 19 years of age and whose income is between 160-212 per cent of the Federal Poverty Level.
      3. ___ / Payment will be waived on case-by-case basis for undue hardship.

   D. Period of determining aggregate 5 percent cap
      Specify the period for which the 5 percent maximum would be applied.
      ___ / Quarterly
      ___ / Monthly

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TN No. 15-0015    Approval Date: FEB 25, 2016    Effective Date: 1/01/2016
Supersedes
TN No. NEW
CMS-101090 (09/06)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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NOTE: MIChild premiums may only be charged to families between 160% and 212% of the FPL and there are no co-payments. The only other eligibility group within this FPL range in the State is for pregnant women. The State does not charge premiums to pregnant women and pregnancy related services have no copays. Therefore, the State anticipates the only Medicaid cost sharing in a Medicaid expansion household would be the $10 per family per month premium, and is not tracking the 5% aggregate limit for Medicaid expansion households.

Approval Date: FEB 25, 2016    Effective Date: 1/01/2016

TN No. 15-0015 Supersedes

TN No. NEW   CMS-101090
(09/06)
The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.
I. Principle

A. Reimbursement Type

The Michigan Medicaid Program in patient reimbursement system is applicable for inpatient hospital services rendered to recipients under the Medicaid and Children's Special Health Care Services programs and to recipients with dual Medicare/Medicaid eligibility.

Reimbursement for inpatient services is not applicable for hospital-acquired conditions (HAC) identified as non-payable by Medicare other than deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. This applies to all Medicaid reimbursement provisions contained in attachment 4.19-a.

Medicaid has adopted Medicare’s policy on reporting present on admission (POA) indicators on inpatient hospital claims and non-payment for hospital acquired conditions (HAC). Hospitals are required to report whether a diagnosis on a Medicaid claim was present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses codes that are included on Medicare’s most recent list of HACS and for which the condition was not present on admission, the HAC secondary diagnosis will not be used for DRG grouping and the claim will be paid as if a HAC secondary diagnoses were not present on the claim.

Medicaid reimbursement is not applicable for other provider-preventable conditions (OPPC) that are identified as non-payable by Medicare: wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. This applies to all Medicaid reimbursement provisions contained in attachment 4.19-a.

In compliance with 42 CFR 447.26(c), the state provides:

1) That no reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

2) That reductions in provider payment may be limited to the extent that the following apply:

   (A) The identified PPC would otherwise result in an increase in payment.
   (B) The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC.

3) Assurance that non-payment for PPCS does not prevent access to services for Medicaid beneficiaries.

Attachment 4.19-A
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

Supersedes
TN No.: 98-08

Approval Date: MAY 25 2012
Effective Date: 07/01/2011

TN NO.: 11-08

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

Reimbursement to hospitals for inpatient services provided to dual eligible, Medicare/Medicaid recipients will be limited to the Medicare coinsurance and deductible amounts except as noted below. Where Medicare payment has been made, Medicaid will not reimburse hospitals for capital.

Reimbursement to hospitals for inpatient services provided to dual eligible, Medicare/Medicaid recipients, who have exhausted their Medicare Part A coverage, will be made in the same amounts, including capital and direct medical education (through June 30, 1997) as reimbursed for Medicaid-only recipients. Reimbursement for capital and direct medical education (through June 30, 1997) will be made at final settlement.

1. Diagnosis Related Groups

All hospitals participating in the Medical Assistance Program are reimbursed for operating costs based on Diagnosis Related Groups (DRGs). Exceptions are listed below.

2. Prospective Per Diem

The following groups of hospitals or units are reimbursed for operating costs on a prospective per diem basis:
- freestanding rehabilitation hospitals which are excluded from the Medicare prospective payment system (PPS),
- distinct-part rehabilitation units of general hospitals which have been certified by Medicare and excluded from its PPS,
- freestanding psychiatric hospitals which are excluded from the Medicare PPS, and
- distinct-part psychiatric units of general hospitals which have been certified by Medicare and excluded from its PPS,
- State-owned psychiatric hospitals.

Services provided to patients in sub-acute ventilator-dependent units are reimbursed using a prospective per diem rate that includes capital.

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3. Capital

Capital costs are reimbursed using a system based on allowable costs with occupancy limitations for some hospitals and units.

4. Graduate Medical Education

Graduate medical education costs are reimbursed by formula and grant as explained in Section 111-J.

B. Lesser of Rate or Charges

Total payments for program inpatient services will be limited to the lesser of total payments or full charges, in aggregate, for each hospital. If the aggregate program charges are less than total liability payments, the difference will be gross adjusted. This review and adjustment will occur coincident with adjustments for capital at the facility fiscal year end.

C. Interim payments will be made in compliance with 42 CFR 413.60 et seq.

II. Cost Reporting and Audit

A. Cost Reporting

Hospitals must complete and submit a cost report on the form and in the format designated by the Michigan Medical Services Administration (MSA) in accordance with the instructions related to the Medicaid Program. The hospital’s cost report must:

• be HCFA-2552 forms (modifications or changes to meet program needs may be required),

• follow the Medicare Principles of Reimbursement Manual (HIM 15 and 15-1) and all applicable parts of 42 CFR Chapter IV,

• be prepared using the accrual method of accounting (unless an alternative method is approved by the MSA),

• be a separate cost report as well as distinct-part accounting for Medicare certified distinct-part units, and

• include all information necessary for proper determination of costs payable under the program including financial records and any needed statistical data.

AUG 25, 2015

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For cost reporting purposes, the MSA requires each eligible hospital provider to submit periodic reports which generally cover consecutive 12 month periods of operation. Inpatient and/or outpatient cost reports must be filed within five (5) months of the end of the hospital's cost reporting year. State owned hospitals must file cost reports within 180 days after the end of the State's cost reporting year.

Extensions of the filing period may be granted when exceptional circumstances establish good cause. If the hospital requests an extension in writing and documents the exceptional circumstances prior to the date due, extensions may be granted up to a maximum of 30 days. Failure to submit all necessary items and schedules will only delay processing and will result in a reduction of payment or termination as a provider.

Hospitals that fail to submit cost reports as defined previously will receive a delinquency letter from the Department. If an acceptable cost report is not submitted within 30 days of the notice of delinquency, the provider's payments will be stopped. Restitution of withheld payments will be made by the State agency after receipt, of an acceptable cost report.

B. Data Correction

Once a hospital report (e.g. cost, indigent volume, and/or data) has been reviewed and provisionally accepted by the MSA, the hospital is notified in writing of the MSA's acceptance of the report. The hospital then has thirty (30) calendar days in which to notify the MSA of any errors or corrections to the report/data. After the 30 day notification period, the report is deemed accepted by the MSA and shall be used to rebase or update the hospital payments as appropriate.

Only those reports on file and accepted nine months prior to the beginning of a new rate period are used for rebasing.

C. Audit

Audits are performed for Michigan inpatient hospital services provided after February 1, 1985 to determine program cost for capital using Medicare Principles of Reimbursement.

Once any appropriate limits are applied, the capital cost is added to the amount approved as payment for the program operating cost to obtain a total amount approved. The total amount approved in a hospital's fiscal year is compared to the hospital's program charges. The lesser of amount approved or charges is then compared to the amount actually paid throughout the year to determine the amount overpaid or underpaid to the hospital.

III. Payment Determination

A. Reimbursement for Medical and Surgical Hospitals for operating expenses

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1. Description of Medical/Surgical Episode File

The episode file is comprised of the underlying data used to calculate the statewide rate, relative weights, and alternate weights. The costs associated with episodes from the episode file are standardized as described below. The episode file is comprised of two years of Medicaid and Children’s Special Health Care Services fee for service (FFS) paid claims and managed care encounters.

Each claim or encounter from the episode file is assigned a DRG value using the APR-DRG Grouper in effect nationally on October 1 of the applicable rate year. The data are adjusted to:

- Eliminate episodes for dual Medicare/Medicaid eligible beneficiaries, unless paid a full Medicaid DRG.
- Eliminate certain transplants and low day outlier episodes assigned to DRGs reimbursed by multiplying a hospital's operating cost-to-charge ratio by charges.
- Eliminate episodes without any charges or days.
- Assign alternate weights for neonatal services. Two sets of weights are calculated for the DRG classifications representing neonatal services (DRGs 580x-640x). These alternate weights are calculated based on episodes that are assigned to one of these DRGs and include charges for services in a Neonatal Intensive Care Unit (NICU). The remaining claims assigned to these DRGs are used for the base weights. No other alternate weights are assigned.
- Limit episodes to those from Michigan hospitals, including hospitals that are no longer in operation (provided that hospital cost report data is available).
- Limit episodes to those with a valid discharge status.
- Eliminate episodes with a zero dollar Medicaid liability.
- Eliminate episodes that qualify for the Short Hospital Stay rate.
- Determine the low day trim point and average length of stay.
  - See the Relative Weights section of the Reimbursement for Medical and Surgical Hospital section of the State Plan for additional information.
- Limit episodes ending in a transfer to another acute setting to those whose length of stay was at least equal to the published average length of stay for the DRG (Since DRGs 580x and 581x are transfer DRGs, all transfer costs are included within those DRGs).
- Inflate the first year of episodes to the second year through application of an inflation factor derived from IHS Global Insight.
- Recognize area cost differences by dividing the charges for each hospital by an area wage index.
  - See the Area Wage Index section of the Reimbursement for Medical and Surgical Hospital section of the State Plan for additional information regarding the area wage index.
- Adjust charges for high cost outliers to remove the amount paid as an outlier.
  - See the High Cost Outlier section of the Reimbursement for Medical and Surgical Hospital section of the State Plan for additional information regarding cost outliers.
- The adjusted cost for each episode is calculated by multiplying the adjusted charges for the episode by the inpatient operating cost-to-charge ratio.
  - See the Cost-to-Charge Ratio section of the Reimbursement for Medical and Surgical Hospital section of the State Plan for additional information regarding cost-to-charge ratios.
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.
- 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;
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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 \( ((\sum \text{line 7} \times \text{line 4})/\sum \text{line 4}) \);
9) Hospital's Area Wage Index;
10) Apply budget neutrality factor; and
11) 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:
  o 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: \( \text{(MI DRG Severity}_{n+1} \text{ Relative Weight)} \times \text{(National DRG Severity}_{n} \text{ Relative Weight)} / (\text{National DRG Severity}_{n+1} \text{ Relative Weight)} = (\text{MI Relative Weight Factor}_{n}) \)
    • Otherwise, \( \text{(National DRG Severity}_{n} \text{ Relative Weight)} \times (\text{MI Case Mix Factor}_{n}) \)

Attachment 4.19-A
Page 6

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o For severity level 4:
  • If the episode count for the prior severity level is 10 or more, the following calculation is completed: (MI DRG Severityn-1 Relative Weight) x (National DRG Severityn, Relative Weight) / (National DRG Severityn-1 Relative Weight) = (MI Relative Weight Factorₙ)
  • Otherwise, (National DRG Severityn, Relative Weight) x (MI Case Mix Factorₙ)

Where:
• (MI Case Mix Factorₙ) = sum of Michigan specific relative weights multiplied by the number of episodes if the number of episodes is 10 or more divided by the sum of National relative weights multiplied by the number of episodes if the number of episodes is 10 or more.
• (MI Alternate Weight Case Mix Factor) = Average of (MI Alternate Weight DRG Severity) / (MI DRG Severity Relative Weight) for DRGs with an episode count of 10 or more.

Further adjustments are necessary if the resulting adjustment described above is inconsistent with Michigan or National trends and data.
  • Example 1: If an episode count is between 10 and 20 and the alternate weight would be less than the standard relative weight, but other severity levels are not consistent with this, then apply the next severity level imputing method.
  • Example 2: If the episode count is between 10 and 20, the state may consider using the Alternate Weight Case Mix Factor applied to the National Alternate Weight if the alternate weight is not consistent with other severity levels of the same DRG.
  • All relative weights are subject to reasonableness testing.

Relative Weight Trim Points:
The following trim points are established for the relative weighting system.

• The low day trim point is used to determine whether an episode qualifies for a low day outlier and is established as follows.
  • If the episode count for a DRG is 10 or more, the low day trim point is set to the 3rd percentile of the length of stay for the DRG.
  • If the episode count for a DRG is less than 10, the low day trim point is set to the lesser of the national low day trim point or 3rd percentile of length of stay for the DRG.
  • If the episode count for a DRG is zero, the low day threshold is set to the national low day trim point for the DRG.

• The average length of stay (ALOS) is used to price claims episodes involving a transfer from a hospital and is established as follows.
  • If the episode count for a DRG is 10 or more, set the ALOS to the simple average length of stay for the DRG.
  • If the episode count for a DRG is less than 10, set the ALOS to the lesser of national ALOS or the simple average length of stay for the DRG.
  • If the episode count for a DRG is zero, set the ALOS to the national ALOS.
4. Area Wage Index

The area wage index described in this section is used to determine adjusted hospital costs as described in the Episode File section. In addition, it is used to adjust the statewide rate to recognize variances in area labor costs.

To calculate each hospital’s area wage index, two years of Medicare-audited wage data, as published in the Medicare Inpatient Prospective Payment System (IPPS) Final Rule, are obtained for the most recent available hospital fiscal years. Contract labor costs, as defined by Medicare, are included in determining a hospital's wage costs. Hospitals are grouped by U.S. Census Core Based Statistical Areas (CBSAs) as determined by CMS for the Medicare program. Consistent with CMS, the cost report references are obtained from the Medicare Provider Manual, Worksheet S3, Part 3, Line 6 for wages and hours.

The following calculations are completed:

- Each hospital's wage costs are brought to a common point in time by multiplying the hospital's fiscal year end costs by inflation factors derived from IHS Global Insight and weighting factors.
- For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.
- The cost reports do not differentiate salaries/hours by unit type.
- The wage adjustor is based on a two-year moving average with the most recent year weighted at 60 percent and the second year weighted at 40 percent.
- If two or more hospitals merge and are operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data is inflated to a common point in time.
- The average wage for each CBSA is calculated with and without hospital reclassifications:
  - The average wage for each CBSA without reclassifications is determined. The statewide average wage for all hospitals in the state is calculated. Using these data, CBSA-specific area wage indices are calculated by dividing the average wage for the CBSA by the statewide average wage. This quotient is area wage index A.
  - The average wage for each CBSA with reclassifications is determined. Using these data and the statewide average wage for all hospitals in the state, CBSA-specific area wage indices are calculated by dividing the average wage for the CBSA by the statewide average wage. This quotient is area wage index B.
- For hospitals that did not reclassify:
  - If area wage index A is greater than one percent variation from its area wage index B, area wage index A will be used. Otherwise, area wage index B will be used.
- For hospitals that reclassified, area wage index B will be used.
- The state will apply a rural floor whereby no hospital will have an area wage index less than the rural index.

Only the labor share of the statewide rate is adjusted by the area wage index using the following formula:

Medical/Surgical Area Wage Index Adjusted Rate = 0.70 x Area Wage Index + 0.30
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5. Cost to Charge Ratio

The operating cost-to-charge ratios described in this section are used to determine adjusted hospital costs as described in the Episode File section. In addition, they are used to reimburse hospitals for transplant services, cost outliers and low-day outliers. The operating cost-to-charge ratios are updated annually on October 1 by rolling the data forward by one year.

The most recent two years of cost report data for hospitals are used to calculate hospital-specific operating cost-to-charge ratios. For example, for the one year rate that begins on October 1, 2015, data from cost reports with fiscal years ending between October 1, 2011 and September 30, 2013 are used. Data for the most recent year are weighted at 60 percent while data for the second previous year are weighted at 40 percent. Costs and charges for both FFS and managed care are combined so that a weighted operating cost-to-charge ratio is developed. Cost and charge data are inflated to a common point in time using inflation factors from IHS Global Insight. The cost-to-charge ratio will not exceed 1.0.

If two or more hospitals merge and are operating as a single hospital, a cost to charge ratio for the period is computed using the combined cost report data from all hospitals involved in the merger.

The operating cost-to-charge ratios are published on the state Inpatient Hospital website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Inpatient Hospitals.

6. Special Circumstances

Normal reimbursement for a medical/surgical inpatient hospital stay is equal to the applicable statewide rate multiplied by the DRG weight. However, for the following special circumstances, different reimbursement methodologies apply.

A. High Cost Outliers

For unusually high cost stays, the State will use a special reimbursement methodology.

An episode is a high cost outlier when costs (charges X the hospital’s operating cost-to-charge ratio) exceed the computed cost threshold. Transplant claims cannot qualify as a high cost outlier.

Reimbursement for cost outliers is dependent upon the cost threshold.

The cost threshold is the greater of:
- $35,000.

Cost outliers are reimbursed according to the following formula:

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(Hospital DRG Rate x Relative Weight) + [(Charges x Operating Cost-to-Charge Ratio) - (Cost Threshold)] x 85 percent) = Reimbursement for Cost Outlier Claim

B. Low Day Outliers

For services where the length of stay is less than the published low day threshold, reimbursement is charges multiplied by the individual hospital's operating cost to charge ratio, not to exceed the full DRG payment. The specific low day outlier threshold for each DRG is listed on the state website.

C. Transfers

Payment to a hospital that receives a patient as a transfer from another inpatient hospital differs depending on whether the patient is discharged or is subsequently transferred again.

1. Payment to the Transferring Hospital

Except in the cases where the DRG is defined as a transfer of a patient (for which a full DRG payment is made, plus an outlier payment, if appropriate) the transferring hospital is paid a DRG daily rate for each day of the beneficiary's stay, not to exceed the appropriate full DRG payment, plus an outlier payment, if appropriate.

2. Payment to the Receiving Hospital

If the patient is discharged, the receiving hospital is paid the full DRG payment, plus an outlier payment if appropriate.

Reimbursement is based on discharge in the following situations. If the beneficiary:

a. Is formally released from the hospital, or
b. Is transferred to home health services, or
c. Dies while hospitalized, or
d. Leaves the hospital against medical advice, or
e. Is transferred to a long-term care facility.

If the patient is transferred again, the hospital is paid as a transferring hospital.

D. Readmissions

Readmissions within 15 days for a related condition, whether to the same or a different hospital, are considered a part of a single episode for payment purposes.

If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment is never less than zero for the episode.

Readmissions for an unrelated condition, whether to the same or a different hospital, are considered separate episodes for payment purposes.

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E. Transplant Services

Transplant services are paid using the following formula:

Hospital Charges x Hospital operating cost-to-charge ratio = Hospital Payment

Transplant services are defined as claims which fall under the following DRGs:

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>001x</td>
<td>Liver Transplant &amp;/or Intestinal Transplant</td>
</tr>
<tr>
<td>002x</td>
<td>Heart &amp;/or Lung Transplant</td>
</tr>
<tr>
<td>006x</td>
<td>Pancreas Transplant</td>
</tr>
<tr>
<td>440x</td>
<td>Kidney Transplant</td>
</tr>
</tbody>
</table>

Organ acquisition within these DRGs is billed at acquisition cost, and is reimbursed at 100% of acquisition cost.

F. Hospitals Outside Michigan

Medical/surgical hospitals not located in Michigan are reimbursed under the DRG system. The DRG price is the statewide rate multiplied by an area wage index of 1.0. All other reimbursement policies apply.

Hospitals that have charges that exceed $250,000 during a single fiscal year (using the State of Michigan fiscal year – October 1st through September 30th) may be reimbursed the hospital’s inpatient operating cost to charge ratio for those Michigan Medicaid DRGs reimbursed by percentage of charge. The hospitals’ chief financial officer must submit and the MSA must accept documentation stating the hospital’s Medicaid cost to charge ratio in the state that the hospital is located. Once accepted, the hospital’s actual cost to charge ratio is applied prospectively to those DRGs and claims subject to percentage of charge reimbursement using the Michigan DRG payment system.

G. New Hospitals

A new medical/surgical hospital is one for which no Michigan Medicaid program cost or paid claims data exists during the period used to establish hospital rates or one which was not enrolled in the Medicaid program when hospital rates were last established. Hospitals that experience a change of ownership or that are created as the result of a merger are not considered new hospitals.

The DRG rate for new general hospitals is the statewide rate multiplied by the applicable area wage index.

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B. Reimbursement for Long Term Acute Care Hospitals (LTACHs) and Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units

Episodes of care for LTACHs and Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units will be reimbursed using a statewide per diem rate.

1. Description of LTACH and Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units Episode File

The episode file is comprised of the underlying data used to calculate the statewide per diem rates. The costs associated with episodes from the episode file are standardized as described below. The episode file is comprised of two years of Medicaid and Children's Special Health Care Services FFS paid claims and managed care encounters.

The data is adjusted to:

- Eliminate episodes with any Medicare charges. (For dual Medicare/Medicaid eligible beneficiaries, only claims paid a full Medicaid payment are included.)
- Eliminate episodes without any charges or days.
- Eliminate episodes with a zero dollar Medicaid liability.
- Limit episodes to those from Michigan hospitals (provided that hospital cost report data is available)
- Limit episodes to those with a valid discharge status.

Total charges and days paid are summed by hospital.

The cost for each hospital is calculated by multiplying the charges for the hospital by the operating cost-to-charge ratio for the hospital.

- See the Cost-to-Charge section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information.

The cost per day by hospital is calculated by dividing the sum of the costs by the number of days for the hospital. To determine a statewide per diem base rate:

- 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.
- Recognize area cost differences by dividing the costs for each hospital by an area wage index.
  - See the Area Wage Index section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information.
- Calculate the statewide operating rate (by provider type). A separate operating rate will be calculated for LTACHs and for Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units. This is a weighted mean of all hospitals' individual rates.
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- The per diem rate for each provider type is the weighted mean adjusted by the area wage index specific to the hospital.

2. LTACH and Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units outside of Michigan

LTACHs, freestanding rehabilitation hospitals, and distinct part rehabilitation units not located in Michigan are reimbursed using the per diem rate applicable to their provider type.

3. New LTACHs, Freestanding Rehabilitation Hospitals, and Distinct Part Rehabilitation Units

If a hospital at least doubles the number of licensed beds in its distinct part unit and the number of licensed beds in the units increases by at least 20, the entire unit is treated as a new distinct part unit for determining the per diem rate. In order for this provision to apply, the hospital must request in writing that the unit is treated as a new unit. The new unit rate will become effective on the date that the number of licensed beds doubles and the increase is at least 20 beds, or the date on which the request is received by MSA, whichever is later.

New LTACHs, freestanding hospitals, and distinct part units are reimbursed using the per diem rate applicable to their provider type.
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Subsections C and D have been eliminated. The next subsection is “E. Frequency of Updates”.

E. Frequency of Updates

The State will update area wage index, cost to charge ratio, relative weights, APR-DRG grouper, DRG rates, and per diem rates on an annual basis.

F. Mergers

1. General Hospitals

In the event of a merger between two or more hospitals, the DRG rate for the surviving hospital will be computed as follows:

   a. The statewide rate will be adjusted by applicable area wage index.
   b. The cost to charge ratios of the hospitals will be combined to create a new cost to charge ratio.
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2. LTACHs, Freestanding Psychiatric and Rehabilitation Hospitals/Distinct Part Psychiatric and Rehabilitation Units

In the event of a merger between two or more hospitals, the resulting per diem rate for the surviving hospital will be computed as follows:

a. The statewide rate will be adjusted by applicable area wage index.

b. The cost to charge ratio of the hospitals will be combined to create a new cost to charge ratio.

G. Other Reimbursement Methods
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1. Sub-Acute Ventilator-dependent Care

Sub-Acute Ventilator-dependent Care - If a hospital has a sub-acute ventilator-dependent care unit, the unit must be certified and meet all other requirements established by the Michigan Department of Health and Human Services.

Each admission must be prior authorized by the Michigan Department of Health and Human Services. Payment for services provided to patients in sub-acute ventilator-dependent units (SVDUCU) is made using a negotiated prospective per diem rate that includes capital and direct medical education costs.

The per diem rate is based on cost estimates for the upcoming year. The negotiated per diem rate is not to exceed the average outlier per diem rate that would be paid for outlier days between DRG 004X and DRG 005X. The payment rate for patients in subacute ventilator-dependent care units is an all-inclusive facility rate. No additional reimbursement is made for capital or direct medical education costs. These units are not eligible for indigent volume adjustor or indirect medical education adjustor payments.

2. Michigan State-Owned Psychiatric Hospitals

Reimbursement to Michigan state-owned psychiatric hospitals is a prospective per diem rate.

H. Disproportionate Share

Minimum Eligibility Criteria

Indigent volume data is taken from each hospital's cost report and from supplemental forms that each hospital must file with its cost report. Data from the most recent available filed cost report are used to calculate a disproportionate share adjustor. New adjustors are calculated and become effective concurrently with annual inflation updates. Separate indigent volume data is collected for and applied to distinct part psychiatric units.

Indigent volume is measured as the percentage of inpatient indigent charges to a hospital's total inpatient charges. Indigent charges are the annual charges for services rendered to patients eligible for payments under the Medicaid, CSHCS and the Adult Benefits Waiver plus uncompensated care charges. Uncompensated care is limited by Medicare standards and is offset by any recoveries.

Each hospital must have a Medicaid utilization rate of at least 1%. Medicaid utilization is measured as:

\[
\text{Medicaid Inpatient Days (Whole Hospital including Subproviders)} \div \text{Total Hospital Days (Whole Hospital including Subproviders)}
\]

Individual inpatient hospital claims will be paid without DSH adjustments. Inpatient DSH payments will be made annually in a single distribution based on charges converted to cost

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using a cost to charge ratio. The payment will be made normally during the first quarter of the state fiscal year. Each hospital's indigent volume will be taken from hospital cost reporting periods ending during the second previous state fiscal year.

Title XIX charges used to compute DSH payments will be the sum of the Title XIX charges and the Title XIX HMO charges from hospital indigent volume reports for cost periods ending during the second previous state fiscal year. Data for cost period of more or less than one year will be proportionally adjusted to one year.

Hospital operating cost ratios will be taken from hospital cost reporting periods ending during the second previous state fiscal year. For hospitals with more than one cost reporting period ending in this date range will have their data from the two periods added and a single ratio will be computed. If the ratio is greater than 1.0 a ratio of 1.0 will be used.

Reimbursement for inpatient services under Title V will not include DSH payments.
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In order to qualify for DSH payments, hospitals must have at least one percent Medicaid inpatient days to total inpatient days.

Hospitals that fail to supply indigent volume data will not be eligible to receive disproportionate share payments.

For new hospitals, disproportionate share payments will be withheld until the hospital’s indigent volume can be calculated and applied in the normal update process.

For new distinct part psychiatric units of general hospitals, the indigent volume data from the general hospital will be used to determine DSH payments applicable to the distinct part psychiatric units until the unit’s indigent volume can be calculated and applied in the normal update process.

To be eligible to receive DSH payments, hospitals must also meet at least one of the following criteria. Except for hospitals and distinct part psychiatric units eligible under the fourth criteria (>) listed below, hospitals will be contacted annually by letter and asked to report their status on these criteria.

The hospital must:

- have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are eligible for Medicaid services; or
- be located in a rural area (as defined for purposes of section 1886 of the Social Security Act) and have at least two (2) physicians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are eligible for Medicaid services; or
- serve as inpatients a population predominantly comprised of individuals under 18 years of age; or
- as of December 22, 1987, not have offered non-emergency obstetric services to the general population.

1. Inpatient Hospitals

State fiscal year 1997 disproportionate share hospital payments for services in all hospitals, except for state-owned mental hospitals, are fixed at $45 million. The pool allocations were determined as follows:

\[ \frac{\sum \text{DSH Shares for Group}}{\text{Total DSH Shares}} \times 45 \text{ Million} \]

The determination of the share of the allocated DSH pool will be made using the DSH share. The payment will be made by:
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\[
\frac{\text{Hospital's DSH Share}}{\sum \text{DSH Shares for the Group}} \times \text{Allocated DSH Pool}
\]

The individual pool amounts are listed below.

a. DRG Reimbursed Hospitals

The DSH payments for DRG reimbursed hospitals are split into two pools. The indigent volume is shown on hospital price sheets for rates effective October 1, 1992.

- Hospitals with at Least 50% IV

The share of the DSH payment paid to hospitals with at least 50% indigent volume (IV) is approximately $7.3 million and is based on a DSH computed as:

\[
\text{Title XIX Charges} \times \text{Operating Ratio} \times (\text{IV} - 0.5)
\]

- Hospitals with at Least 20% IV

The share of the DSH payment paid to hospitals with at least 20% IV is approximately $30.2 and is based on the following DSH amount. This is in addition to the amount above:

\[
\text{Title XIX Charges} \times \text{Operating Ratio} \times (\text{IV} - 0.2)
\]

b. Per Diem Reimbursed Hospitals
   (Including TEFRA Option Rehab Hospitals)

Per diem reimbursed hospitals are allocated approximately $7 million for DSH payments. The per diem factor is set prospectively using current indigent volume survey data. The share of the DSH paid to hospitals with IV of at least 20% is based on a DSH share of:

\[
\text{Title XIX Charges} \times \text{Operating Ratio} \times (\text{IV} - 0.2)
\]
c. Distinct Part Rehab Units

*Title XIX Charges x Operating Ratio x (IV - 0.2)*

2. Special Pools

In addition to the regular DSH pools of $45,000,000, the single state agency (SSA) is establishing the following special pools:

a. Effective June 1, 2006, a separate DSH pool will be created annually for areas covered by an Indigent Care Agreement (ICA) approved by the Director of the SSA. The areas covered by an ICA must be within reasonable geographic proximity to the hospital receiving the ICA DSH payment. The ICA must be between the hospital and a partner health care related entity in the area. The ICA must stipulate that direct or indirect healthcare services be provided to low-income patients with special needs who are not covered under other public or private health care programs. This pool will be $172,343,362 in fiscal year 2006, $147,687,951 in fiscal year 2007, $122,707,686 in fiscal year 2008, $110,937,485 in fiscal year 2009, $125,001,655 in fiscal year 2010, $107,926,496 in fiscal year 2011, $124,803,035 in fiscal year 2012, $111,026,217 in fiscal year 2013, $86,173,665 in fiscal year 2014, $10,000,000 in fiscal year 2015, and $0 in fiscal year 2016 and each subsequent fiscal year. All payments made under (a) in fiscal year 2006 will occur on or after June 1, 2006. No payment will be made under (a) to any hospital with a contractual obligation to forward that payment to a partner health care related entity in the area.

To be eligible for DSH payments made under (a), hospitals must meet minimum federal requirements for Medicaid DSH payments and have an approved ICA in place. A table showing the eligible hospitals and their annual allocations from this pool is included in Appendix B.

b. The single state agency (SSA) is creating a special DSH payment pool of $2,772,003 million in fiscal year 2005, $2,764,340 for fiscal years 2006 – 2012, and $3,500,000 for each subsequent fiscal year.

The purpose of this pool is to:

- Assure continued access to medical care for indigents, and
- Increase the efficiency and effectiveness of medical practitioners providing services to Medicaid beneficiaries under managed care.

The SSA will approve one (1) agreement statewide each state fiscal year. To be eligible for the pool, a hospital must meet the following criteria:

- Meet the minimum federal requirements for DSH eligibility listed in Section III.H.
- Have in place an approved agreement between itself and a university with both a college of allopathic medicine and a college of osteopathic medicine that specifies all services and activities to be conducted.

This agreement shall not require the hospital to donate money or services to the other party in the agreement.
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All payments made under (b) in fiscal year 2006 will occur on or after September 27, 2006. Effective September 27, 2006, no payment will be made under (b) to any hospital with a contractual obligation to forward that payment to a university with both a college of allopathic medicine and a college of osteopathic medicine.

Note: Subsection "c" has been deleted. The next subsection is "d".

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Note: Subsection "d." has been deleted. The next subsection is "e."
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c. Institute for Mental Disease

A special DSH pool of $144,665,900 will be established to take into account the situation of State psychiatric hospitals that serve indigent persons with serious mental illness requiring inpatient treatment. For fiscal year 2010 and subsequent fiscal years, the pool size will equal the calculated Institutions for Mental Diseases (IMD) DSH limit (including the state share), reduced by all other DSH payments that IMDs are scheduled to receive that fiscal year. To qualify for this pool, a hospital must comply with all of the following conditions:

1) Meet minimum federal requirements for Medicaid DSH Payments including
   a. requirements for participation as a hospital under 42 CFR 482.1(a)(5)
   b. a valid provider agreement under 42 CFR 431.107
   c. at least a one percent Medicaid inpatient utilization rate based on active participation in the Medicaid program as required under section 1923(d) of the Social Security Act
   d. when calculating DSH limits at 1923(g) excluding uncompensated costs incurred in providing inpatient and outpatient hospital services to Medicaid and uninsured patients who are considered prisoners consistent with Section 1905(a) of the Social Security Act and the regulations at 42 CFR 435.1008 and 435.1009 which prohibit (FFP) for services provided to inmates of public institutions.

2) Function as one of the following stand-alone psychiatric hospitals operated by the state:
   1. Walter P. Reuther Psychiatric Hospital
   2. Caro Regional Mental Health Center – Psychiatric Hospital
   3. Kalamazoo Psychiatric Hospital
   4. Hawthorn Center – Psychiatric Hospital
   5. Center for Forensic Psychiatry

Payments from the pool will be distributed sequentially to the hospitals listed in condition two above based on the order they are listed. They will be distributed up to each qualified hospital’s DSH ceiling as specified below. Payments will be distributed to the first hospital meeting the minimum Federal requirements for Medicaid DSH funding up to its DSH ceiling. Once this occurs, payments will be distributed to the second hospital meeting the minimum Federal requirements for Medicaid DSH funding up to its DSH ceiling. Payments will continue to be distributed to the third, fourth and fifth hospitals using the same methodology until all hospitals have reached their DSH ceilings or until the pool is exhausted of funds.

Notwithstanding the above, no payment will be made to the Center for Forensic Psychiatry until the State demonstrates to the Secretary that all the Federal conditions for Medicaid DSH payment listed above have been met.

Payments to individual hospitals are limited to hospital specific DSH limits defined in section 1923(g) of the Social Security Act.
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f. Government Provider DSH Pool

A special pool for non-state government-owned or operated hospitals will be established and renewed annually. The purpose of the pool is to assure funding for costs incurred by public facilities providing inpatient hospital services which serve a disproportionate number of low-income patients with special needs. The size of the pool will be the lesser of $88,168,000 for fiscal year 2006, $62,064,198 for fiscal year 2007, $49,172,890 for fiscal year 2008, $73,117,228 for fiscal year 2009 and 2010, $82,086,703 for fiscal year 2011 and each subsequent fiscal year, or the calculated Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care amounts eligible for Federal financial participation. Allocations for individual hospitals will be determined based upon non-reimbursed costs certified as public expenditures in accordance with 42 CFR 433.51.

To be eligible for the Government Provider DSH Pool, the following must apply:

1. Hospitals must meet minimum federal requirements for Medicaid DSH payments; and
2. Hospitals must be non-state government-owned or operated.

Medicare 2552 cost reports, supplemented by Michigan Medicaid Forms (MMFs) will be used to determine each hospital’s allowable DSH costs eligible for federal financial participation.

An interim payment and reconciliation process will be employed when making allocations from this pool. Allowable DSH costs will be determined based on information obtained from the cost report periods ending during the second previous state fiscal year. Costs will be obtained from the most recently filed Medicare 2552 cost report and Michigan Medicaid Forms for that period. These costs will be trended to the current state fiscal year using an inflation factor taken from Health-Care Cost Review published quarterly by Global Insight. Interim payments will then be made.

Interim payments will be reconciled twice. First, an interim reconciliation of the original payments will be conducted based on updated allowable DSH costs. Information needed to reconcile initial payments will be obtained from hospital Medicare 2552 cost reports filed with the fiscal intermediary and Michigan Medicaid Forms for the applicable reporting period. Second, payments will be adjusted for a final time based on Medicare 2552 cost reports finalized with the fiscal intermediary and Michigan Medicaid Forms for the applicable reporting period.
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Aggregate DSH expenditures will be made in accordance with Section 1923(g)(1)(A) of the Social Security Act. Prior to computing the amount of payment each individual hospital is eligible to receive from this pool, all other DSH and Medicaid payments that the hospital is scheduled to receive will be counted against the hospital’s DSH limit.

g. Outpatient Uncompensated Care DSH Pool

A special pool will be created annually for the purpose of reimbursing hospitals for a portion of their uncompensated care. The pool amount will be $145,000,000 in fiscal year 2015 and each subsequent fiscal year. Payments from the pool will be made annually.

In order to qualify for a payment from the Outpatient Uncompensated Care DSH Pool, hospitals must meet the minimum requirements for Medicaid DSH payments as specified in Section H. Funds will be distributed from the Outpatient Uncompensated Care DSH Pool to qualifying Privately-Owned or Operated and Non-State Government-Owned or Operated DSH eligible hospitals in Michigan.

The Outpatient Uncompensated Care DSH Pool will be split into Small and Rural and Large-Urban components as follows:

<table>
<thead>
<tr>
<th>Component</th>
<th>FY 2015 and Subsequent Fiscal Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small and Rural components</td>
<td>$45,000,000</td>
</tr>
<tr>
<td>Large-Urban components</td>
<td>$100,000,000</td>
</tr>
<tr>
<td>TOTALS</td>
<td>$145,000,000</td>
</tr>
</tbody>
</table>

For purposes of distributions from this pool, any qualifying DSH hospital located in Michigan with less than 100 acute care beds or any qualifying DSH hospital located in a Michigan rural or Micropolitan County will be eligible to receive a proportional share of the Small and Rural components of the pool.

Also for purposes of distributions from this pool, any qualifying DSH hospital with 100 or more acute care beds and located in an urban Michigan county will be eligible to receive a proportional share of the Large-Urban components of the pool.

The distribution of funding from the Outpatient Uncompensated Care DSH Pool will be based on each hospital’s proportion of outpatient uncompensated care relative to other hospitals in the pool. The formula below will be used to calculate the distribution of payments from the Outpatient Uncompensated Care DSH Pool.

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Each hospital's data for the formula will be taken from hospital cost reports for cost periods ending during the second previous state fiscal year.

1. \( \frac{\text{Hospital Title XIX Outpatient FFS Payments}}{\text{Hospital Title XIX Outpatient FFS Charges}} = \text{Hospital Title XIX Outpatient Payment to Charge Ratio} \)

2. \( \text{Hospital Uncompensated Outpatient Charges} - \text{Hospital Uncompensated Outpatient Payments} = \text{Net Hospital Uncompensated Outpatient Charges} \)

3. \( \text{Hospital Title XIX Outpatient Payment to Charge Ratio} \times \text{Net Hospital Uncompensated Outpatient Charges} = \text{Net Hospital Outpatient Uncompensated Title XIX Equivalent Payments} \)

4. \( \frac{\text{Net Hospital Outpatient Uncompensated Title XIX Equivalent Payments}}{\sum \text{Net Hospital Outpatient Uncompensated Title XIX Equivalent Payments}} = \text{Outpatient Uncompensated DSH Hospital Pool Factor} \)

5. \( \text{Outpatient Uncompensated DSH Hospital Pool Factor} \times \text{Outpatient Uncompensated DSH Pool Component Amount} = \text{Outpatient Uncompensated DSH Hospital Pool Component Payment} \)

Beginning in FY 2015, $5,000,000 of the large-urban component of the pool will be distributed to reward and incentivize hospitals providing low cost and high quality Medicaid services. The Medicare Value Based Purchasing (VBP) Adjustment Factor will be obtained annually from the Federal Register. Each hospital’s respective payment from the $5,000,000 pool component will be calculated as follows:

- \( \text{Hospital's Outpatient Uncompensated DSH Hospital Pool Factor} \times \text{Hospital's VBP Adjustment Factor} = \text{Hospital's Outpatient Uncompensated DSH Value Adjustment Factor} \)

- \( \text{Hospital Outpatient Uncompensated DSH Value Adjustment Factor} / (\sum \text{All Hospital Outpatient Uncompensated DSH Value Adjustment Factors}) \times \text{Total Pool Amount} = \text{Outpatient Uncompensated DSH Value Payment} \)

Payments to individual hospitals will be limited to the room available under each hospital's specific DSH ceiling. If payments calculated for individual hospitals exceed that hospital's DSH ceiling, the amounts in excess of the ceiling will be placed back into the pool. These amounts will then be reallocated to the remaining hospitals in the pool which have not exceeded the room available under their individual hospital DSH ceiling based on the formula above. This process will be repeated as many times as necessary to expend all funds in the pool.

h. Harper University Hospital DSH Pool

Effective for FY 2014, a one year DSH pool will be established totaling $9,994,952 to be distributed to Harper University Hospital. This pool will be used to reduce uncompensated care the hospital incurs delivering newborns at that location. Harper University Hospital is the largest Medicaid birthing hospital in the state, performing over 3,800 Medicaid newborn deliveries. This equates to 8% of all Medicaid deliveries in the State.

3. Public Hospitals DSH Sunset Provision

Medicaid DSH payments to public hospitals are made up to the public hospital DSH ceiling as permitted by current federal regulations.

These payments are authorized to continue through September 30, 2005. The state may submit state plan amendments effective after September 30, 2005 that re-implement the current payment structure or different payment methodologies.

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4. DSH Process

The State will implement a multiple-step DSH process as follows.

**Step 1: Initial DSH Calculation Step**

Hospital-specific DSH limits, DSH payment allocations and Medicaid utilization rates will be calculated during the State FY as part of its Initial DSH Calculation. Inpatient and outpatient cost and payment data from the hospital’s cost reporting period ending during the second previous State FY will be used for the DSH limit, DSH payment and Medicaid utilization rate calculations. The data will be trended to the current FY for DSH limit calculation purposes. The State will trend base year hospital costs using the CMS Hospital Prospective Reimbursement Market Basket to approximate current year costs. Costs will be prorated on a quarterly basis based on the fiscal years of the respective hospitals. The State will also trend base year costs and payments using a volume trend based on changes in the Medicaid caseload from the base year period to the current year to approximate current year volume.

Beginning with State FY 2013, hospitals will be able to decline DSH funds and also request a downward adjustment to their DSH limit during the Initial DSH calculation. Upon receipt of this feedback from hospitals, each hospital’s calculated DSH limit will be reduced to the requested amount. If a hospital declines the DSH funds, the State will recalculate DSH amounts with that hospital’s limit at zero. To the extent that payment allocations are affected by a hospital’s request to reduce its DSH limit or decline DSH payments altogether, payments from the applicable pool(s) will be allocated to other hospitals eligible for payments from the pool(s). If no hospital is eligible to accept the DSH payment during this step, the unpaid amount will be paid to eligible hospitals during the Step 2: Interim DSH Settlement calculations. No hospital will receive a DSH payment in excess of its initial DSH limit.
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DSH payments will be applied against a hospital's DSH limit in the following order:

1. Institute for Mental Disease Pool
2. Harper University DSH Pool
3. $45 Million Pool
4. Outpatient Uncompensated Care DSH Pool
5. University with Both a College of Allopathic Medicine and a College of Osteopathic Medicine Pool (University Pool)
6. Indigent Care Agreements Pool (ICA Pool)
7. Government Provider DSH Pool (GP Pool)

Step 2: Interim DSH Settlement Step

DSH limits, DSH payments and Medicaid utilization rates are recalculated using new cost report data during the Interim DSH Settlement step. DSH funds will be reallocated in a manner that maintains the pool order outlined in the Initial DSH Calculation step.

The State will recalculate hospital-specific DSH limits, DSH payment allocations and Medicaid utilization rates following the year following the applicable DSH year. Inpatient and outpatient cost and payment data from cost reports with hospital FYs ending during the previous calendar year will be utilized for DSH limit, DSH payment, and Medicaid utilization rate recalculations. For example, during 2012, data from hospital cost reports with FYs ending between January 1, 2011 and December 30, 2011, will be used to complete the FY 2011 Interim DSH Settlement calculations. The State will maintain its current pool-specific payment allocation during this step.

Beginning with State FY 2011, hospitals will be able to decline DSH funds and also request a downward adjustment to their DSH limit during the Interim DSH Settlement. Upon receipt of this feedback from hospitals, each hospital's calculated DSH limit will be reduced to the requested amount.

If a hospital declines DSH funds, the State will recalculate DSH amounts with that hospital's limit at zero. To the extent that payment allocations are affected by a hospital's request to reduce its DSH limit or decline DSH payments altogether, payments from the applicable pool(s) will be allocated to other hospitals eligible for payments from the pool(s). If no hospital is eligible to accept the DSH payment during this step, the unpaid amount will be paid to eligible hospitals during the Step 3: Final DSH Audit-Related DSH Redistribution calculations.

No hospital will receive a DSH payment in excess of its Interim DSH Settlement limit.

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Step 3: Final DSH Audit-Related DSH Redistribution

If the Final DSH Audit determines that a hospital has been paid in excess of its hospital-specific DSH limit, funds will be recovered from hospitals in the following order:

1. Funds from pools allocated exclusively to State government-owned or operated, or non-State government-owned or operated public hospitals
2. All other DSH Pools

The State will recoup all payments that exceed audited hospital-specific DSH limits in the order stated above and then apply the following redistribution process. Only funds that exceed the audited hospital-specific DSH limit will be recovered and redistributed:

1. Funds recovered from pools allocated exclusively to State government-owned or -operated, or non-State government-owned or -operated public hospitals are reallocated to other like hospitals up to the lesser of the audited hospital-specific limits or other Federal limits. No hospital is to receive a DSH payment that exceeds its audited hospital-specific DSH limit. Unspent DSH funds will be added to the “All Other DSH Pools” described in Step 2 below. The formulas to redistribute these recouped funds are as follows:

   a. \( \frac{\text{(Eligible Hospital’s Remaining Audited DSH Limit Capacity)}}{\sum \text{(all Eligible Hospitals’ Audited Remaining DSH Limit Capacity)}} \times \text{(Hospital Pool Factor)} = \text{Pool Payment} \)

2. Funds recovered from the other DSH pools, plus any unspent DSH funds recouped from pools allocated exclusively to State government-owned or -operated, or non-State government-owned or -operated public hospitals, are reallocated to all remaining eligible hospitals proportionately based on their share of remaining audited hospital-specific DSH limit capacity adjusted to exclude the DSH payment amounts hospitals received from the ICA, University and GP DSH Pools during the Initial DSH Calculation and Interim DSH Settlement steps. No hospital will receive an allocation in excess of its remaining audited hospital-specific DSH limit capacity or other federal limits. The formulas to redistribute these recouped funds are as follows:

   a. \( \frac{\text{(Eligible Hospital’s Remaining Audited DSH Limit Capacity + ICA DSH Payment Amount + University DSH Payment Amount + GP DSH Payment Amount)}}{\sum \text{(all Eligible Hospitals’ Audited Remaining DSH Limit Capacity + ICA DSH Payment Amount + University DSH Payment Amount + GP DSH Payment Amount)}} \times \text{(Hospital Pool Factor)} = \text{Pool Payment} \)
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b. (Hospital Pool Factor) x (Pool Amount) = Pool Payment

Pool payments calculated for individual hospitals that are in excess of a hospital's audited DSH limit will be placed back into that pool. These payments will then be reallocated to the remaining hospitals in that component of the pool which have not exceeded their audited hospital-specific DSH limit capacity. The reallocation will be based on the funding formula specified above. Only hospitals with available audited DSH limit capacity will be included.

In addition, any unspent Federal DSH allotment will be distributed using the formula outlined in Step 3: Final DSH Audit-Related DSH Redistribution through a new pool. Funds from this pool will first be allocated to state government-owned or –operated hospitals up to applicable Federal DSH limits. Any remaining unspent DSH allotment will be allocated proportionally to all other hospitals based on remaining DSH limit capacity.

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Methods of Payment of Reasonable Costs - Inpatient Hospital Services

I. Capital

Capital costs are reimbursed using a hospital-specific prospective rate. A prospective per-discharge amount will be calculated for medical/surgical hospitals, including critical access hospitals and children’s hospitals. State-owned psychiatric hospitals, freestanding rehabilitation hospitals and distinct part rehabilitation units will be reimbursed a prospective per diem capital rate.

When calculating the prospective capital rates, data from the second previous state fiscal year will be used. For example, capital costs from a hospital’s September 30, 2013 cost report will be used to calculate that hospital’s 2015 prospective capital rate.

Effective January 1, 2015, the capital amount for the medical/surgical component of the hospital is established using the following lines (or comparable lines from succeeding cost reports) from the hospital’s cost report. The data for routine capital costs is obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX Column 7, Lines 30-35 and 43. The ancillary capital costs are obtained from the CMS 2552-10 Worksheet D, Part II, Title XIX, Column 5, Lines 50-77 and 90-92. The sum of routine and ancillary cost for FFS is then divided by the medical/surgical FFS discharges for the same period to calculate the hospital-specific prospective per discharge rate. Effective October 1, 2015, the FFS data described above will be combined with the equivalent managed care data to calculate each hospital’s capital rate.

Effective January 1, 2015, the capital amount for freestanding rehabilitation hospitals or distinct part rehabilitation units is established using the following lines (or comparable lines from succeeding cost reports) from the hospital’s cost report. The data for routine capital costs is obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX, Line 41. The ancillary capital costs are obtained from the CMS 2552-10, Worksheet D, Part II, Title XIX, Column 5, Lines 50-76.99 and 90-92. The sum of the routine and ancillary cost for FFS is then divided by the FFS rehabilitation Medicaid days for the same period to calculate the hospital-specific prospective per diem rate. Effective October 1, 2015, the FFS data described above will be combined with the equivalent managed care data to calculate each hospital’s capital rate.

Capital amounts may be adjusted due to significant changes in capital costs that are not reflected in the most recent cost report.

The Medicaid share of allowable capital costs is determined using Medicare Principles of Reimbursement.

Net licensed beds are used to determine net licensed bed days for capital reimbursement and include all beds temporarily delicensed, except for rural banked beds, with rural as defined under section 2 below. Net licensed bed days are:

Total Licensed Bed Days - Rural Banked Bed Days

A hospital may apply for a reduction in net licensed beds days to subtract bed days unavailable due to construction or renovation. Such a reduction is only available for beds which are taken out of service for construction or renovation for a limited period of time and which are returned to active inpatient service at the end of the construction or renovation project. Documentation of the construction or renovation project will be required.

Occupancy limits described below will be observed when the hospital specific capital rates are set. Occupancy limits will not apply to state psychiatric hospital capital rates.

Occupancy is:

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Total Inpatient Days (Including Nursery Days)
Net Licensed Beds Days

1. Sole Community Provider Eligible Hospitals

If the hospital is eligible for sole community provider status (as defined by Medicare standards), the Medicaid share of allowable capital costs is reimbursed in full.

The Medicaid share of allowable capital costs of any distinct part psychiatric units in sole community provider eligible hospitals is reimbursed in full.

2. Rural Hospitals

If a hospital is located in a rural area (defined as located outside a city of 40,000 or more people by a distance of 10 miles or more and based on U.S. Census Bureau population data) capital reimbursement will be limited if occupancy in the hospital is less than 60% during the hospital’s fiscal year. For hospitals with occupancy less than 60%, the Medicaid reimbursement for capital will be:

\[
\text{Occupancy} \times \frac{\text{Medicaid Share of Capital}}{0.6}
\]

If occupancy is at least 60%, the Medicaid reimbursement for capital will be 100% of the Medicaid share of Capital.

3. Other Hospitals

If a hospital is not eligible to be a sole community provider and is not located in a rural area, capital reimbursement will be limited if occupancy in the hospital is less than 75% during the hospital’s fiscal year. For hospitals with occupancy less than 75%, the Medicaid reimbursement for capital will be:

\[
\text{Occupancy} \times \frac{\text{Medicaid Share of Capital}}{0.75}
\]

If occupancy is at least 75%, the Medicaid reimbursement for capital will be 100% of the Medicaid share of capital.

4. Hospitals Outside of Michigan

Medical/surgical hospitals not located in Michigan receive a per case add-on amount to cover capital cost.

Freestanding psychiatric hospitals and distinct part psychiatric units of hospitals not located in Michigan receive a per day add-on amount to cover capital cost.

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The add-on amount is an estimate of the statewide average paid to hospitals located in Michigan. Capital payments to out-of-state hospitals are not cost settled.

J. Graduate Medical Education

Dental and Podiatry Residence Programs

To obtain an average FTE payment for dental and podiatry residents, the GME liability for those hospitals operating only dental and podiatry residency programs will be summed. Each hospital’s GME liability will be taken from calendar year 1995 estimates of GME liability used to make GME payments to hospitals between July 1, 1997 and December 31, 2001. The summed total of these liabilities will be divided by the total number of dental and podiatry FTEs (for the same hospitals that the liability data is drawn). The FTEs will be drawn from hospital cost reports from the first state fiscal year for which complete data is available. The product will be an average dental and podiatry FTE dollar payment to all hospitals reporting these FTEs.

Annually each hospital reporting dental and podiatry FTEs will be reimbursed the average dental and podiatry FTE payment as calculated above for each of its dental and podiatry FTEs. Hospital FTEs will be drawn from hospital cost reports for the most recent state fiscal year for which complete data is available (this will be the same FTE count used to distribute the GME Funds and Primary Care Pools).

The dental and podiatry FTE payments made to all hospitals will be summed and the total will be deducted from the GME Funds Pool before any other distributions are made from this pool. Once the dental and podiatry FTE payments have been deducted, the remaining funds in the GME Funds Pool will be distributed as described below in the sections labeled GME Funds Pool and Primary Care Pool.

Each hospital’s dental and podiatry FTE count and the total dollar amount allocated to pay hospitals for dental and podiatry FTEs will be updated annually. The average dental and podiatry FTE dollar payment will not. The average dental and podiatry FTE dollar payment will only be adjusted when the GME Funds and the Primary Care Pools are adjusted. Any adjustment to the average dental and podiatry FTE dollar payment will be proportional to the changes in these two pools.

Distribution of GME Funds

Distribution of graduate medical education funds will be calculated annually to coincide with the state fiscal year (October 1 to September 30) for two formula pools – the GME Funds and the Primary Care Pools. In order to receive funds for graduate medical education, a hospital must have operated a nationally accredited medical education program(s) in the fiscal year that data is drawn from the hospital cost reports used to calculate the GME payments. Payments will be fixed, prospective payments made in full and are not subject to future cost settlement or appeal. Payments will be made only to hospitals that provide requested information by the dates required. Separate gross adjustments will be made for each pool payment.

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Only intern and resident FTEs in approved programs as specified in 42 CFR 413.75 will be eligible for inclusion in the data used to calculate the distribution of the GME Funds and Primary Care Pools.

To distribute funds from the GME Funds and the Primary Care Pools, data will be drawn from accepted hospital cost reports for the most recent fiscal year that data is available. For the GME Funds Pool, the un-weighted full-time-equivalent (FTE) count will be used (line 3.05 from E-3, Part IV). For the Primary Care Pool, the weighted FTE count for primary care physicians will be used (line 3.07 from E-3, Part IV). If the cost report is changed, equivalent data will be used.

Both the hospital and its residency programs must be operating during the funding period in order to receive GME funds. Hospitals must notify the department in writing at least 30 days prior to the termination date of any of its residency programs. Funds distributed to ineligible hospitals are subject to recovery.

GME payments to hospitals that merge during an academic year will be combined, provided that the surviving hospital continues to operate all residency programs that the pre-merger hospitals operated. The surviving hospital must notify the department within 30 calendar days after the merger is completed, of any reductions or terminations to its residency programs. The GME payments to the surviving hospital will be reduced proportionately to the reduction in its GME programs. Overpayments to surviving hospitals based on reductions in GME programs are subject to recovery.

GME Pool

To calculate each eligible hospital’s share of the GME FUNDS Pool the following formulas will be used:

\[ \text{FTEs} \times \text{Casemix} \times \left( \frac{\text{Hospital's Title V & Title XIX Days}}{\text{Hospital's Total Days}} \right) = \text{Adjusted FTEs} \]

\[ \text{GME Funds Pool Size} \times \left( \frac{\text{Adjusted FTEs}}{\sum \text{Adjusted FTEs}} \right) = \text{Hospital's Distribution} \]

In FY 2007, the GME Funds Pool size will be $83,669,700. For FY 08 through FY 2011, the GME Funds Pool size will be $61,406,400. For FY 2012, the GME Funds Pool size will be $52,797,200. For FY 2013 and each subsequent year, the GME funds pool size will be $52,565,600.

Primary Care Pool

To calculate each hospital’s share of the Primary Care Pool, the following formula will be used:

\[ \text{FTEs} \times \left( \frac{\text{Hospital's Title V & Title XIX Outpatient Charges}}{\text{Hospital's Total Charges}} \right) = \text{Adjusted FTEs} \]

\[ \text{Primary Care Pool Size} \times \left( \frac{\text{Adjusted FTEs}}{\sum \text{Adjusted FTEs}} \right) = \text{Hospital’s Distribution} \]
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In FY, 2007 the Primary Care Pool size will be $10,285,100. For FY 2008 through FY 2011, the Primary Care Pool size will be $7,548,400. For FY 2012 and each subsequent year, the primary care pool size will be $10,322,700.

Definitions/Notes

Title V & Title XIX Days – includes fee-for-service days. Days will include those from distinct-part psychiatric and distinct-part rehabilitation units.

Title V & Title XIX Outpatient Charges – includes fee-for-service outpatient charges. Charges will include those from distinct-part psychiatric units.

Hospital’s Case Mix – the sum of the relative weights for all Medicaid admissions divided by the number of Medicaid admissions during the period covered.

# of Hospital Eligible Resident FTEs – for the GME Funds and Primary Care Pools FTE data will be drawn from hospital cost reports as indicated above.

GME Payment Schedule

Payments from the GME funds and the Primary Care Pools are made quarterly, in four equal payments. The dental and podiatry pool payment is made once annually during the final quarter of the state fiscal year.

GME Innovations Pool

The GME Innovations Pool is established to support innovative GME programs that emphasize the importance of coordinated care, health promotions and psychiatric care in integrated systems. The purpose of this training is to develop the skills and experience necessary to provide psychiatric services utilized by Michigan Medicaid patient groups.

The single state agency will approve three (3) agreements statewide each fiscal year. One agreement will be with Detroit Receiving Hospital for $8,929,800. The second agreement will be with Hurley Medical Center for $2,018,078 in FY 2018. In FY 2019 and future years, the agreement will amount to $4,381,078. The third agreement will be with Pine Rest Christian Mental Health Services. In FY 2017, the agreement will amount to $3,960,000. In FY 2018, the agreement will amount to $6,336,000. In FY 2019 and future years, the agreement will amount to $7,603,200. To be eligible for the pool, a hospital must meet the following criteria:

- The hospital must be a Medicaid enrolled provider.
- The hospital must have in place an approved agreement between itself, a university psychiatric residency training program and one or more community mental health services programs to provide accredited psychiatric residency training.
- The hospital must provide assurances that all training will take place in Michigan and prepare health care professionals to provide care to populations with the special characteristics of Michigan Medicaid patient groups.

Upper Payment Limit

In the event that GME distributions would result in aggregate Medicaid payments exceeding the upper payment limit (UPL), the size of the pool(s) and/or additional payments will be reduced to bring aggregate Medicaid payments within the UPL.
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GME Innovations Sponsoring Institution Programs

The GME innovations sponsoring institution program supports limited non-hospital affiliated GME programs that meet requirements listed below. This includes sponsoring institutions whose primary purpose is to provide educational programs and/or health care services. A sponsoring institution assumes the financial and academic responsibility for a GME program.

The single state agency will approve one (1) agreement statewide each fiscal year. This agreement will be with Authority Health for $2,800,000 for FY 2017 and $3,100,000 for FY 2018 and subsequent years. To be eligible for the GME innovations program without a hospital partner, an organization must meet the following criteria:

- The organization must possess appropriate accreditation credentials.
- The organization must meet the requirements associated with receiving Medicaid payments.
- The organization must have an approved agreement with a sponsoring institution, a university psychiatric residency training program and one or more community mental health services programs to provide accredited psychiatric residency training.
- The organization must provide assurances that all training will take place in Michigan and prepare health care professionals to provide care to populations with the special characteristics of Michigan Medicaid patient groups.
- If GME distributions exceed the expenses incurred by the sponsoring institution in residency training, the size of the payment will be reduced to bring these elements into alignment.

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IV. Appeals

A. Price Appeals

The MSA will consider appeal requests received within thirty (30) calendar days from the date of notice to the hospital advising it of a change in its pricing components. Appeal requests must be submitted in writing to the MSA. Requests must clearly state the item(s) being appealed, the remedy being sought and must include all necessary documentation to support the hospital's position. Appeal requests received after thirty (30) calendar days will not be accepted. Appeal requests may not be used as a means to delay submission or fail to produce cost reports in the format and within the time frame required. Failure to include all necessary documentation to support the hospital's position may result in a hospital's appeal request being rejected.

Items subject to appeal include:

1. Interpretations and/or application of program:
   a) Policy
   b) Procedures
   c) Formulas
   d) Pertinent laws and regulations (e.g. Code of Federal Regulations, HIM-15, etc.)

2. Incorrect data and/or paid claims information used in price calculations – excluding data and paid claims information from the hospital's annual cost report previously submitted by it and accepted by the MSA.

Items not subject to appeal include:

1. Data previously submitted by the hospital and accepted by the MSA
2. The establishment and use of DRGs
3. The Medicare Principles of Reimbursement (e.g. 42 CFR, HIM-15, etc.) as adopted by the MSA and used to reimburse providers
4. The use of relative weights as part of the DRGs
5. Interim payment rates which are in compliance with state and/or federal regulations, and

Appeal requests must be sent to: Appeals Section, Department of Community Health, P.O. Box 30479 Lansing, Michigan 48909.

B. Appeal Process

Upon receipt of an appeal request, a bureau conference is scheduled and conducted by a MSA staff person from the Appeals Section. During this conference, issues related to the appeal are discussed by the MSA staff and hospital representatives.

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Failure to appear at a scheduled bureau conference without good cause and reasonable
advance written or telephone notification to the MSA staff person assigned to the appeal
is considered an abandonment of the appeal.

After the bureau conference, a final determination notice is sent to the hospital outlining
the MSA position on the item(s) appealed.

A price appeal decision may include a correction to the data used to set rates. If so, the
corrected data is used beginning with the rate period for which the appeal was filed. Data
corrections and any resultant price component changes which are accepted through pre-
hearing conference or prevail at hearing are made for the current base period only for the
hospital filing the appeal. The MSA may make changes to price components which affect
all providers in subsequent rebasing periods.

Hospitals wishing to proceed to the next level of the appeal process have two options:

- The hospital may elect to appeal through an administrative hearing as provided in
  the department's administrative rules, R400.3406 through R400.3424.
  Administrative appeal requests must be sent to: Administrative Tribunal, Health
  Legislation and Policy Development, Department of Community Health, P.O. Box
  30479, Lansing, Michigan 48909.

- The hospital may waive its right to appeal through the administrative rules,
  R400.3406 through R400.3424, and instead elect to request a hearing before the
  State Hospital Appeal Panel. A waiver statement, signed by a duly authorized
  representative of the hospital, must accompany the appeal request. Appeals to
  this panel must be sent to: State Hospital Appeals Panel Coordinator, Department
  of Community Health, P.O. Box 30479, Lansing, Michigan 48909.

Only issues raised at the bureau conference are accepted for review at either of the two
hearing processes. Appeal requests must be received by the MSA within thirty (30)
calendar days from the date of the final determination notice sent to the hospital
subsequent to the bureau conference. Failure to submit an appeal request within thirty
(30) calendar days shall be deemed an abandonment by the hospital of all further
administrative appeal rights.

C. Administrative Hearings

Hearings conducted by the department's Administrative Tribunal follow the Department of
Community Health's Medicaid Provider Reviews and Hearings rules found at R400.3406
through R400.3423.

D. State Hospital Appeal Panel

The State Hospital Appeal Panel shall consist of one member chosen by the hospital, one
independent member (selected by the MSA from a list of prospective members supplied
or approved by the hospital industry), and one representative of the MSA.
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The appeal panel coordinator shall schedule the times and places for the pre-hearing conference and the appeal panel hearing. Written notice of the hearing shall be mailed to the parties not later than thirty (30) calendar days from the date the appeal request is received by the appeal panel coordinator. The pre-hearing conference and panel hearing shall be held in Lansing. Failure to appear at a scheduled pre-hearing conference or hearing without good cause and reasonable advance written or telephone notification shall be deemed an abandonment of the appeal. Actions described in the final determination notice shall then be implemented without further notice to the hospital.

All time requirements for appeal to the panel may be extended by mutual agreement of the parties involved.

Each party must submit a position paper to the appeal panel along with all necessary documentation to support its position. In order to be considered, position papers and supporting documentation must be received by the appeal panel coordinator no later than fifteen (15) calendar days prior to the scheduled hearing date.

The appeal panel shall give each party an adequate amount of time to present its evidence and arguments. The appeal panel reserves the right to exclude testimony or evidence which it deems to be immaterial, repetitious, or irrelevant.

Each party is entitled to call persons to testify at the hearing.

A complete record of the hearing is made by a licensed Certified Electronic Reporter. The record may be transcribed and reproduced at the request of either party. The transcription cost is the responsibility of the party making the request.

The appeal panel may affirm, modify, or reverse a bureau conference decision upon the affirmative vote of two or more of its members.

The appeal panel shall issue a written recommendation no later than sixty (60) calendar days after the closing date of the hearing. The written recommendation shall include findings of fact and relevant conclusions of law.

The recommendation decision of the appeal panel shall be forwarded to the Director of the Department of Community Health with copies mailed to the hospital and appropriate MSA appeals staff.

Either party may file exceptions to the recommended decision. Exceptions must be filed within twenty (20) calendar days of the issuance of the appeal panel's recommended decision. Such exceptions must be submitted to the department director with copies sent to the opposing party and the appeal panel coordinator. Exceptions filed after 20 days will not be considered.

The department director may accept, modify or reverse the recommended decision of either the panel or the administrative law judge. The decision of the department director shall be binding unless the hospital wishes to appeal the decision to a court of appropriate jurisdiction.

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If an appeal results in a change which affects claims already processed, three alternatives to implement the change shall be available.

1. The hospital may elect to submit adjustments through the normal billing process.
2. The hospital may request an early initial settlement for the entire hospital. The initial settlement will incorporate the appeal decision in determining the gross program liability. Initial settlements are done only after the end of a hospital's fiscal year end.
3. The impact of the appeal decision may be incorporated into the hospital's final settlement process.

V. Medicaid Access to Care Initiative (MACI) Payments

1. FY'03 & FY'04 MACI Payments

The Department of Community Health (the department) is establishing four special funding pools for the next two State fiscal years (FY's '03 & '04). To keep payments within the Medicaid upper payment limits, separate pools will be established for privately-owned or operated hospitals and non-state government-owned or operated hospitals for inpatient hospital services. Only hospitals located within Michigan, enrolled in the Medicaid program, open and admitting Medicaid fee for service (FFS) and managed care patients 10 days prior to a scheduled payment will be eligible to receive distributions from these pools.

Allocation of payments from the inpatient hospital pools for fiscal year 2003 will be made based on inpatient FFS hospital paid claims for hospital admissions from September 1, 1999 to August 31, 2000. (The last year of paid claims data used to rebase hospitals in FY'02 will be used.) Allocation of payments for FY'04 will be made based upon similar data drawn from FY'03 payments.

Privately-Owned or Operated Inpatient Hospital Pool ($120 million)

This inpatient pool will be computed based upon the total number of DRG reimbursed hospitals and distinct part rehabilitation units. Freestanding rehabilitation hospitals with Medicaid FFS payments will participate in this pool, also.

Hospitals with Medicaid inpatient FFS payments will share proportionately in a pool of $120 million based on each hospital's total Medicaid FFS inpatient payments divided by the total Medicaid FFS inpatient payments for all privately-owned and operated hospitals and units.

Non-State Government-owned or Operated Inpatient Hospital Pool ($19 million)

This inpatient pool will be computed based upon the total number of DRG reimbursed hospitals and distinct part rehabilitation units. Freestanding rehabilitation hospitals with Medicaid FFS payments will participate in this pool, also.

Hospitals with Medicaid inpatient FFS payments will share proportionately in a pool of $19 million based on each hospital's total Medicaid FFS inpatient payments divided by the total Medicaid FFS inpatient payments for all non-state government-owned or operated hospitals and units.
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Payments will be made only after the department has received approval for this policy from the Centers for Medicare & Medicaid Services. Once approval has been received, the initial payment will be made within 45 days. Subsequent payments will be made within 45 days of the beginning of each quarter. The quarterly payments will be made in four equal installments based on the total annual amount each hospital is eligible to receive. If a hospital closes or is determined ineligible to receive funds from a pool, its funds will be redistributed to the remaining eligible hospitals based on the original distribution formula. All funds from both inpatient hospital pools will be distributed to eligible hospitals.

2. FY'04 Expansion & Extension of MACI Payments

To ensure continued access by Medicaid beneficiaries to high quality hospital care, the Michigan Department of Community Health (the department) is establishing two special funding pools. To keep payments within the federal Medicare upper payment limit (UPL), separate pools will be established for privately-owned or operated hospitals and non-state government-owned or operated hospitals for inpatient hospital services. Only hospitals located within Michigan, enrolled in the Medicaid program, open, treating, and admitting Medicaid fee for service (FFS) and managed care beneficiaries ten (10) days prior to a scheduled payment will be eligible to receive distributions from these pools.

For FY 2004, the expansion of the inpatient hospital MACI pools covered here will be in addition to, and will supplement, the existing MACI pools as described in sub-section 1. The policy for the supplemental MACI pools is effective April 1, 2004 and applies to the second half of the year only.

The distribution of payments from these pools will supplement the hospital's regular DRG and per diem payments (for rehabilitation units and hospitals) and is not considered part of the fee for service (FFS) reimbursement. Medicaid payers that normally match the department's FFS payments to medical providers are not required to include the distribution payments from the pools described here as part of their FFS payments.

Full pool sizes will be renewed annually for FY 2005 and beyond. Pool sizes will be established based on the calculated difference between the federal Medicare upper payment limit and annual Medicaid payments.

Payment Share - Inpatient Paid Claims File

To determine each hospital's share of a pool, the department will use paid claims for the fiscal year ending two years prior to the current fiscal year. Claims will be restricted to those paid by June 30th of the following fiscal year (e.g., paid claims from FY 2002 will be used to calculate payments in FY 2004 with claims limited to those paid by June 30, 2003). The paid claims file will include all Medicaid FFS payments made for both Medicaid and CSHCS

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eligible beneficiaries through the Medicaid Invoice Processing System including DRG and per diem payments, DRG outlier payments, and claims paid based on a percent of charge. Paid claims will include those with other insurance and patient-pay amounts. Inpatient services will include acute and rehabilitation services provided through distinct part rehabilitation units and freestanding rehabilitation hospitals, and sub-acute ventilator-dependent care units. Services paid to LTC providers will not be included with the exception of services paid to sub-acute ventilator-dependent care units with beds licensed as hospital beds. Revenue from licensed hospital beds utilized at less than an acute or rehabilitation level of care will be excluded from the paid claims file with the exception of revenue from sub-acute ventilator-dependent care beds licensed as hospital beds. Payments made outside the Invoice Processing System, such as for capital, graduate medical education (GME), or disproportionate share hospital (DSH), will not be included in the paid claims file used to distribute the MAC1 pools.

Allocation of Pool

MAC1 distributions are made prospectively based on historical data. Eligible hospitals will share proportionately from each pool based upon a hospital’s total Medicaid paid claims, divided by the total Medicaid paid claims for all eligible hospitals, times the dollar amount of the individual pool. If a hospital closes, is determined ineligible to receive distributions from a pool, or its MAC1 distribution causes the hospital’s Medicaid payments to exceed charges, its MAC1 distribution in excess of charges will be redistributed to the remaining eligible hospitals based on the original distribution formula. All funds from the inpatient hospital pools will be distributed to eligible hospitals until the pools are empty. In the event that MAC1 distributions would result in aggregate Medicaid payments to exceed the UPL, the size of the pool(s) will be reduced to bring aggregate Medicaid payments within the UPL. All MAC1 payments are final.

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Payment Schedule

Payments will be made only after the department has received approval for this policy from the Centers for Medicare & Medicaid Services. Once approval has been received, the initial payment will be made within 45 days. Subsequent payments will be made within 45 days of the beginning of each quarter. Quarterly payments will be made in four equal installments based on the annual amount each hospital is eligible to receive.

If a hospital closes, or is determined ineligible to receive funds from a pool, its funds will be redistributed to the remaining eligible hospitals based on the original distribution formula. All funds from both inpatient hospital pools will be distributed to eligible hospitals.

VI. Special Payment Adjustments

Effective August 1, 2007 and each subsequent fiscal year, the Department is directed to reduce hospital payments in each respective fiscal year by $45,872,360. During fiscal year 2007, the reductions were made in August and September. Payment reductions will be made during the 4th quarter of each subsequent fiscal year. These reductions are pursuant to the Governor’s Executive Orders No. 2001-9, 2002-22, 2005-07 and to budgetary savings included in Act 330 of 2006 and in subsequent annual appropriation Acts.

A calculated share of the total annual reduction will be assessed to all hospitals and units operating and enrolled in the Medicaid program on the date the E.O. reductions are processed. A hospital’s annual reduction will be based on its inpatient hospital paid claims for hospital admissions from October 1 to September 30 of the second previous fiscal year. (The same paid claims file is used to calculate the hospital MACI payments and the E.O. reductions for the fiscal year.) Paid claims include Title V, Title XIX, and Title V/XIX inpatient hospital claims. A hospital’s share of the annual reduction is calculated by dividing the total of its paid claims by the total of the paid claims for all affected hospitals times the total amount of funds to be recovered.

Merged hospitals have their reductions combined. Reductions are taken from the surviving hospital. Should a hospital or distinct part unit close prior to the end of the fiscal year its reduction becomes part of the hospital’s final settlement.

Each hospital’s paid claim file is reviewed and appealed at the time the data are submitted with the hospital’s cost report. No further appeal of the inpatient hospital paid claims data will be allowed. These reductions are included in the hospital’s settlement.

Each hospital’s share of the reductions is made by gross adjustment to the hospital’s inpatient hospital Medicaid ID number. Recoveries are taken from the hospital’s payments until the E.O. Reductions are complete.

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VII. Short Hospital Stay Reimbursement

The State utilizes a short hospital stay (SHS) rate of reimbursement for certain outpatient and inpatient hospital stays. The SHS encompasses funding for both operating and capital costs. The SHS rate will be identical for inpatient and outpatient services, and will apply to all services billed on the claim. The SHS rate is applied for outpatient dates of service or inpatient discharges on or after July 1, 2015. The agency’s current rates of reimbursement were set as of January 1, 2018 and are effective for outpatient dates of service or inpatient discharges on or after that date. All rates of reimbursement for the SHS rates are published on the State website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> “Inpatient Hospitals” or “Outpatient Hospitals.”

The SHS rate of reimbursement does not modify billing requirements for hospitals. If the patient meets criteria for an inpatient admission, the invoice must be submitted as an inpatient claim. Conversely, if the patient does not meet criteria for an inpatient admission, the invoice must be submitted as an outpatient claim. In either case, if the criteria for the SHS rate are met, the hospital will receive the same reimbursement for services rendered. The SHS rate only applies to discharges from a facility, and does not apply to transfers, leaving against medical advice (AMA), or other discharge statuses.

The SHS rate of reimbursement applies to both emergent and elective claims. Short hospital stays are defined using the following criteria.

1. Outpatient Hospital Claims Qualification

   An outpatient hospital claim will qualify for the SHS rate if all of the following criteria are met:
   - The primary diagnosis code billed on the outpatient claim is an applicable diagnosis code as listed on the MDHHS website.
   - The claim does not include a surgical revenue code (36X) billed on any line of the outpatient claim.
   - The claim does not include cardiac catheterization lab revenue code 481.
   - The claim includes observation revenue code 762.

2. Inpatient Hospital Claims Qualification

   An inpatient hospital claim will qualify for the SHS rate if all of the following criteria are met:
   - The primary diagnosis code billed on the inpatient claim is an applicable diagnosis code as listed on the MDHHS website.
   - The claim does not include a surgical revenue code (36x) billed on any line of the inpatient claim.
   - The claim has a date of discharge equal to or one day greater than the date of admission.
   - The claim does not include cardiac catheterization lab revenue code 481.

3. Exclusions

   The SHS rate will not apply to inpatient or outpatient claims with the following conditions:
   - Claims where Medicaid is the secondary payer.
   - Claims for patients who leave the hospital AMA.
   - Claims for deceased patients.
   - Claims that include primary diagnoses that are not an applicable diagnosis code as listed on the MDHHS website.
4. Diagnoses

As indicated, in order to qualify for the SHS rate, a claim must include one of the primary diagnosis codes for outpatient dates of service and inpatient dates of discharge on or after July 1, 2015. The current list of ICD-10 diagnoses used were set as of January 1, 2018 and are effective for outpatient dates of service or inpatient discharges on or after that date. All applicable diagnosis codes for the SHS rates are published on the State website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> “Inpatient Hospitals” or “Outpatient Hospitals.”
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

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TN NO.: 18-0001  Approval Date: APR 18, 2018  Effective Date: 01/01/2018

Supersedes
TN No.: 15-0009

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

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TN NO.: 18-0001 Approval Date: APR 18, 2018 Effective Date: 01/01/2018

Supersedes
TN No.: 15-0009

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

Rural Access Pool

The State will establish a Rural Access Pool beginning in State FY 2013 for hospitals that provide Medicaid services to low income rural residents. To be eligible for this pool, hospitals must be categorized by the Centers for Medicare & Medicaid Services as a sole community hospital, or meet both of the following criteria.

1. A hospital must have 50 or fewer staffed beds. The State will calculate staffed beds by dividing the total hospital days reported by the hospital on its Medicaid cost report with a fiscal year ending between October 1, 2010 and September 30, 2011, by the number of days covered in the cost report; and

2. A hospital must be located in a county with a population of not more than 165,000 and within a city, village, or township with a population of not more than 12,000. The population threshold will be measured against population counts from the 2000 federal decennial census.

Each hospital’s allocation from this pool will be calculated as the unreimbursed cost the hospital incurred providing inpatient services to Michigan Medicaid beneficiaries during its cost period that ended during the second previous fiscal year. For example, to calculate the 2013 pool, hospital cost reports with fiscal years ending between October 1, 2010 and September 30, 2011 will be used.

Provider costs will be determined using data reposted on the following lines of the CMS 2552-96 or their equivalent lines on the CMS 2552-10. Inpatient costs are obtained from Worksheet D-1, Part II, Title XIX, Line 49. The following gross Medicaid payments from this cost report period will be applied against cost to determine unreimbursed cost: operating, capital, graduate medical education, executive order reductions, and Medicaid access to care initiative, or any other supplemental payment.

Payments will be made within 45 days of the beginning of each quarter. The quarterly payments will be made in four equal installments based on the total annual amount the hospital is eligible to receive.

The total amount of the rural access pool payments is the sum of each hospital’s allocation from this pool described above.

In the aggregate, the State reimburses hospitals up to maximum allowable under the Federal upper payment limits for inpatient services provided to Medicaid beneficiaries. To keep total Medicaid fee-for-service payments to hospitals within the Federal upper payment limits, the State will reduce the size of the applicable year’s MACI Pool payments by the size of the Rural Access Pool.

TN NO.: 12-20 Approval Date: OCT 31 2013 Effective Date: 11/01/2012

Supersedes
TN No.: N/A – New Page

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Michigan Department of Community Health
Indigent Care Agreement DSH Pool
Eligible Hospitals and Allocations

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TN NO.: 14-014  Approval Date: JUN 8, 2015  Effective Date: 09/30/2014
Supersedes
TN No.: 13-13

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

Michigan Department of Community Health
Indigent Care Agreement DSH Pool
Eligible Hospitals and Allocations

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### Michigan Department of Community Health

**Indigent Care Agreement DSH Pool**

**Eligible Hospitals and Allocations**

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Supersedes

**TN No.: 13-13**

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# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

## Methods and Standards for Establishing Payment Rates

### Inpatient Hospital Care

Michigan Department of Community Health

Indigent Care Agreement DSH Pool

Eligible Hospitals and Allocations

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| Borgess Hospital                                    | 23-0117         | 2009        | $1,485,890 |
| Bronson Methodist Hospital                          | 23-0017         | 2009        | $3,510,890 |
| Carson City Osteopathic Hospital                    | 23-0208         | 2009        | $1,635,034 |
| Central Michigan Community Hospital                 | 23-0080         | 2009        | $725,019   |
| Charlevoix Area Hospital                            | 23-1322         | 2009        | $663,657   |
| Chippewa War Memorial Hospital                      | 23-0239         | 2009        | $316,804   |
| Edward W. Sparrow Hospital                          | 23-0230         | 2009        | $4,435,384 |
| Genesys Regional Medical Center                     | 23-0197         | 2009        | $6,369,784 |
| Gerber Regional Medical Center                      | 23-0106         | 2009        | $993,428   |
| Grand View Hospital                                 | 23-1333         | 2009        | $463,020   |

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Inpatient Hospital Care

Michigan Department of Community Health
Indigent Care Agreement DSH Pool
Eligible Hospitals and Allocations

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| Allegiance Health                      | 23-0092         | 2011        | $2,177,900 |
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| Battle Creek Health System             | 23-0075         | 2011        | $1,877,044 |
| Bay Regional Medical Center            | 23-0041         | 2011        | $1,146,261 |

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**Indigent Care Agreement DSH Pool**

**Eligible Hospitals and Allocations**

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<th>Medicare Number</th>
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**TN NO.: 14-014**  
**Approval Date: JUN 8, 2015**  
**Effective Date: 09/30/2014**

**Supersedes**

**TN No.: 13-13**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care

Michigan Department of Community Health
Indigent Care Agreement DSH Pool
Eligible Hospitals and Allocations

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TN NO.: 14-014                                      Approval Date: JUN 8, 2015 Effective Date: 09/30/2014

Supersedes
TN No.: 13-13

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Michigan Department of Community Health  
Indigent Care Agreement DSH Pool  
Eligible Hospitals and Allocations

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| Borgess Hospital                     | 23-0117         | 2014        | $1,485,896  |
| Bronson Battle Creek Hospital        | 23-0075         | 2014        | $1,146,264  |

State of MICHIGAN  
Methods and Standards for Establishing Payment Rates  
Inpatient Hospital Care

Acceptance of Agreement  
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Attachment 4.19-A  
Appendix B Page 9

Supersedes  
TN No.: 14-014  
Approval Date: JUN 8, 2015  
Effective Date: 09/30/2014

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

### State of MICHIGAN

*Methods and Standards for Establishing Payment Rates*

*Inpatient Hospital Care*

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### Michigan Department of Community Health

**Indigent Care Agreement DSH Pool Eligible Hospitals and Allocations**

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McLaren Flint                        | 23-0141         | 2015        | $733,457    |
Mercy Health Partners - Hackley Campus | 23-0066   | 2015        | $383,073    |
MidMichigan Medical Center - Gladwin | 23-1325         | 2015        | $147,891    |
MidMichigan Medical Center - Gratiot  | 23-0030         | 2015        | $49,297     |
Mount Clemens Regional Medical Center | 23-0227    | 2015        | $3,455,550  |

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Approval Date: **DEC 17, 2015**

Effective Date: **09/30/2015**

Supersedes

TN No.: **14-014**

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### Inpatient Hospital Care

Michigan Department of Community Health Indigent Care Agreement DSH Pool
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<td>23-0156</td>
<td>2015</td>
<td>$862,093</td>
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<td>St. Joseph Mercy Livingston Hospital</td>
<td>23-0069</td>
<td>2015</td>
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<td>St. Mary's Health Care (Grand Rapids)</td>
<td>23-0059</td>
<td>2015</td>
<td>$300,000</td>
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<td>St. Mary's of Michigan Medical Center</td>
<td>23-0077</td>
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October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Section 4 – General Program Administration

Provider payment rates are not applicable for Other Provider-Preventable Conditions (OPPC) that are identified as non-payable as indicated below. This applies to all Medicaid reimbursement provisions contained in Attachment 4.19-B.

No payment shall be made for Other Provider-Preventable Conditions that are identified as non-payable by Medicaid:

1) wrong surgical or other invasive procedure performed on a patient;
2) surgical or other invasive procedure performed on the wrong body part;
3) surgical or other invasive procedure performed on the wrong patient.

In compliance with 42 CFR 447.26(c), the state provides:

1) that no reduction in payment for a Provider Preventable Condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

2) that reductions in provider payment may be limited to the extent that the following apply:
   (A) the identified PPC would otherwise result in an increase in payment.
   (B) the state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC.

3) Assurance that non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

This applies to all Medicaid reimbursement provisions contained in Attachment 4.19-B.

Specific payment methodologies and effective dates are listed in the Attachment 4.19-B payment pages that follow.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

1. Individual Practitioner Services

Payment rates are established by the Medical Services Administration as a fee screen for each procedure. The fee schedule is designed to enlist the participation of an adequate number of providers. The Medicare prevailing fees, the Resource Based Relative Value Scale (RBRVS) and other relative value information, other state Medicaid fee screens, and providers' charges may be utilized as guidelines or reference in determining the maximum fee screens for individual procedures. The state assures that both public and private providers are paid under the same fee screens for the same services. Fee schedules are updated annually using the Resource Based Relative Value Scale (RBRVS) Medicare January release. The Medicaid fee screens can be found at www.michigan.gov/medicaidproviders.

For the following practitioners, the Agency's fee schedule rate was set as of 7/1/2009 and is effective for services provided on or after that date.

- Physicians (MD and DO)
- Ophthalmologists
- Oral Surgeons
- Physician's Assistants
- Nurse Practitioners
- Certified Nurse Midwives

For beneficiaries with no Medicare or commercial insurance coverage, providers are reimbursed the lesser of:

- the Medicaid fee screen minus any applicable Medicaid co-payment, patient pay, or spend-down amounts.
- the provider's usual and customary charge minus any applicable Medicaid co-payment, patient pay, or spend-down amounts.

For beneficiaries with Medicare and/or commercial insurance coverage, providers are reimbursed the lesser of:

- the Medicaid beneficiary's liability for Medicare/commercial insurance coinsurance, co-payments, and/or deductibles minus any applicable Medicaid co-payment, patient pay, or spend-down amounts.
- the Medicaid fee screen minus any third party payments, contractual adjustments, and any applicable Medicaid co-payment, patient pay, or spend-down amounts.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

- the provider's usual and customary charge minus any third party payments, contractual adjustments, and any applicable Medicaid co-payment, patient pay, or spend-down amounts.

A provider's customary charge refers to the amount which the individual practitioner charges in the majority of cases for a specific medical procedure exclusive of token charges for charity patients and substandard charges for welfare and other low income patients.

Payment adjustments will be made for practitioner services provided through the following public entities:

- University of Michigan Health System
- Wayne State University
- Hurley Hospital
- Michigan State University
- Oakland University
- Western Michigan University
- Central Michigan University

Adjustments apply to dates of service on or after April 1, 2006. Beginning January 1, 2011, Oakland University will be eligible for pricing adjustments under this program. Beginning July 1, 2012, Western Michigan University will be eligible for pricing adjustments under this program. Beginning January 1, 2013, Central Michigan University will be eligible for pricing adjustments under this program. Eligibility for these adjustments is limited to individual practitioners or practitioner groups designated by the public entities. Service provided by the following practitioners, when not included in facility payments to the public entity, are included:

- Physicians (MD and DO)
- Ophthalmologists
- Oral Surgeons
- Dentists
- Podiatrists
- Physician's Assistants
- Nurse Practitioners
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Certified Anesthesiologist Assistants
- Optometrists

Adjustments apply to both public and private practitioners and practitioner groups. Practitioners and practitioner groups are either employees of the public entity or are under a contract with the public entity. All services eligible for the payment adjustment are billed under the federal employer number of the public entity or under the employer identification number of the practitioner/practitioner group. Billings are submitted by the public entity or by the practitioners/ practitioner groups. The Medical Services Administration must concur with the public entity's designations in order for the payment adjustment to be applied.

Approval Date:  April 10 2013    Effective Date:  01/01/2013
The payment adjustment will be the lesser of:

- The difference between 95.7% of the average commercial rate for services provided on or after January 17, 2010. The average commercial rate is established separately for each public entity. It is derived by calculating a weighted average by procedure code, of a minimum of five non-governmental payers whose combined business constitutes not less than 50% of a practice or practice groups’ commercial business. In order to derive the average commercial rate for procedures, each participating public entity must submit commercial fee schedules for the taxable entity most representative of the primary provider group of the public entity's medical group. The fee schedules submitted must clearly demonstrate pricing information by procedure code by commercial payer. Additionally, the public entity must indicate the percent of business each commercial payer constitutes of their total commercial business revenue. A weighted average by procedure code will be calculated at the public entity level from the submitted fee schedules. The state will calculate average rates on an annual basis using fee schedules in effect for the calendar year which includes the first quarter of the fiscal year for which the average rates will be applied. Beginning April 1, 2013, providers participating in the Public Entity Adjustment Program shall receive the difference between 100% of the average commercial rate and the total base payments already made to the providers by Medicaid and any other payer.

- The difference between the practitioner FFS Medicaid fee screens and the practitioner's customary charge.

Services to beneficiaries enrolled in Medicaid Managed Care Organizations (MMCOs) are not included in the payment adjustments. No provider will receive payments that in aggregate exceed their customary charges.

Practitioners will receive a base payment equal to the FFS payment to other practitioners when they bill for services. For each fiscal quarter, the public entity will provide a listing of the identification numbers for their practitioners/ practitioner groups that are affected by this payment adjustment to the MSA. The MSA will generate a report, which includes the identification numbers and utilization data for the affected practitioners/ practitioner groups. This report will be provided to the public entity. The public entity must review the report and acknowledge the completeness and accuracy of the report. After receipt of this confirmation, the MSA will approve and process the payment adjustments for each fiscal quarter within 60 days. The process includes a reconciliation that takes into account all valid claim replacements affecting claims that were previously processed.

After the MSA confirms the accuracy of the payment adjustments, the adjustments will be sent to the practitioners/ practitioner groups through the identification number used to bill Medicaid under the FFS program.

Service providers may bill Medicaid for vaccines/toxoids which they have purchased. Medicaid reimburses the provider up to Medicare reimbursement rates.
Payment Adjustments for Children with Special Health Care Needs Approved Specialty Physicians.

Effective April 1, 2009, the payment adjustment method determined by the Medical Services Administration is the lesser of:

- The difference between the fee-for-service (FFS) Medicaid fee screens and the average commercial rate.

- The difference between the FFS Medicaid fee screens and the physician’s customary charge.

The Average Commercial Rate is derived by calculating a weighted average by procedure code, of the non-governmental payers constituting greater than 50% of a practice or practice groups’ Commercial Business. In order to derive the average commercial rate for procedures, any practice or practice group wishing to receive adjustments under this section must submit Commercial Fee Schedules that clearly demonstrate pricing information by procedure code by Commercial Payer, and indicate the percent of business each Commercial Payer constitutes of their total commercial business revenue. For purposes of this section, “business revenue” is defined as revenue received for professional medical services rendered.

A physician’s customary charge refers to the Amount which is charged in the majority of cases for a specific medical procedure exclusive of token charges for charity patients and substandard charges for welfare and other low income patients.

Children with special health care needs approved specialty physician receive a base payment equal to the FFS payment paid to other physicians. Each fiscal quarter, the Medical Services Administration (MSA) generates a report for the affected providers. When the participating physicians and the MSA confirm the accuracy of the report, the payment adjustments are determined. The payment adjustments are made for each fiscal quarter. The process includes a reconciliation that takes into account all valid claim replacements affecting claims that were previously processed.

Approval Date: MAR 15 2010  
Effective Date: 04/01/2009

TN NO.: 09-09
Supersedes: 11-14
Supersedes: N/A – New Page

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
Other than Inpatient Hospital and Long-Term-Care Facilities

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS. The state will utilize the fee schedule provided by CMS and Deloitte based on the November 2012 Medicare release and the 2009 conversion factor. The state will not adjust the fee schedule to account for changes in Medicare rates throughout the calendar year.

☑ The rates reflect all Medicare site of service and locality adjustments.

☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☑ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:

Method of Payment

☑ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of MICHIGAN

Policy and Methods for Establishing Payment Rates
Other than Inpatient Hospital and Long-Term-Care Facilities

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

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☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

<table>
<thead>
<tr>
<th>Code</th>
<th>Date Added</th>
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</tr>
<tr>
<td>90461</td>
<td>01/01/2011 (rate is $0.00)</td>
</tr>
<tr>
<td>99495</td>
<td>01/01/2013</td>
</tr>
<tr>
<td>99496</td>
<td>01/01/2013</td>
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</tbody>
</table>

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate
☒ State regional maximum administration fee set by the Vaccines for Children program
☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: **$7.00**.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: .
Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

Note: This section contains a description of the state’s methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Vaccine Administration

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of MICHIGAN

Policy and Methods for Establishing Payment Rates
Other than Inpatient Hospital and Long-Term-Care Facilities

Primary Care Services Incentive Payment

Primary Care Physician Services
Physicians with primary specialty designations of family medicine, general internal medicine, pediatric medicine, or general practice may qualify as primary care providers for purposes of increased payment.

Eligible providers will be identified as if the methodology described in 42 CFR 447.400(a)(1) and (2) remains in effect. However, if otherwise eligible physicians have subspecialty practice designations, only those providers with subspecialty designations of adolescent medicine and geriatric medicine will be eligible for the rate increase.

Non-physician Practitioners, specifically Nurse Practitioners (NPs) and Physician Assistants (PAs), who provide primary care services under the personal supervision of an eligible primary care physician, will be eligible for the enhanced rate.

Method of Payment
For primary care providers identified as eligible for the primary care rate adjustment, payment will be made on the qualified procedure codes as published in a separate Medicaid Practitioner Fee Schedule. The Primary Care Fee Schedule will reflect rates that have been adjusted in compliance with expenditure levels established by state law.

Unless otherwise noted in the state plan, Michigan’s Medicaid payment rates are uniform for private and governmental providers.

Primary Care Services Affected by this Payment Methodology
Primary care physician services subject to the enhanced primary care rate are defined as Healthcare Common Procedure Coding System (HCPCS) codes:

- 99201 through 99215 for new and established patient office or outpatient evaluation and management (E/M) visits
- 99304 through 99318 for initial, subsequent, discharge and other nursing facility E/M services
- 99324 through 99337 for new and established patient domiciliary, rest home or custodial care E/M Services
- 99341 through 99350 for new and established patient home E/M visits
- 99381 through 99397 for new and established patient preventive medicine services

Effective Date of Payment
This reimbursement methodology applies to services rendered by physicians with the primary specialty designation of family medicine, general internal medicine and pediatric medicine on and after January 1, 2015 and for services provided by physicians with the primary specialty designation of general practice on and after January 1, 2018. The Michigan Medicaid Fee Schedule for the qualified procedure codes is published at www.michigan.gov/medicaidproviders.

TN NO.: 17-0015 Approval Date: JAN 25, 2018 Effective Date: 01/01/2018
Supersedes
TN No.: 14-0018

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Physician Services, Emergency Department Case Rate Payments

Attending Physician Emergency Department Services

Reimbursement for Evaluation and Management (E/M) services provided by an attending physician in the emergency department (ED) of a hospital is made in accordance with the ED case rate methodology. The ED case rate is a two-tiered fee screen based on whether the beneficiary is:

- Treated and released from the ED; or
- Treated and admitted to the hospital or transferred to another hospital.

ED attending physician services subject to the case rate payment methodology are defined as Healthcare Common Procedure Coding System (HCPCS) codes:

- 99281 through 99285 for new or established patient ED E/M services

Payment Methodology

Payments utilizing the case rate methodology are calculated by using a blend of the current Medicaid payment rates for the E/M HCPCS codes 99281-99285 and the historic utilization for these codes in relation to whether a beneficiary is treated and released or treated and admitted to the hospital. The rates associated with these HCPCS codes are updated annually using the Resource Based Relative Value Scale (RBRVS) CMS January release.

Services Excluded from the Case Rate Payment Methodology

Excluded from the ED case rate are the separately billable physician services and the services of other physicians who provide E/M or other services in the ED. When billing for these services HCPCS coding conventions and Medicaid program guidelines must be followed. The standard Medicaid fee screens apply.

Fee Schedules

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Michigan Medicaid's fee schedule rates were set as of July 1, 2009 and are effective for services provided on or after that date. Michigan Medicaid's fee schedule is published on the MDHHS web site at www.michigan.gov/medicaidproviders>>Billing and Reimbursement>>Provider Specific Information>>Physicians/Practitioners/Medical Clinics.
Physician Services, Neonatal Critical Care and Intensive Care Services

Neonatal Services Reimbursement Methodology

Reimbursement for neonatal critical care and intensive care services is 64% of the annual Medicare rates published January of each year. 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.

Effective Date of Payment

This reimbursement methodology applies to services rendered on and after January 1, 2018. All rates are published at www.michigan.gov/medicaidproviders.
Physician Services, Obstetrical Services

Obstetrical Services Reimbursement Methodology

Reimbursement for obstetrical services is 95% of the annual Medicare rates published January of each year. 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.

Effective Date of Payment

This reimbursement methodology applies to services rendered on and after October 24, 2017. All rates are published at www.michigan.gov/medicaidproviders.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

2. Drug Product Reimbursement

   a) Outpatient drug ingredient Reimbursement shall be based upon the lower of: Actual Acquisition Cost (AAC) as defined in (A) I and II below plus the professional dispensing fee, Wholesale Acquisition Cost (WAC) plus the professional dispensing fee, Maximum Allowable Cost (MAC) plus the professional dispensing fee, or the provider's charge.

      I. For drugs that are not purchased through the 340B program, Federal Supply Schedule, or at the Nominal Price, AAC is based on the National Average Drug Acquisition Cost (NADAC).

      II. For drugs that are purchased through the 340B program, AAC is based on the actual invoice cost for a drug product to the pharmacy or company, organization, corporation, or affiliate with which it is associated. The provider must indicate the AAC as their ingredient cost charge included in their usual and customary charge.

   b) Outpatient drug ingredient reimbursement described in (2)(a) shall apply to the following:

      I. Brand Drugs
      II. Generic drugs
      III. Clotting factor dispensed by specialty and non-specialty pharmacies
      IV. Specialty drugs
      V. Drugs not distributed by a retail community pharmacy (such as a long-term care facility)
      VI. Drugs purchased through the federal supply schedule (FSS) shall be reimbursed at no more than the FSS price.
      VII. Drugs purchased through the 340b program shall be reimbursed at no more than the 340b ceiling price.
      VIII. Drugs purchased through the 340b program, and dispensed by 340b contract pharmacies will not be reimbursed by the state, unless the 340b covered entity, contract pharmacy and the department have established an arrangement to prevent duplicate discounts.
      IX. Drugs purchased at nominal prices shall be reimbursed at no more than the nominal price.

TN NO.: 17-0005 Approval Date: SEPT 20, 2017 Effective Date: 04/01/2017

Supersedes
TN No.: 15-0011

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
c) The State has established professional dispensing fees. Effective April 1, 2017 professional dispensing fee reimbursement for pharmacies is the lesser of the standard professional dispensing fee included as a component of the pharmacy's usual and customary charge. The standard professional dispensing fee is the following:
   I. $20.02 for specialty drugs
   II. Non-specialty drugs
      1. $10.64 for drugs not on the department's preferred drug list (PDL)
      2. $9.00 for drugs indicated as non-preferred on the department's PDL
      3. $10.80 For drugs indicated as preferred on the department's PDL

d) Payments for multiple source drugs in the aggregate are equal to or less than Federal Upper Limits, in compliance with federal law.

e) For non-pharmacy providers, physician-administered drugs and biologicals that are not paid on a cost or prospective payment basis will be reimbursed in accordance with Medicare Part B payment limits. The State’s published fee schedule will be based upon average sales price (ASP) drug pricing files supplied by CMS with updates on a quarterly basis.

f) Hemophilia drugs will be reimbursed in accordance with the rules of this section.

g) Pharmacy claim payments are not included in the encounter rate for federally qualified health centers (FQHCs). Pharmacy claims from FQHCs will be reimbursed using the rates described in (2)(a).

h) Drugs that are determined to be experimental or investigational are not covered benefits. Such determinations will be made by the Medical Services Administration, based on qualified medical advice that the drugs have not been generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are being used or are to be used. This advice will originate from established sources such as Medicare, National Institutes of Health, Food and Drug Administration, American Medical Association, etc. The determinations are not judgments that a physician’s choice is inappropriate or that a patient does not need treatment.

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TN NO.: 17-0005  Approval Date: SEPT 20, 2017  Effective Date: 04/01/2017

Supersedes
TN No.: N/A–New Page

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

3. Outpatient Hospital Services and Other Outpatient Prospective Payment System (OPPS) Reimbursed Facilities

Reimbursement to individual hospitals, including off-campus satellite clinics, hospital-owned ambulance services, freestanding dialysis centers, comprehensive outpatient rehabilitation facilities (CORFs) and rehabilitation agencies for outpatient services is made in accordance with Medicaid's OPPS. Payments made under OPPS will be calculated utilizing the current Medicare conversion factors/rates with an MDHHS reduction factor (RF) applied to the calculated payment (Medicare fee x RF = Medicaid fee) to maintain statewide budget neutrality. As of January 1, 2016 the OPPS reduction factor is 52.6%. The current Michigan Medicaid fee schedule is available at www.michigan.gov/medicaidproviders.

a) Monitoring of outpatient hospital expenditures will be conducted and the reduction factor adjusted to maintain statewide budget neutrality. A wage index of 1.0 is applied for all hospitals.

b) Medicare's APC weights are utilized.

c) Services paid reasonable cost under OPPS are paid by applying individual hospital cost-to-charge ratios to charges.

d) Updates of each hospital's outpatient cost-to-charge ratios are done in conjunction with updates of the inpatient operating ratios.

e) For out of state hospitals, the default cost-to-charge ratio is the average statewide outpatient cost-to-charge ratio.

When service coverage/reimbursement methodology differences exist between Medicare and Medicaid, Medicaid fee schedules are utilized. Methodology differences only exist when Medicare does not cover a facility-based service provided. The current Michigan Medicaid fee schedule, available at www.michigan.gov/medicaidproviders, is updated to conform to Medicare OPPS and is effective for dates of service on or after January 1, 2016.

TN NO.: 16-0006 Approval Date: NOV 9, 2016 Effective Date: 01/01/2016

Supersedes
TN No.: 07-01

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)

A. Children’s Outpatient Hospital Adjustor Pool

The State is ending this funding pool and will no longer make this payment for SFY 2014 effective on or after July, 1, 2014.
B. Short Hospital Stay Reimbursement

The State utilizes a short hospital stay (SHS) rate of reimbursement for certain outpatient and inpatient hospital stays. The SHS encompasses funding for both operating and capital costs. The SHS rate will be identical for inpatient and outpatient services, and will apply to all services billed on the claim. The SHS rate is applied for outpatient dates of service or inpatient discharges on or after July 1, 2015. The agency’s current rates of reimbursement were set as of January 1, 2018 and are effective for outpatient dates of service or inpatient discharges on or after that date. All rates of reimbursement for the SHS rates are published on the State website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> “Inpatient Hospitals” or “Outpatient Hospitals.”

The SHS rate of reimbursement does not modify billing requirements for hospitals. If the patient meets criteria for an inpatient admission, the invoice must be submitted as an inpatient claim. Conversely, if the patient does not meet criteria for an inpatient admission, the invoice must be submitted as an outpatient claim. In either case, if the criteria for the SHS rate are met, the hospital will receive the same reimbursement for services rendered. The SHS rate only applies to discharges from a facility, and does not apply to transfers, leaving against medical advice (AMA), or other discharge statuses.

The SHS rate of reimbursement applies to both emergent and elective claims. Short hospital stays are defined using the following criteria.

1. Outpatient Hospital Claims Qualification

   An outpatient hospital claim will qualify for the SHS rate if all of the following criteria are met:
   - The primary diagnosis code billed on the outpatient claim is an applicable diagnosis code as listed on the MDHHS website.
   - The claim does not include a surgical revenue code (36X) billed on any line of the outpatient claim.
   - The claim does not include cardiac catheterization lab revenue code 481.
   - The claim includes observation revenue code 762.

2. Inpatient Hospital Claims Qualification

   An inpatient hospital claim will qualify for the SHS rate if all of the following criteria are met:
   - The primary diagnosis code billed on the inpatient claim is an applicable diagnosis code as listed on the MDHHS website.
   - The claim does not include a surgical revenue code (36x) billed on any line of the inpatient claim.
   - The claim has a date of discharge equal to or one day greater than the date of admission.
   - The claim does not include cardiac catheterization lab revenue code 481.

3. Exclusions

   The SHS rate will not apply to inpatient or outpatient claims with the following conditions:
   - Claims where Medicaid is the secondary payer.
   - Claims for patients who leave the hospital AMA.
   - Claims for deceased patients.
   - Claims that include primary diagnoses that are not an applicable diagnosis code as listed on the MDHHS website.
4. Diagnoses

As indicated, in order to qualify for the SHS rate, a claim must include one of the primary diagnosis codes for outpatient dates of service and inpatient dates of discharge on or after July 1, 2015. The current list of ICD-10 diagnoses used were set as of January 1, 2018 and are effective for outpatient dates of service or inpatient discharges on or after that date. All applicable diagnosis codes for the SHS rates are published on the State website at [www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> “Inpatient Hospitals” or “Outpatient Hospitals.”](http://www.michigan.gov/medicaidproviders)
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C. Special Outpatient Adjustor Pool

$14,000,000 will be distributed to eligible Michigan hospitals in the form of an outpatient hospital adjustor for the period July 1, 2001 through February 14, 2002. The funds will be distributed in two pools. The first pool, in the amount of $4.7 million will be distributed to hospitals based on each hospital's Title XIX fee-for-service outpatient hospital charges. The second pool, in the amount of $9.3 million, will be distributed to hospitals based on each hospital's Title XIX HMO outpatient hospital charges. To receive funds from either of the pools, a hospital must be open and operating on the date the payment is made. Outpatient hospital data used to calculate the distributions will be drawn from hospital cost reports ending in state fiscal year 1998/99 (between October 1, 1998 and September 30, 1999). Outpatient hospital charges will be limited to those charges eligible for reimbursement under Title XIX. Allowable charges will also include Title XIX psychiatric charges. Charges will be converted to costs using each hospital's outpatient hospital cost to charge ratio. If a hospital's cost to charge ratio is greater than one, then one will be used. Costs will be inflated to a common point in time. Inflation factors will be taken from Standard and Poor's DRI - Health Care Cost Review - First Quarter 2000. Hospitals with year ends during a quarter will be inflated using the inflation factor for the quarter in which the hospital's year ends. A hospital's distribution from a pool will be determined by dividing its adjusted costs by the adjusted costs for all eligible hospitals times the available funds in the pool.

Hospitals that filed more than a single cost report during the eligibility period for these pools will have their cost report data combined and annualized to allow for only twelve months of combined cost data. Hospitals that merged during the eligibility period will have their distribution payments combined. Payments will be made to the surviving hospital.

Charge data taken from hospital cost reports is subject to review and appeal at the time the cost report is filed. The hospital's outpatient hospital cost to charge ratio is subject to review at rebasing. No further appeal of either the charge data or the outpatient hospital cost to charge ratio, as part of the distribution of funds from these pools, will be allowed.

Aggregate Medicaid reimbursement to Michigan outpatient hospitals (including the special indigent pools) will not be allowed to exceed the federally mandated upper payment limit for outpatient services provided to Michigan beneficiaries. To account for varying hospital year end dates, the test will be made based on data taken from hospital fiscal years ending during the same state fiscal year used to do the distribution (e.g. the test for 2000 will use hospital cost report years ending between October 1, 1998 and September 30, 1999). If the test against the upper payment limit finds that the upper payment limit was exceeded, the size of these pools will be reduced proportionately by the amount in excess of the limit.

Inflation factors used to inflate costs to September 30, 2000 are as follows:

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9/30/99  

Fee-For-Service Pool  

Distributions from the fee-for-service outpatient hospital adjustor pool will be calculated as follows:  

Charges are limited to outpatient hospital charges for provider types 40, 41, and 75.  

Hospital Charges = Title XIX FFS outpatient hospital charges  
Hospital Costs = Hospital Charges x CC Ratio x Inflation Factor  

Hospital’s Distribution = \[
\frac{\text{Hospital’s Costs}}{\sum \text{Hospital’s Costs}} \times 4,700,000
\]  

Title XIX = Medicaid fee-for-service charges  
CC Ratio = Hospital’s outpatient cost-to-charge ratio  

Managed Care Pool  

To receive funds from the managed care outpatient hospital adjustor pool, a hospital must meet by September 14, 2001, the following criteria:  

- If no Medicaid HMO has been authorized by Medicaid to enroll beneficiaries in the county in which the hospital is located, or in a hospital’s service area within the county, the hospital will be allowed to participate in the distribution of funds from this pool.  
- If only a single Medicaid HMO has been authorized by Medicaid to enroll beneficiaries in the county in which the hospital is located, then the hospital must have a signed agreement with that HMO.  
- If two or more Medicaid HMOs have been authorized by Medicaid to enroll beneficiaries in the county in which the hospital is located, then the hospital must have a signed agreement with at least two of these HMOs.  

At a minimum, agreements must provide for appropriately authorized, medically necessary inpatient hospital, outpatient hospital, emergency and clinical care arranged by a physician with admitting privileges to the facility and credentialed by the HMO.  

Distributions from the managed care outpatient hospital adjustor pool will be calculated as follows:  

Charges are limited to outpatient hospital charges for provider types 40, 41, and 75.  

Hospital Charges = Title XIX HMO outpatient hospital charges  
Hospital Costs = Hospital Charges x CC Ratio x Inflation Factor  


Supersedes TN No.: 11-14  
TN No.:  NEW  
Supersedes TN No.: N/A – New Page  
Supersedes TN No.:  

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\[ \text{Hospital's Distribution} = \frac{\text{Hospital's Costs}}{\sum \text{Hospital's Costs}} \times 9,300,000 \]

\[ \text{Title XIX} = \text{Medicaid} \]
\[ \text{CC Ratio} = \text{Hospital's outpatient cost-to-charge ratio} \]

Funds from both pools will be distributed prior to February 14, 2002. Should a hospital fail to qualify for a distribution from either pool, its share will not be redistributed.

D. FY’02 Outpatient Hospital Adjustor Pool

Section 1645 of P.A. 60 of 2001 directs the Department of Community Health (DCH) to distribute $14,011,000 in funds to eligible Michigan hospitals in the form of an outpatient hospital adjustor for state fiscal year (SFY) 01/02.

The first pool, in the amount of $5,604,400 will be distributed to hospitals based on each hospital's Title XIX fee-for-service outpatient hospital charges. The second pool, in the amount of $8,406,600 will be distributed to hospitals based on each hospital's Title XIX HMO outpatient hospital charges.

To receive funds from either of the pools, a hospital must be open and operating on the date the payment is made. In order to calculate each hospital's distribution for each pool, outpatient hospital data will be drawn from hospital cost reports ending in SFY 99/00 (between October 1, 1999 and September 30, 2000). Outpatient hospital charges will be limited to those charges eligible for reimbursement under Title XIX. Allowable charges will also include Title XIX psychiatric charges. Charges will be converted to costs using each hospital's outpatient hospital cost to charge ratio. If a hospital's cost to charge ratio is greater than one, then one will be used. Costs will be inflated to a common point in time. Inflation factors will be taken from Standard and Poor's DRI - Health Care Cost Review - Second Quarter 2001. Hospital costs will be inflated using the inflation factor for the quarter in which the hospital's cost year ends. A hospital's distribution from a pool will be determined by dividing its adjusted costs by the adjusted costs for all eligible hospitals times the available funds in the pool.

Hospitals that filed more than a single cost report during the eligibility period for these pools will have their cost report data combined and annualized to allow for only twelve months of combined cost data. Hospitals that merged during the eligibility period will have their distribution payments combined. Payments will be made to the surviving hospital.

Charge data taken from hospital cost reports is subject to review and appeal at the time the cost report is filed. The hospital's outpatient hospital cost to charge ratio is subject to review at rebasing. No further appeal of either the charge data or the outpatient hospital cost to charge ratio, as part of the distribution of funds from these pools, will be allowed.

Aggregate Medicaid reimbursement to Michigan hospitals for outpatient services (including the special indigent pools) will not be allowed to exceed the federally mandated upper payment

Superseded by

TN No.: 01-011

Approval 6/19/02 Effective Date 2/15/02

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limit for outpatient services provided to Michigan beneficiaries. To account for varying hospital year end dates, the test will be made based on data taken from hospital cost years ending during the same state fiscal year used to do the distribution (e.g. the test for 2002 will use hospital cost years ending between October 1, 1999 and September 30, 2000). If the test against the upper payment limit finds that the upper payment limit was exceeded, the size of these pools will be reduced proportionately by the amount in excess of the limit.

Inflation factors used to inflate costs to September 30, 2000 are as follows:

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Fee-For-Service Pool

Distributions from the fee-for-service outpatient hospital adjustor pool will be calculated as follows:

\[
\text{Hospital Charges} = \text{Title XIX FFS outpatient hospital charges} \\
\text{Hospital Costs} = \text{Hospital Charges} \times \text{CC Ratio} \times \text{Inflation Factor} \\
\text{Hospital's Distribution} = \frac{\text{Hospital's Costs}}{\sum \text{Hospitals' Costs}} \times 5,604,400 \\
\text{Title XIX FFS} = \text{Medicaid fee-for-service} \\
\text{CC Ratio} = \text{Hospital's outpatient cost- to- charge ratio}
\]

Managed Care Pool

To receive funds from the managed care outpatient hospital adjustor pool, a hospital must meet by February 15, 2002, the following criteria:

- If no Medicaid HMO has been authorized by Medicaid to enroll beneficiaries in the county in which the hospital is located or in a hospital's service area within the county, the hospital will be allowed to participate in the distribution of funds from this pool.
- If only a single Medicaid HMO has been authorized by Medicaid to enroll beneficiaries in the county in which the hospital is located, the hospital must have a signed agreement with that HMO.
- If two or more Medicaid HMOs have been authorized by Medicaid to enroll beneficiaries in the county in which the hospital is located, the hospital must have a signed agreement with at least two of the HMOs.
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At a minimum, agreements must provide for appropriately authorized, medically necessary inpatient hospital, outpatient hospital, emergency and clinical care arranged by a physician with admitting privileges to the facility and credentialed by the HMO.

Distributions from the managed care outpatient hospital adjustor pool will be calculated as follows:

Charges are limited to outpatient hospital charges for provider types 40, 41, and 75.

Hospital Charges = Title XIX HMO outpatient hospital charges
Hospital Costs = Hospital Charges x CC Ratio x Inflation Factor

\[
\text{Hospital's Distribution} = \frac{\text{Hospital's Costs}}{\sum \text{Hospitals' Costs}} \times 8,406,600
\]

Title XIX = Medicaid Health Maintenance Organization
CC Ratio = Hospital's outpatient cost – to – charge ratio

Distribution of funds from all pools will be made prior to September 30, 2002. Should a hospital fail to qualify for a distribution from either pool, its share will not be redistributed.

E. Medicaid Access to Care Initiative (MACI) Payments

TN NO.: 15-0016 Approval Date: AUG 16, 2016 Effective Date: 11-01-15

Supersedes
TN No.: 04-05

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FY 2005 and Beyond

To ensure continued access by Medicaid beneficiaries to high quality hospital care, the Michigan Department of Health and Human Services (DHHS) is establishing two special funding pools. To keep payments within the federal Medicare upper payment limit (UPL), separate pools will be established for privately-owned or operated hospitals and non-state government-owned or operated hospitals for outpatient hospital services. Only hospitals located within Michigan, enrolled in the Medicaid program, open, treating, and admitting Medicaid beneficiaries ten (10) days prior to a scheduled payment will be eligible to receive distributions from these pools. The state uses a cost based UPL methodology whereby the Medicare Cost-to-charge ratio is multiplied by Medicaid covered outpatient charges and summed by hospital class.

Cost-to-Charge Ratio Data Source – CMS 2552:

Medicare Outpatient Charges
Hospitals, Free Standing Rehab & Rehab Sub-providers:
Worksheet D Part V Columns 2, 3, & 4 (Including all subscripts)
Total of Lines 50 - 93 and 94 - 95 (Including subscripted lines)

Medicare Outpatient Costs
Hospitals, Free Standing Rehab & Rehab Sub-providers:
Worksheet D Part V Columns 5, 6, & 7 (Including all subscripts)
Total of Lines 50 - 93 and 94 - 95 (Including subscripted lines)

Trend Factors

Inflation – Market Basket Index used, prorated quarterly, and Applied to Medicaid charges only

Volume/Utilization: Applied to both Medicaid payments and charges.

The distribution of payments from these pools will supplement the hospital’s regular outpatient services payments and is not considered part of the fee for service (FFS) reimbursement. Medicaid payers that normally match the department’s FFS payments to medical providers are not required to include the distribution payments from the pools described here as part of their FFS payments.

Attachment 4.19-B
Page 2.b.6

TN NO.: 15-0016 Approval Date: AUG 16, 2016 Effective Date: 11-01-15

Supersedes
TN No.: 04-05

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
Full pool sizes will be renewed annually. For FY 2005 and beyond, pool sizes will be established based on the calculated difference between the federal Medicare upper payment limit and annual Medicaid payments.

Payment Share – Outpatient Paid Claims File

To determine each hospital’s share of a pool, the department will use paid claims for the fiscal year ending two years prior to the current fiscal year. Adjudicated claims will be restricted to those paid by June 30th of the following fiscal year (e.g. paid claims from FY 2014 will be used to calculate payments in FY 2016 with claims limited to those paid by June 30, 2015). The paid claims file will include all Medicaid FFS payments made for both Medicaid and dual Medicaid children’s special health care services (CSHCS) eligible beneficiaries through the Medicaid Invoice Processing System. Outpatient services will include both acute and rehabilitation services. Payments made outside the Invoice Processing System, such as for capital, graduate medical education (GME), or disproportionate share hospital (DSH), will not be included in the payments used to distribute the MACI pools.

Allocation of Pool

MACI payments are made prospectively based on historical data. Eligible hospitals will share proportionately from each pool based upon a hospital's payments from adjudicated Medicaid claims, divided by the total Medicaid payments from adjudicated Medicaid claims for all eligible hospitals, times the dollar amount of the individual pool. If a hospital closes, is determined ineligible to receive funds from a pool, or its MACI distribution causes the hospital's Medicaid payments to exceed costs, its MACI distribution in excess of costs will be redistributed to the remaining eligible hospitals based on the original distribution formula. All funds from the outpatient hospital pools will be distributed to eligible hospitals until the pools are empty. In the event that MACI distributions would result in aggregate Medicaid payments exceeding the UPL, the size of the pool(s) will be reduced to bring aggregate Medicaid payments within the UPL. All MACI payments are final.

Payment Schedule

Subsequent payments will be made within 45 days of the beginning of each quarter. The quarterly payments will be made in four equal installments based on the total annual amount each hospital is eligible to receive.
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Payment Schedule

Payments will be made only after MDCH has received approval of this policy from the Centers for Medicare & Medicaid Services. Once approval is received, the initial payment will be made within 45 days. Subsequent payments will be made within 45 days of the beginning of each quarter. Quarterly payments will be made in four equal installments based on the annual amount each hospital is eligible to receive.
4. Home Health Services

Reimbursement to home health agencies is made on a per visit basis in accordance with Medicaid's maximum fee screens or the home health agency's usual and customary charge (acquisition cost for medical supply items), whichever amount is less. The Michigan Medicaid rates were set April 1, 2007. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Michigan Medicaid fee schedule effective for dates of service on or after July 1, 2018, may be found at www.michigan.gov/medicaidproviders.

Supersedes
TN No.: 09-15

Approval Date: JULY 26, 2018
Effective Date: 07/01/2018

TN NO.: 18-0003
4. Home Health Services

Effective on or after April 1, 2010, providers may bill for pediatric electrolyte products as a non-pharmacy nutritional supplement. Providers are reimbursed the lesser of the Medicaid fee screen or the provider’s usual and customary charge minus any third party payment. The provider’s usual and customary charge should be the fee most frequently charged to patients. The payment rate is uniform for private and governmental providers. The current Michigan Medicaid fee schedule is available at www.michigan.gov/medicaidproviders.
4. Home Health Services (continued)

Medical Supplies

Payment rates for medical supplies are established by the Medical Services Administration (MSA) as a fee screen. The MSA uses the Medicare prevailing fees, the Resource Based Relative Value Scale (RBRVSW) and other relative value information, other State Medicaid fee screens and providers’ charges as guidelines or reference in determining the maximum fee screens for individual items. Providers are reimbursed the lesser of the Medicaid fee screen or the provider’s usual and customary charge minus any third party payment. The provider’s usual and customary charge should be the fee most frequently charged to patients. Michigan meets the certification requirements of section 1902(A)(23) of the Social Security Act to permit the selection of one or more providers, through a competitive bidding process, to deliver incontinent supplies on a statewide basis under the authority of section 1915(a)(1)(B) of the social security act and 42 CFR 431.54(d). The state Medicaid incontinent supply rates were set January 1, 2016. Except as otherwise noted in the plan, state-developed fee schedule rates for home health medical supplies are the same for both governmental and private providers. The Michigan Medicaid fee schedule is effective for dates of service on or after July 1, 2018 and may be found at www.michigan.gov/medicaidproviders.

Oxygen

The payment rate for oxygen is established by the Medical Services Administration (MSA) as a fee screen. The MSA uses the Medicare prevailing fees, the Resource Based Relative Value Scale (RBRVSW) and other relative value information, other State Medicaid fee screens and providers’ charges as guidelines or reference in determining the maximum fee screens for individual items. Providers are reimbursed the lesser of the Medicaid fee screen or the provider’s usual and customary charge minus any third party payment. The provider’s usual and customary charge should be the fee most frequently charged to patients. The payment rate is uniform for private and governmental providers. The Michigan Medicaid fee schedule, effective for services rendered on or after July 1, 2009 is available at www.michigan.gov/medicaidproviders.

Ambulatory uterine activity monitors

Ambulatory uterine activity monitors are paid a per diem rate. All equipment, perinatal nursing services, technical services and supplies necessary for the provision of the monitor are considered included in this rate. Providers’ charges and other states’ Medicaid fee screens are utilized as guidelines or reference in determining the fee screen. The per diem rate is the lesser of the single state agency’s fee screen or the provider’s usual and customary charge minus any third party payment. The provider’s usual and customary charge should be the fee most frequently charged to patients. The payment rate is uniform for private and governmental providers. The Michigan Medicaid fee schedule, effective for services rendered on or after July 1, 2009 is available at www.michigan.gov/medicaidproviders.
5. Rural Health Clinic Services

RHCs will be reimbursed under one of the methodologies as described below:

(a) an RHC that is not reimbursed under (b) below will be reimbursed based on the new Medicaid prospective payment system (PPS) enacted into law under section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Under the PPS, an RHC will be reimbursed on a per visit basis for Rural Health Clinic services. The per visit payment will be based on the average of the RHC's reasonable costs of providing Medicaid services during FY 1999 and FY 2000. Reasonable costs are defined as the per visit amount approved and paid by Medicare.

Effective October 1, 2001, the per visit amount will be adjusted each year using the Medicare Economic Index. The per visit amount may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by the RHC. An adjustment to the per visit amount based upon a change in the scope of services will be prospective and will become effective when the change is approved by the State. The adjustment may result in either an increase or decrease in the per visit amount paid to the RHC.

RHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive prospective, quarterly supplemental payments that are an estimate of the difference between the payments the RHC receives from the MCE and the payments the RHC would have received under the PPS. At the end of each RHC's fiscal year, the total amount of supplemental and MCE payments received by the RHC will be reviewed against the amount that the actual number of visits provided under the RHC's contract with one or more MCEs would have yielded under the PPS. The RHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the RHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The RHC will refund the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the RHC, if the PPS amount is less than the total amount of supplemental and MCE payments.
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5. Rural Health Clinic Services (continued)

OR

(b) an alternative payment methodology that is agreed to by the State and the RHC that provides reimbursement at least equal to that which the RHC would receive under the PPS. If such an alternative payment methodology is agreed to, it will be submitted to HCFA as a State Plan Amendment.

An entity that first qualifies as an RHC after fiscal year 2000, will be paid a per visit amount that is equal to 100% of the costs of furnishing such services during such fiscal year based on the rates established under the PPS for the fiscal year for other RHCs located in the same or adjacent area with a similar case load. If there is no other RHC similarly situated, the newly established RHC shall be paid a per visit amount based on an estimate of its reasonable costs of providing such services and cost settled at the end of its first fiscal year of operation. Reasonable costs are defined as the per visit amount approved and paid by Medicare as adjusted to reflect the cost of providing services to Medicaid beneficiaries that are not covered by Medicare – i.e., dental services, Maternal/Infant Support services, on-site laboratory and x-ray, substance abuse, non-emergency transportation and outreach. In subsequent fiscal years, the newly established RHC shall be paid using one of the methodologies described above.

If a newly established RHC enters into contracts with one or more MCEs, it will be eligible for quarterly supplemental payments as described in (a) above.
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Section 1697 of P.A. 114 of 1999 directs the Department of Community Health to distribute $20,675,500 in funds to eligible hospitals in the form of an outpatient adjustor for state fiscal year 1999/2000.

The department is directed to divide the available funds into two equal pools in the amount of $10,337,750 each to be distributed to eligible hospitals. The first pool will be distributed to eligible rural and sole community hospitals. The second pool will be distributed to eligible urban hospitals.

The definitions of sole community, rural and urban hospitals found in Attachment 4.19-A, Section I., Capital, will be used to determine eligibility for each of the two pools.

To be eligible to receive funds from either pool, a hospital must be operating as of April 1, 2000 and have outpatient hospital charges on its cost report ending in State Fiscal Year 1997/98 (between October 1, 1997 and September 30, 1998). Outpatient hospital charges will be limited to those charges eligible for reimbursement from the following funding sources: Title V, Title XIX, and the State Medical Program. Allowable charges will also include Title XIX psychiatric charges, charges for clients enrolled in Title XIX qualified health plans, and uncompensated charges for outpatient hospital services. Recoveries and offsets will be deducted. Charges will be converted to costs using each hospital's outpatient cost to charge ratio. This is the ratio used in the FY 2000 disproportionate share hospital calculations. If a hospital's cost to charge ratio is greater than one, then one will be used. Costs will be inflated to a common point in time (September 30, 2000). Inflation factors will be taken from Standard and Poor's DRI - Health Care Cost Review - Second Quarter 1999. Hospitals with year ends during a quarter will be inflated using the inflation factor for the quarter in which the hospital's year ends. A hospital's distribution from a pool will be determined by dividing its adjusted costs by the adjusted costs for all eligible hospitals times the funds available in the pool.

Inflation factors used to inflate costs to September 30, 2000 are as follows:

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To summarize each pool's distribution:

Charges are limited to outpatient hospital charges.

*Hospital Charges = Title V + Title XIX + Title XIX-QHP + SMP + Psychiatric + Uncompensated - (Recoveries & Offsets)*

Supersedes: 11-14 Supersedes: N/A – New

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\[ \text{CC Ratio} = \text{Hospital's outpatient operating cost-to-charge ratio} \]
\[ \text{Hospital Costs} = \text{Hospital Charges} \times \text{CC Ratio} \times \text{Inflation Factor} \]
\[ \text{Each Hospital's Distribution} = \frac{\text{Hospital's Costs}}{\sum \text{Hospital's Costs}} \times \$10,337,750 \]

QHP = Qualified Health Plan
SMP = State Medical Program

Hospitals which filed more than a single cost report during the eligibility period for these pools will have their cost report data combined and annualized to allow for only twelve months of combined cost data. Hospitals which have merged will have their distribution payments combined. Payments will be made to the surviving hospital.

Charge data taken from hospital cost reports is subject to review and appeal at the time the cost report is filed. The hospital's outpatient cost to charge ratio is subject to review at rebasing. No further appeal of either the charge data or the outpatient cost to charge ratio, as part of the distribution of funds from these pools, will be allowed.

Aggregate Medicaid reimbursement to Michigan outpatient hospitals (including the special indigent pools) will not be allowed to exceed the federally imposed upper limit for outpatient services provided to Michigan recipients. To account for varying hospital year end dates, this test will be made annually based on hospital fiscal years ending during the State fiscal year (e.g. the test for 2000 will use hospital years ending between October 1, 1997 and September 30, 1998). If the test against the upper limit finds that the upper limit was exceeded, the size of the special indigent pools will be reduced by the amount in excess of the limit. If the upper limit test supports our claim that Medicaid's total payment is less than the Medicare payment would have been for comparable services under comparable circumstances, the amount up to the upper limit may be dispersed to the qualifying hospitals.

A single distribution of funds from the two rural/urban pools will be made prior to September 30, 2000. A table listing eligible hospitals and distributions from each pool is attached as appendix A.
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6. Dentures, prosthetic devices and eyeglasses/optical house services

A. Dentures

The agency’s fee schedule rate was set using the same methodology that applies to Item 19, Dental Services.

B. Prosthetic Devices

1.) Hearing Aids

The Michigan Medicaid payment rates established via a multi-state volume purchasing agreement with hearing aid manufacturers rates were set September 1, 2017. Michigan meets the certification requirements of section 1902(A)(23) of the Social Security Act to permit the selection of one or more providers, through a competitive bidding process, to deliver hearing aids on a statewide basis under the authority of section 1915(a)(1)(B) of the Social Security Act and 42 CFR 431.54(d). The Michigan Medicaid fee schedule is effective for dates of service on or after July 1, 2018 and may be found at www.michigan.gov/medicaidproviders.

For hearing aids not included in the agreement, that is those reimbursed on a fee for service basis, payment rates and reimbursement are prior authorized and are based on documentation of the manufacturer’s invoice price minus any discounts and includes actual shipping costs. The provider’s usual and customary charge should be the fee most frequently charged to patients.

Effective November 1, 2002 hearing aid providers were able to split out a dispensing fee from their total charge as a separate billing activity and the Michigan Medical Services Administration (MSA) paid a separate benefit for the service. Other states’ Medicaid fee screens and providers’ charges for hearing aid dispensing fees were used as guidelines or reference in determining the maximum payment amount. Providers are reimbursed the lesser of the Medicaid fee screen or the provider’s usual and customary charge minus any third party payment. The provider’s usual and customary charge should be the fee most frequently charged to patients. The payment rate is uniform for private and governmental providers.

2.) Cochlear implants

Payment rates for services related to cochlear implants are based on the rate for the HCPCS/CPT code in the National Physician Fee Schedule multiplied by the conversion factor for Michigan Medicaid, which is currently 21.53 and then minus any other reduction (i.e., 2009 budget reductions).

______________________________________________________________________

TN NO.: 18-0003      Approval Date: JULY 26, 2018      Effective Date: 07/01/2018

Supersedes
TN No.: 09-15
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3.) Shoe Stores

Payment rates for shoes are established by the Medical Services Administration (MSA) as a fee screen. Providers are reimbursed the lesser of the Medicaid fee screen or the provider’s usual and customary charge minus any third party payment. The provider’s usual and customary charge should be the fee most frequently charged to patients.

C. Eyeglasses/optical house services/Optician services

Payment for optical house services is on the basis of contracted prices established in conformance with federal procurement policies. Optical houses are reimbursed only for materials.

Providers furnishing materials obtained from an optical house under contract with the State are reimbursed only for the services involved in dispensing such materials. Providers are reimbursed the lesser of the Medicaid fee screen or the provider’s usual and customary charge minus any third party payment. The provider’s usual and customary charge should be the fee most frequently charged to patients.

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Approval Date: AUG 08 2011  Effective Date: 07/01/2009
Supersedes TN No.: 11-14
Supersedes TN No.: N/A – New Page

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7. Personal Care Services

Reimbursement is made according to variable rates, depending upon the setting of service delivery, payment levels determined by policy or the legislature, and beneficiary needs.

Basic rates for personal care services provided in a beneficiary's own home, or his/her place of employment, are as established by Medicaid policy. A Medicaid approved case manager performs an assessment of the beneficiary's needs and determines the amount of care required. Tasks are assigned minute values and the minutes are converted to hours and billed as a total (of hours) at the end of the month. The case manager is permitted to authorize services up to a specified level. The Medicaid agency allows designated local agencies to make exceptions to the maximum specified authorization level, with supervisory approval, if a beneficiary's needs are extensive or intensive enough to require more, or more costly services. For cases exceeding the designated local agency's maximum authorization level, decisions are referred to the single state agency to consider the documented need.

Beneficiaries in general adult foster care facilities or homes for the aged, have, in accordance with a standardized assessment, a documented need for personal care services.

For the majority of beneficiaries, required services are provided on a daily basis. Beneficiary/service care provider encounters occur no less frequently than once a week. Services are provided in weekly units and billed monthly.

The reimbursement methodology for personal care services for beneficiaries in general adult foster care facilities or homes for the aged will end effective September 30, 2009. The agency's rates were set as of October 1, 2008 and are effective for services on or after that date. The rate is uniform for governmental and private providers unless otherwise indicated in the State Plan. The amount of the rate may be found at www.michigan.gov/medicaidproviders.

Personal care in specialized foster care facilities is covered under Michigan's 1915(b) waiver for specialty supports and services for people with developmental disabilities, serious mental illness, serious emotional disturbance and substance use disorder. The service is carved out of the state plan benefit and managed by pre-paid inpatient health plans (PIHPs) that are governmental entities receiving a capitation payment for an array of services that includes personal care as well as other state plan and 1915(b)(3) services. PIHPs purchase personal care services from adult foster care providers whose facilities have been certified by the state to provide specialized services. Personal care in specialized residential settings must be medically necessary for the Medicaid beneficiaries who receive it. PIHPs establish a rate for personal care services based on an assessment of the severity of each individual’s needs and the amount, scope and duration of the personal care activities and tasks identified during person-centered planning to meet the individual’s needs. Medicaid beneficiaries who receive personal care in specialized residential settings have documented needs that are higher than beneficiaries who receive services in general foster care settings.
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9. Case Management Services

A. Reimbursement for Targeted Group A case management services will be on a Fee-for-Service basis. For mental health, preliminary fee screens are adjusted to final once each year. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Michigan Medicaid fee schedule effective for dates of service on or after May 1, 2005, may be found at www.michigan.gov/medicaidproviders.

B. Reimbursement for Targeted Group C case management services will be on a Fee-for-Service basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Michigan Medicaid fee schedule effective for dates of service on or after May 1, 2005, may be found at www.michigan.gov/medicaidproviders.

C. Reimbursement for Targeted Group D case management services will be on a Fee-for-Service basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Michigan Medicaid fee schedule effective for dates of service on or after April 14, 2004, may be found at www.michigan.gov/medicaidproviders.

D. Reimbursement for Targeted Group E case management services will be through an Annual Reconciliation Cost based Settlement Process after the end of the school fiscal year.

E. Reimbursement for Targeted Group F case management services will be on a Fee-for-Service basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Michigan Medicaid fee schedule effective for dates of service on or after May 9, 2016, may be found at www.michigan.gov/medicaidproviders.

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10. Hospice Services

Michigan will pay the Medicaid Hospice rates developed annually by the Centers for Medicare and Medicaid Services and apply the appropriate local wage index for the following categories or levels of care provided. The “appropriate local wage index” is the index indicated for the recipient’s county of residence. With the exception of payment for physician services, Medicaid reimbursement for hospice care will be made at predetermined rates for each day the individual receives care under one of the following categories or levels of hospice care.

There are four categories or levels of Medicaid hospice care:

A. Routine Home Care, (RHC)
   Hospice providers are paid at one of two tiers of RHC. Effective for dates of service on or after January 1, 2016. A higher rate is paid for day one (1) through day sixty (60) of hospice care
   - A decreased rate is paid for hospice days 61 and beyond
   - A minimum of sixty (60) days gap in hospice services must elapse before the hospice day count resets to the higher level of RHC reimbursement.

B. Continuous Home Care (CHC)
   CHC is to be provided only during a period of crisis. CHC is covered when a patient requires primarily nursing care to achieve palliation or management of acute-medical symptoms. This care need not be continuous (i.e. 4 hours could be provided in the morning and another 4 hours provided in the evening of that day). A minimum of eight hours of care per day must be provided to qualify as continuous home hospice care. At least half of the hours of CHC must predominantly be that of nursing care provided by either a registered nurse or licensed practical nurse in a crisis situation. Home health aide or homemaker services may be provided in addition to nursing care. Payment is made for the hours of continuous care provided, up to 24 hours in one day. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.

C. Inpatient Respite Care
   Inpatient Respite Care is defined as short-term inpatient care to relieve the primary caregiver(s) providing at-home hospice care for the beneficiary. Hospice care may be provided in a licensed hospice residence, hospital, or nursing facility meeting hospice standards for staffing and patient areas. Medicaid inpatient respite care will pay for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. Medicaid will pay for the sixth and any subsequent days at the routine home care rate. Inpatient Respite care may not be provided when the hospice patient is a nursing home resident.

D. General Inpatient Care
   General inpatient care is covered when the beneficiary’s condition is such that their symptoms cannot be adequately treated under the routine hospice care benefit. It is
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defined as short-term inpatient care provided in a licensed hospice residence, hospital, or Nursing Facility meeting hospice standards for staffing and patient areas. This brief episode of care is usually for pain control, or acute or chronic symptom management, that cannot be reasonably treated in another setting. General inpatient care is not to be used solely if a beneficiary requires care in a facility setting. Michigan Medicaid provides payment for room and board in a nursing facility if the beneficiary’s hospice care would be more appropriately provided in this setting under the routine hospice benefit.

Service Intensity Add-On
Effective for dates of service on or after January 1, 2016, a Service Intensity Add-on (SIA) rate will be reimbursed to hospice agencies for services provided by a registered Nurse (RN) or Social Worker in the last seven days of a hospice beneficiary’s life, under the following conditions:

1) The SIA payment is provided for visits of a minimum of 15 minutes but not more than four hours combined in a day.
2) During the last seven days of a beneficiary’s life for in-person visits made by an RN and/or Social worker when the beneficiary is receiving routine home care.
3) The SIA payment is made in addition to the routine home care rate for the day. However, the total of combined time rendered by an RN and Social Worker will not be reimbursed for more than four hours a day.

Direct patient care provided by the hospice medical director, hospice employed physician or consulting physician must be billed by the hospice, using the appropriate Common Procedure Coding System code(s) and will be reimbursed at the applicable Medicaid fee screen.

If the beneficiary is residing in a Medicaid enrolled nursing facility, Michigan will pay the hospice an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility. The amount is determined in accordance with the rates established under Section 1902 (a)(13) of the Act. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility must equal at least 95 percent of the per diem rate that Michigan would have paid to the nursing facility for that individual in that specific facility under Michigan’s Medicaid State Plan.

Medicaid will pay a hospice agency serving a beneficiary in a nursing facility, to hold the beneficiary’s bed for hospital and therapeutic leave when the requirements described under nursing facility reimbursement for hospital and therapeutic leave are met (Attachment 14.9-C, pages 1 and 2).

For fiscal year 2014, and each subsequent year, failure to submit Medicare required quality data shall result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.
11. Maternal Infant Health Program

Reimbursement for Maternal Infant Health Program Services will be the lesser of the provider’s charge or Program fee schedules established relative to similar services reimbursed by the department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Maternal Infant Health Program Services. The Maternal Infant Health Program fee schedule rates were set as of July 1, 2009 and are effective for services provided on or after that date. All rates are reviewed and updated annually and are published on the MDHHS web site at www.michigan.gov/medicaidproviders.
12. Medical care furnished by practitioners within the scope of their practice as defined by state law.

A. Certified Registered Nurse Anesthetists (CRNAs)
   Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of CRNA services. The Agency’s fee schedule rate was set as of 7/1/2009 and is effective for services provided on or after that date. All rates are published on the Agency’s website at www.michigan.gov/medicaidproviders.

B. Chiropractors
   Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of chiropractic services. The Agency’s fee schedule rate was set as of 7/1/2009 and is effective for services provided on or after that date. All rates are published on the Agency’s website at www.michigan.gov/medicaidproviders.

C. Podiatrists
   Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of podiatry services. The Agency’s fee schedule rate was set as of 7/1/2009 and is effective for services provided on or after that date. All rates are published on the Agency’s website at www.michigan.gov/medicaidproviders.

D. Optometrist
   Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of optometry services. The Agency’s fee schedule rate was set as of 7/1/2009 and is effective for services provided on or after that date. All rates are published on the Agency’s website at www.michigan.gov/medicaidproviders.

E. Pharmacists
   Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of pharmacy services. The agency’s fee schedule rate was set as of 4/1/2017 and is effective for services provided on or after that date. All rates are published on the agency’s website at www.michigan.gov/medicaidproviders.
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E. Registered/Licensed Dental Hygienists (RDHs)

Unless otherwise noted, Michigan’s Medicaid payment rates are uniform for private and governmental providers. The Michigan Medicaid fee schedule effective for dates of service on or after October 1, 2010, may be found at www.michigan.gov/medicaidproviders.

For services reimbursed under the fee for service methodology as administered by the Michigan Department of Health and Human Services, providers are reimbursed the lesser of the Medicaid fee screen or the provider's usual and customary charge minus any third party payment. A provider’s usual and customary charge should be the fee they most frequently charge their patients with regard to special considerations or financial status.

F. Psychologists

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of behavioral health services. The Agency’s fee schedule rate was set as of 9/1/2015 and is effective for services provided on or after that date. All rates are published on the Agency’s website at www.michigan.gov/medicaidproviders.

G. Social Workers

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of behavioral health services. The Agency’s fee schedule rate was set as of 9/1/2015 and is effective for services provided on or after that date. All rates are published on the Agency’s website at www.michigan.gov/medicaidproviders.

H. Professional Counselors

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of behavioral health services. The Agency’s fee schedule rate was set as of 9/1/2015 and is effective for services provided on or after that date. All rates are published on the Agency’s website at www.michigan.gov/medicaidproviders.

I. Marriage and Family Therapists

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of behavioral health services. The Agency’s fee schedule rate was set as of 9/1/2015 and is effective for services provided on or after that date. All rates are published on the Agency’s website at www.michigan.gov/medicaidproviders.
12.1 Physical Therapy and Related Services

A. Physical therapists

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physical therapy services. The agency’s fee schedule rate was set as of 1/1/2018 and is effective for services provided on or after that date. All rates are published on the agency’s website at www.michigan.gov/medicaidproviders.

B. Occupational therapists

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of occupational therapy services. The agency’s fee schedule rate was set as of 1/1/2018 and is effective for services provided on or after that date. All rates are published on the agency’s website at www.michigan.gov/medicaidproviders.

C. Speech-language pathologists

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of speech therapy services. The agency’s fee schedule rate was set as of 1/1/2018 and is effective for services provided on or after that date. All rates are published on the agency’s website at www.michigan.gov/medicaidproviders.

D. Audiologists

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of audiology services. The agency’s fee schedule rate was set as of 1/1/2018 and is effective for services provided on or after that date. All rates are published on the agency’s website at www.michigan.gov/medicaidproviders.
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13. Rehabilitation Services

a. Rehabilitation Services for Neurological Damage

Reimbursement for rehabilitation services for persons with neurological damage will be according to per diem, individually priced, negotiated rates which reflect the service needs and a reasonable cost basis for the services rendered. Reimbursement will exclude payment for room and board, educational and vocational services.

b. Mental Health Community Rehabilitation Services

Reimbursement for mental health community rehabilitation services will be on a fee-for-service basis. Payment will be the lesser of charge or fee screen. Preliminary fee screens are adjusted to final once each year. When there are comparable services offered by other provider types, fee screens will be established at comparable levels.

c. Substance Abuse Treatment Rehabilitation Services

Reimbursement for substance abuse treatment rehabilitation services will be on a fee-for-service basis. Payment will be the lesser of charge of fee screen. Preliminary fee screens are adjusted to final once each year. When there are compatible services offered by other provider types, fee screens will be established at comparable levels.

d. Mental Health Psychosocial Rehabilitation Programs (PSR)

The Medicaid-covered components of PSR are reimbursed as a package using one procedure code for the total components. The rate was established at the 90th percentile of the cost range of existing PSR programs based on a survey of those programs. Providers will be reimbursed the lesser of charge of the established fee screen. Preliminary fee screens are adjusted to final once each year.
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13.e) Intensive/Crisis Residential Services

Reimbursement will be the provider's usual and customary charge to the general public or a maximum allowable cost, on a per diem basis, whichever is less. Preliminary fee screens are adjusted to final once each year. The per diem rate will be an inclusive rate for the covered services provided in the residential setting. Separate rates will be established for persons who attend out of home day programs and those who do not. Medicaid will not pay for room, board and routine supervision for any crisis residential participant.

13.f) Intensive/Crisis Stabilization Services

Reimbursement will be the provider's usual and customary charge to the general public or a maximum allowable cost, whichever is less. Preliminary fee screens are adjusted to final once each year. The reimbursement rate is an inclusive rate for the covered services provided during the crisis stabilization service and is based on a half-hour of intensive/crisis stabilization services.

Note: Page 6b has been deleted. The next page is 5c.
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14. Federally Qualified Health Center Services

As set forth in Section 1902(bb), all FQHCs that provide services (defined in section 1905(a)(2)(C)) after January 1, 2001 are reimbursed under either a prospective payment system (PPS) or an alternative payment methodology (APM) as selected by the FQHC.

Effective for dates of service on or after January 1, 2014, FQHCs providing specific Non-FQHC procedures in the FQHC setting will be Reimbursed pursuant to the payment methodology described under Attachment 4.19-B, Individual practitioner services. These non-FQHC procedures will not be subject to the PPS per visit amount.

The following are considered non-FQHC procedures:

- Endometrial ablation, thermal, without hysteroscopic guidance
- Endometrial cryo ablation with ultrasonic guidance, including endometrial curettage, when performed
- Hysteroscopy with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermo ablation)
- Hysteroscopy with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants

Effective for dates of service on or after January 1, 2014, FQHCs administering specific vaccines and drugs in the FQHC setting will be reimbursed pursuant to the payment methodology described under Attachment 4.19-B, Individual Practitioner Services.

The following vaccine and drugs that will not be subject to the PPS per visit amount include:

- Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use
- Rho(D) immune globulin (Rhlg), human, full-dose, for intramuscular use
- Human Papilloma virus (HPV) vaccine, types 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use (Applicable to adult beneficiaries age 19 years and over only)
- Physician administered drugs, including chemotherapy drugs (Commonly referred to as J-Codes)

FQHCs will be reimbursed under one of two methodologies as described below.

(a) an FQHC that is not reimbursed under (b) will have eligible encounters reconciled to the Medicaid prospective payment system (PPS), as described. Under the PPS, an FQHC will be reimbursed on a per visit basis. The per visit payment was based on the average of the FQHC’s reasonable costs of providing Medicaid Services during FY 1999 and FY 2000. Reasonable costs are defined as the per visit amount approved by Medicare as of October 1, 2001 and then adjusted to reflect the cost of providing services to Medicaid beneficiaries that are not covered by Medicare.

The baseline per visit amount will be adjusted annually, beginning October 1, 2001, using the Medicare Economic Index as designated in Section 1902(bb)(3)(A).

The per visit amount may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by the FQHC. An adjustment to the per visit amount based upon a change in the scope of services will be prospective and will become effective when the change is approved by the State. The adjustment may result in either an increase or decrease in the per visit amount paid to the FQHC.

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive prospective, quarterly supplemental payments that are an estimate of the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received under the PPS. At the end of each FQHC’s fiscal year, the total amount of the supplemental and MCE payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHC’s contract with one or more MCEs would have yielded under the PPS. The FQHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC. If the PPS amount exceeds the total amount of supplemental and MCE payments, the FQHC will refund the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC. If the PPS amount is less than the total amount of supplemental and MCE payments.
14. Federally Qualified Health Center Services (continued)

OR

(b) An FQHC may agree in writing, through a Memorandum of Agreement, to be reimbursed under the alternate payment methodology (APM) described in this subsection. For an FQHC paid under the APM, the PPS base methodology described in Subsection (a.) will be maintained to ensure compliance with Section 1902(bb)(6)(B) of the Act.

Effective for dates of service on or after January 1, 2014, an FQHC paid under this APM in accordance with Section 1902(bb)(6) of the Act will receive 100% of their rate in effect as of this date as determined and described in (a) above, plus the following, as applicable:

1.) For FQHCs providing dental care, an amount will be added on to a dental encounter that includes restorative services, endodontics, or extractions to account for the additional costs associated with these non-preventive procedures. The per visit add on amount will be adjusted annually using the Medicare economic index as described in subsection (a.).

FQHCs that provide services under a contract with a Medicaid managed care entity (MCE) will receive prospective, quarterly supplemental payments that are an estimate of the difference between the payments the FQHC receives from the MCE and the payments the FQHC would have received under the PPS. At the end of each FQHC’s fiscal year, the total amount of the supplemental and MCE payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHC’s contract with one or more MCEs would have yielded under the PPS. The FQHC will be paid the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount exceeds the total amount of supplemental and MCE payments. The FQHC will refund the difference between the PPS amount calculated using the actual number of visits and the total amount of supplemental and MCE payments received by the FQHC, if the PPS amount is less than the total amount of supplemental and MCE payments.

Newly Created FQHCs

An entity that first qualifies as an FQHC after fiscal year 2000 will be paid a per visit amount that is equal to 100% of the costs of furnishing such services during such fiscal year based on the rates established under the PPS for the fiscal year or other FQHCs located in the same or adjacent area with a similar case load. If there is no other FQHC similarly situated, the newly established FQHC shall be paid a per visit amount based on the statewide average of its reasonable costs of providing such services and will be cost settled at the end of its first fiscal year of operation. Reasonable costs are defined as the per visit amount approved and paid by Medicare as of October 1, 2001 and then adjusted to reflect the cost of providing services to Medicaid beneficiaries that are not covered by Medicare. In subsequent fiscal years, the newly established FQHC shall be reimbursed using (a) or (b), described above. A newly established FQHC is eligible for quarterly supplemental payments. The amount of the quarterly supplemental payment will be estimated based on available information.
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15. Public Clinic Services

Reimbursement for Public Clinic Services, other than dental services, is at reasonable and allowable full costs as described below.

Effective for services provided on or after January 1, 2011, the methodology for achieving actual incurred cost reimbursement is fee for service and Medicaid managed care billings which are subsequently cost settled. To participate in this methodology, qualified providers must supply the Program with a CMS approved Michigan Medicaid cost report - Local Health Department, which lists medical costs, revenue, and encounters for services covered by this section. The cost reports must be in compliance with 2 CFR 225: Cost Principles for State, Local and Indian Tribal Governments (OMB Circular A-87).

Annual cost settlements are performed to ensure that the initial payments were made at reasonable and allowable actual incurred cost. As necessitated by the cost settlement process, any financial adjustments are made with the provider. The settlements are performed for each public clinic and for each fiscal year. The CMS approved Medicaid cost report is due from the Local Health Department five months after their fiscal year end. The initial settlement will be processed within six months of receiving an approved filed cost report. The final settlement will be processed within twenty-four months of receiving the approved filed cost report.

If Medicaid reimbursement exceeds cost then an overpayment has been made. The Michigan Department of Community Health (MDCH) will begin collections of interim payments that exceed the final rate immediately upon final determination.
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POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES OTHER THAN INPATIENT HOSPITAL AND LONG-TERM CARE FACILITIES)

16. Other Services

Other services listed in Section 1905(a) of the act that are not heretofore described are reimbursed on the basis of reasonable charge, as defined in number 1 above.

Michigan will follow the procedures contained in Section 3006(B)(C) of the Medicare Carrier's Manual.
16. Other Services (continued)

Vaccinations –

Effective for services provided on or after June 1, 2015, the administration of vaccines is reimbursed the lesser of the Medicaid fee screen or the provider’s usual and customary charge minus any third party payment. The provider’s usual and customary charge should be the fee most frequently charged to patients. The payment rate is uniform for private and governmental providers. The Michigan Medicaid fee schedule effective June 1, 2015, may be found at www.michigan.gov/medicaidproviders.
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MEDICAL ASSISTANCE PROGRAM

STATE   MICHIGAN

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

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<th>Item</th>
<th>Payment of Title XVIII Part A and Part B Deductible/Coinsurance</th>
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Except for a nominal recipient co-payment, if applicable, the Medicaid agency uses the following method:

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<th>Medicare-Medicaid/QMB</th>
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*For those title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in Attachment 3-A, page 1a.

T.N. No. 29-18
Supersedes Approval Date 6-11-92 Effective Date 02-01-89

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17. An EPSDT visit is paid a flat rate for the visit, and if the following are performed, reimbursement is made over and above of the visit rate:
   - urine test
   - hematocrit or hemoglobin
   - TB test
   - hearing test using a pure tone audiometer
   - developmental test
   - immunizations

EPSDT is paid on a weekly cycle through the invoice processing system using established HCPCS codes and the normal Medicaid methods.

Whenever an EPSDT component that has an HCPCS code is provided outside of an EPSDT package, it is billed under regular Medicaid. An example would be if the only service provided to a child is a developmental test, it is billed separately to Medicaid because there is no method for tracking the child to assure that the rest of the components are performed.

EPSDT visit rates are set under individual practitioner services for given HCPCS codes. (See Attachment 4.19-B, Page 1, 1)

Investigations to determine the necessity for the abatement of blood lead risks are reimbursed at a flat rate taking into account costs associated with assessment of the site, on-site testing, and professional services used per environmental investigation. External laboratory testing of water, paint and soil are not covered. Payment is limited to services provided by certified assessors in accordance with state law.

Medicaid covers the on-site investigation of a child’s home or primary residence as a diagnostic service. A maximum of two sites may be investigated.

Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers of lead investigations. The Michigan Medicaid fee schedule was last updated July 1, 2009 and may be found at http://www.michigan.gov/medicaidproviders.

The following services are covered when prior authorized by the single state agency:
   - private duty nursing – reimbursement will be made on a fee for service basis
   - religious non-medical health care nursing services (formerly Christian Science nursing services) – reimbursement will be on a fee for service basis

Screening and preventive services’ reimbursement is governed by the applicable category of the specific service.

Reimbursement for EPSDT support services is on a fee for service basis, within Medicaid established frequency limits, to providers that have been certified by the single state agency as qualified to provide these services.

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Supersedes
TN No.: 09-07

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Behavioral Health Treatment services are covered when prior authorized by the single state agency:

Except as otherwise noted in the plan, Michigan's Medicaid payment rates are uniform for both private and governmental providers of Behavioral Health Treatment. The Michigan Medicaid fee schedule rates were set as of October 1, 2016, and are effective for dates of service on or after that date. The fee schedule may be found at www.michigan.gov/medicaidproviders.

Reimbursement is made in accordance with Medicaid's maximum fee screens associated with direct Behavioral Health Treatment or the usual and customary charge for these types of services, whichever amount is less.
Pediatric Outpatient Intensive Feeding Services

Reimbursement for the pediatric outpatient intensive feeding services is a bundled rate based on the covered services provided by a multidisciplinary team. This service is reimbursed as a daily rate comprised of all costs associated with the services provided within the day program including: indirect support and patient care expenses compliant with 2 CFR 200; medical care services provided by the physician and other licensed practitioners; and diagnostic, screening and rehabilitative services.

The state assures that it will monitor the provision of services paid under the bundled rate to ensure that beneficiaries receive the types, quantity and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient. Except as otherwise noted in the plan, state developed fee schedule rates for pediatric outpatient intensive feeding program services are uniform for both private and governmental providers. The reimbursement methodology applies to services delivered on or after May 1, 2018. All rates are published at www.michigan.gov/medicaidproviders.
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18. Indian Health Centers (IHC) Services

If eligible, a Tribal 638 facility may choose to participate in the Medicaid Program and receive reimbursement for Medicaid covered services under one of three options.

Option 1: Fee-For-Service

If the 638 facility or the urban center chooses to bill as a fee-for-service provider, the provider may receive reimbursement as established in the State Plan’s Attachment 4.19-B, Page 1, Item 1.

Option 2: Federally Qualified Health Center (FQHC) Payment Methodology

As a provider of Federally Qualified Health Center (FQHC) services, the IHC may receive reimbursement as established in State Plan Attachment 4.19-B, Page 6c, Item 14. Payments must comply with all requirements set forth within State Plan Attachment 4.19-B, Page 6c, Item 14.

Section 5006(d) of the American Recovery and Investment Act of 2009 protects Indian FQHC providers that are not participating providers of a managed care network when serving an American Indian or Alaska Native by requiring the supplemental payment from the state even if there is no contract with the managed care entity.

Option 3: All-Inclusive Rate Payment Methodology

The Indian Health Service (IHS) per visit outpatient rate will be reimbursed by the Indian Health Service in accordance with the annual federal register notice.

As a Tribal 638 facility, the IHC may, in accordance with the Federal Regulations, receive the IHS per visit outpatient rate for a face-to-face visit at the IHC for fee-for-service and managed care enrollees.

A visit is a face-to-face contact within the IHC between a Medicaid beneficiary and the provider of health care services who exercises independent judgment in the provision of Medicaid covered services. All outpatient ancillary Medicaid services are bundled in the per visit rate and cannot be billed as a separate visit. The IHC provider may be credited with no more than one face-to-face visit with a given beneficiary per day, except when the beneficiary, after the first visit, suffers illness or injury requiring additional diagnosis or treatment.

Payments must comply with requirements under Section 1932(h) of the Social Security Act and Section 5006(d) of the American Recovery and Investment Act of 2009 for all contracts with Medicaid Managed Care Organizations (MCO).

The IHCs that provide services with or without a contract with a MCO will receive prospective, quarterly supplemental payments that are an estimate of the difference between the payments the IHC receives from the MCO and the payments the IHC would have received under the IHS per visit outpatient rate.

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At the end of each IHC’s fiscal year, the total amount of the supplemental and MCO payments will be reviewed against the amount that the actual number of visits provided to the enrollees of the MCOs would have yielded under the IHS per visit outpatient rate. The IHC will be paid the difference between the IHS amount calculated using the actual number of visits and the total amount of supplemental and MCO payments received by the IHC, if the IHS amount exceeds the total amount of supplemental and MCO payments. The IHC will refund the difference between the IHS amount calculated using the actual number of visits and the total amount of supplemental and MCO payments received by the IHC, if the IHS amount is less than the total amount of supplemental and MCO payments.

The IHC is free to negotiate contracts with the MCO and receive reimbursement at the contracted rate for managed care enrollees. The negotiated rate may or may not be the IHS rate.

Under all 3 options described above, it is the IHCs responsibility to pursue reimbursement from all legally liable third parties, including Medicare, prior to seeking payment for services from Medicaid.
19. Dental Services

Unless otherwise noted, Michigan's Medicaid payment rates are uniform for private and governmental providers. The Michigan Medicaid fee schedule effective for dates of service on or after July 1, 2009, may be found at www.michigan.gov/medicaidproviders.

For services reimbursed under the fee for service methodology as administered by the Michigan Department of Community Health, providers are reimbursed the lesser of the Medicaid fee screen or the provider's usual and customary charge minus any third party payment. A provider's usual and customary charge should be the fee they most frequently charge their patients with regard to special considerations or financial status.
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B. Dental Services Provided by Practitioners Working in an Eligible Public Dental Clinic

Supplemental payment adjustments equal to the difference between the Medicaid fee for service rate and the average commercial rate will be paid to qualifying providers for services provided on or after April 1, 2005.

Qualifying providers under this payment include any dentists practicing at a Public Dental Clinic as identified in Sections 333.4213, 333.2415 and 333.2421 of the Michigan Public Health Code (PA 368 of 1978 as amended).

Supplemental payment is determined in the following manner:

1. Payment Ceiling Calculated

   First, the payment ceiling is calculated. On a per billing code basis, the Medicaid volume is determined annually. This data is accumulated for each dental provider using paid claims data from the State MMIS system from the most recently completed fiscal year. Next, the volume per dental billing code is multiplied by the average commercial rate paid by third party payers to providers eligible for this supplemental payment. The sum of the products represents the payment ceiling above which supplemental payment may not be made. The data used to determine the average commercial rate will be derived either from dates of service from the most recently completed fiscal year or the current period, depending on the availability of the data.

2. Supplemental Payment Calculated

   Supplemental payment is the difference between the payment ceiling and the base fee for service rate normally paid to qualifying providers. Supplemental payment is made quarterly and subject to an end of year reconciliation. This process consists of comparing interim payment to a recalculated payment ceiling using data from the preceding year in which interim payment was made. If a provider's interim payments, together with the base payment exceed the ceiling, the provider will be required to return the difference. Conversely, if a provider has been paid less than the supplemental payment ceiling, the State will make additional payment. Settlement will occur as a separate transaction from any future base or interim payment and is performed for each Public Dental Clinic and for each fiscal year which ends after September 30, 2005. Settlement of interim payment will occur within one fiscal year following the preceding year's fourth quarterly/interim payment.

Supersedes
TN No.: 05-12

Supersedes
TN No.: N/A new page
20. Laboratory Services

Payment rates for clinical laboratories, physician's offices and clinics are established by the Michigan Department of Community Health as a fee screen for each procedure. The fee schedule is designed to enlist the participation of an adequate number of providers. The Medicare prevailing fees are used as a guidelines or reference in determining the maximum fee screens for individual procedures.

Providers other than the State Bureau of Laboratories are reimbursed the lesser of the Medicaid fee screen or the provider's usual and customary charge minus any third party payment. A provider's usual and customary charge should be the fee most frequently charged to patients. The State Bureau of laboratories may be reimbursed up to the Medicare prevailing fees.

Laboratory services provided by outpatient hospitals or ESRD facilities are reimbursed through the Medicaid OPPS and are not limited by a maximum payment rate per beneficiary per day.

Unless otherwise noted, Michigan’s Medicaid payment rates are uniform for private and governmental providers. The Michigan Medicaid fee schedule effective for dates of service on or after July 1, 2009, may be found at www.michigan.gov/medicaidproviders.
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21. Hearing Aids

For most analog and digital and/or programmable hearing aids, payment rates are established via a multi-state Medicaid volume purchasing agreement directly with hearing aid manufacturers. Providers are reimbursed the vendor prices listed in the agreement and are not allowed to discount or bill more than the contract established prices.

For hearing aids not included in the agreement, that is those reimbursed on a fee for service basis, payment rates and reimbursement are prior authorized and are based on documentation of the manufacturer’s invoice price minus any discounts and includes actual shipping costs. The provider’s usual and customary charge should be the fee most frequently charged to patients. The payment rate is uniform for private and governmental providers. The Michigan Medicaid fee schedule effective February 1, 2009 may be found at www.michigan.gov/medicaidproviders.

Effective November 1, 2002 hearing aid providers were able to split out a dispensing fee from their total charge as a separate billing activity and the Michigan Medical Services Administration (MSA) paid a separate benefit for the service. Other states’ Medicaid fee screens and providers’ charges for hearing aid dispensing fees were used as guidelines or reference in determining the maximum payment amount. Providers are reimbursed the lesser of the Medicaid fee screen or the provider’s usual and customary charge minus any third party payment. The provider’s usual and customary charge should be the fee most frequently charged to patients. The payment rate is uniform for private and governmental providers. The Michigan Medicaid fee schedule effective February 1, 2009 may be found at www.michigan.gov/medicaidproviders.
22. Intermediate School Districts Services (ISD)

Reimbursement for services provided in the school setting is based on a provider specific, cost-based methodology that is reconciled annually.

An interim payment is issued based on the following determination of estimated cost. The interim payments are based on previous year cost reports and paid to the ISDs on a schedule determined by the ISDs.

Services include: Occupational Therapy, Physical Therapy, Speech Language and Hearing, Psychological, Physician, Nursing, Personal Care, Targeted Case Management and Transportation. Descriptions of each service are included in the Supplement to Attachment 3.1-A section of this State Plan.

The following providers with current credentials may provide services in the school setting:
- Certified and registered occupational therapists
- Certified occupational assistants
- Certified orientation and mobility specialists
- Licensed physical therapists
- Certified physical therapist assistants
- Licensed speech-language pathologists
- Teachers of students with speech and language impairments
- Licensed audiologists
- Licensed psychologist
- Limited-licensed psychologist
- Licensed counselor
- Limited-licensed counselor
- Licensed social worker
- Limited-licensed social worker
- Licensed psychiatrist
- Licensed physician (M.D. & D.O)
- Registered nurse
- Licensed practical nurse
- Aides (providing personal care)
- Bachelors degree case managers

A. Direct Medical Services Payment Methodology

Determination of Total Medicaid Reimbursable Cost:

1. Data capture for the cost of providing health-related services is accomplished utilizing various sources. Medicaid allowable non-federal costs are captured from the following reports:
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a. Medicaid allowable costs reported on the annual SE-4096 – Special Education Actual Cost Report Medical Costs Supplement. This is an ISD specific report that identifies direct costs specified in item #2. Each ISD reports costs only for the specific staff that are identified and included in each staff pool. This report does not include any federal dollars.

b. Cost data reports received from the ISD financial contacts. The cost for Personal Care service staff and Targeted Case Management staff is not included in the SE-4096 Medicaid supplemental cost report. These related salaries, fringes, benefits are gleaned from financial worksheets submitted by the ISDs. This cost data is captured utilizing the same methodology currently utilized for the Administrative Outreach Program cost reporting.

c. Michigan Department of Education Indirect Cost Rate

2. Allowable Direct Costs
   Direct costs for direct medical services
   i. Salaries
   ii. Benefits
   iii. Other medically-related costs directly related to the approved direct services personnel for the delivery of medical services such as purchased services/contract costs, travel, materials and supplies.

3. Indirect Cost Rate
   Apply the Michigan Department of Education (MDE) Cognizant Agency Indirect Cost Rate to the net direct costs.

4. Net direct costs and indirect costs calculated in steps 2 and 3 are combined. Random Moment Time Study (RMTS) Discount

5. Random Moment Time Study (RMTS) Discount
   Apply the appropriate direct service percentage obtained from the CMS approved RMTS methodology to determine the percentage of time that approved service personnel spend on direct services, that include Medicaid covered services, general and administrative time and all other activities to account for 100% of time to assure there is no duplicate claiming for all covered services. The RMTS methodology utilizes mutually exclusive staff pool(s) and statewide random moment samples are pulled each quarter to include a sufficient number of personnel from each staff pool to ensure the time study results will be statistically valid.

6. Medicaid Eligibility Rate (MER) Discount
   Medicaid’s portion of total net costs is identified by applying the ISD specific MER to the total net costs.

   The MER is calculated using the following methodology:

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- Using the Fall General Collection Student Count data, a file containing the names and birthdates of the special education students within the ISD with health related IEP is transmitted to the Michigan Department of Community Health (MDCH).

- MDCH uses this list to run an eligibility match process against the Medicaid eligibility system. The ratio of the total number of Medicaid eligible students with health-related IEPs to the total number of students with health-related IEPs is used to determine the Medicaid Eligibility Rate percentage.

B. Specialized Transportation Services Payment Methodology Determination of Total Medicaid Reimbursable Cost:

1. Medicaid allowable direct costs are captured utilizing the following reports:
   a. SE-4094: Special Education costs as reported in the current, CMS approved, SE-4094 Transportation Expenditure Report and identified in Step #2. This report contains only the costs associated with Special Education buses used for the specific purpose of transporting only Special Education children. This report does not include any federal dollars.
   b. Michigan Department of Education Indirect Cost Rate as identified in Step #3.

2. Allowable direct costs as reported on the SE-4094:
   a. Salaries (Sec 52 & Sec 53a; Bus Drivers, Aides & Purchased Service – Staff [Bus Drivers & Aides portion only] lines)
   b. Benefits (Sec 53a; 52 & Sec Employee Benefits line)
   c. Purchased Services - Vehicle Related Costs (Sec 52 & Sec 53a; Pupil Trans. By Carrier, Pupil Trans. By Carrier (b/y), Family Vehicle K Costs, Contracted Taxis, Pupil Trans. Fleet Ins., & Contracted/Leased Busses lines)
   d. Supplies (gasoline, oil/grease, tires, etc.) (Sec 52 & Sec 53a; Gasoline/Fuel, Oil/Grease, & Tires/Batteries lines)
   e. Other expense/Adjustments (Sec 52 & Sec 53a; Other Expense/Adjustment line, only the costs associated with adjustments to allowable costs)
   f. Bus Amortization (Sec 52 & Sec 53a; Bus Amortization line)

3. Indirect Costs
   Apply the Michigan Department of Education Cognizant Agency Indirect Cost Rate to the net direct costs.

4. Net direct costs and indirect costs are combined.

5. Apply Medicaid Eligibility Rate (MER). See Section A, step 6 above.

C. Annual Reconciliation and Cost Settlement Process Health-related services cost reconciliation and settlement:

Within 90 days after the end of the school fiscal year, the ISDs submit the annual cost report (SE-4096 and SE 4094) to the Michigan Department of Education (MOE) and the Michigan Department of Community Health (MDCH). This filed cost report is used by

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MDCH to calculate an interim payment for the following year. Within nine months after the end of the State's fiscal year, the filed cost reports are reviewed by MDE and finalized. The initial settlement is calculated within ninety days of the receipt of the finalized cost reports and may result in either an additional payment or recovery of funds.

Within thirty days MDCH completes the Medicaid Cost Settlement Summary data sheet and Cost Certification form and forwards to the ISDs for approval and signature. The final cost settlement is processed sixty days following the date of the Cost Settlement Summary. If the ISD does not agree with the calculated cost settlement totals they must submit an appeal to MDCH within the first thirty days after receipt of the Cost Settlement Summary. Any discrepancies must be resolved within the ninety days between the initial and the final settlement at which time any under/over adjustments are made.

Specialized transportation cost reconciliation and settlement:

On an annual basis the cost per trip is calculated by dividing the total Medicaid reimbursable cost (Section B, steps 1 through 4) by the number of "allowable" one-way trips paid by the Medicaid Invoice Processing system per ISD. An "allowable" one-way trip is provided to a Medicaid-eligible beneficiary and fulfills all of the following requirements: documentation of ridership is on file, the need for the specialized transportation service is identified in the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), and a Medicaid-covered service is provided on the same date of service.

The Medicaid cost settlement amount is obtained by multiplying the total allowable one-way trips billed through the Medicaid Invoice Processing system times the total cost per trip. This total is compared to the interim payments and any over/under settlements are made.

D. Cost Certification:
Sixty days prior to the final settlement the ISDs receive the Medicaid Cost Settlement Summary report and cost certification form. Both forms must be signed, dated and returned to MDCH prior to the final settlement.
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24. Ambulatory Surgical Centers

Reimbursement to individual Medicare-certified Ambulatory Surgical Centers (ASCs) for outpatient services provided in the ASC setting on or after January 1, 2011 is calculated by applying the MDCH outpatient prospective payment system (OPPS) reduction factor (RF) to current Medicare ASC reimbursement rates. Medicare ASC rate x RF = Medicaid rate.

State-developed fee schedule rates are the same for both governmental and private ASC providers. The ASC reduction factor is monitored and adjusted in accordance with the OPPS reduction factor schedule. The state maintains an up to date reduction factor history posting on the MDCH website that includes the current OPPS/ASC reduction factor, as well as historical OPPS/ASC reduction factors. As of January 1, 2016 the OPPS/ASC reduction factor is 52.6%. A wage index of 1.0 is applied for all ASCs. Services paid by Medicare at reasonable cost and contractor priced items are paid by applying the Medicaid state-wide outpatient hospital cost to charge ratio to the Medicare ASC rate. All rates including the ASC wrap list are published on the MDHHS website at http://michigan.gov/MDHHS.

When service coverage or reimbursement methodology differences exist between Medicare and Medicaid, Medicaid fee schedules are used.

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25. Integrated Care Model (ICM) Payments

Program Description:

Beginning January 1, 2012, the Michigan Department of Community Health (MDCH) will provide care coordination and performance incentive payments to eligible Physician Organizations, (POs), Physician Hospital Organizations (PHOs), and their affiliated primary care practices that serve Medicaid beneficiaries through the Michigan Primary Care Transformation project (MiPCT). MiPCT is a statewide, multi-payer collaboration aimed at reforming primary care payment models and expanding the capabilities of patient-centered medical homes (PCMH) throughout Michigan.

Primary care practices that have achieved Patient-Centered Medical Home (PCMH) designation have a model of care delivery that is patient-centered, team-based, coordinated, accessible, and focused on quality and safety. PCMH has become the widely accepted model for how primary care should be organized and delivered throughout the healthcare system.

PCMH practices deliver care coordination that provides for location, coordination and monitoring of care under the authority of 1905(t) for ICM services. These transformations in the delivery of primary care support the overall goal of MiPCT based on the Institute for Healthcare Improvement’s Triple Aim: to improve patient health status; enhance patients’ overall experience of care; and stabilize or decrease the cost of care. MiPCT strives to create a successful and sustainable model to improve healthcare value and transform primary care delivery in ways that can be replicated statewide.

To be eligible for MiPCT ICM payments, eligible participants must:

- Be part of an existing Physician Organization or Physician Hospital Organization (PO/PHO)
- Have achieved 2010 PCMH designation/recognition through the Physician Group Incentive Program (PGIP) or National Committee for Quality Assurance (NCQA)
- Maintain PCMH designation/recognition
- Sign a participation contract and meet specified MiPCT requirements

Medicaid will use a common approach to reimburse the additional costs for PCMH-related services and reward physicians for delivering coordinated, high-quality care in PCMH-designated practices. Payments will consist of two components:

Care coordination payments will be made quarterly as a $4.50 per member per month (PMPM) payment based on the Medicaid attributed members assigned to those primary care practices that contract with the PO/PHO for care coordination and meet the four criteria specified above.

A $3 PMPM payment will be contributed to a PO/PHO incentive pool. Incentives will be calculated and allocated using an attribution and incentive algorithm based on the multi-payer data in the data repository established for MiPCT. The semi-annual incentive award payments to PO/PHOs will be based on their designated practices’ PCMH implementation activities and performance improvement (compared to other POs/PHOs).
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Performance incentive payments are designed to reward PO/PHOs and their member practices' successful implementation of effective care management practices and PCMH principles. This includes process improvements within practices and achievement of desired health outcomes. Examples include implementation and effective use of appropriate patient disease registries, effective use of care managers to track and follow-up with patients, and ongoing clinical leadership support.

Performance incentive metrics will be established by the Performance Incentive Subcommittee, subject to approval by MDCH. Performance incentive metrics will be assessed every six months of the calendar year. All funds accumulated during that 6-month period will be awarded. The Michigan Data Collaborative (MDC) will calculate a performance incentive score for each PO/PHO.

These payments will be made twice per year after each 6-month cycle.

The PO/PHO performance incentive payment methodology is effective as of February 13, 2012 and can be found at the following location: http://mipctdemo.files.wordpress.com/2011/09/performance-incentive-program-description.pdf.


The 2012 twelve-month performance incentive metrics are effective for July 1, 2012 – December 31, 2012 and published on October 1, 2012. Metrics can be found at the following location: http://mipct.org/resources/miptc-documents-and-presentations/12-month-metrics-final/.

The 2013 six-month and twelve-month performance incentive metrics are effective for both six-month periods in calendar year 2013, January 1, 2013 – June 30, 2013 and July 1, 2013 – December 31, 2013. They were published on April 25, 2013 and can be found at the following location: http://mipct.org/resources/miptc-documents-and-presentations/2013-performance-incentive-metrics/.


Medicaid managed care beneficiaries are attributed to a primary care practice based on the primary care provider (PCP) they choose; if they do not choose a PCP, they are assigned one by their Medicaid Health Plan.

Each month the beneficiary PCP of record is matched against the National Provider Identifiers (NPI) of eligible providers participating in MiPCT. The MiPCT-eligible NPIs are linked with identifiers for the MiPCT eligible practices and POs/PHOs. If a beneficiary changes their PCP to another participating provider, their PCP of record change is captured in the Medicaid data warehouse. The resulting list of Medicaid MiPCT-eligible beneficiaries is grouped by practice and PO. The list is provided to the MDC. On a monthly basis, the MDC posts the enrollee lists on a secure web site and notifies the PO/PHO that the enrollee lists are available.
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On a monthly basis, the MDCH posts the enrollee lists on a secure web site and notifies the PO/PHO that the enrollee lists are available.

The MDCH calculates the care coordination payment amounts quarterly for each PO/PHO by adding the enrollee counts for the applicable PO/PHO for each of the three months in the quarter and multiplying by $4.50.

MDCH transmits quarterly payments to each PO and practice through a gross adjustment payment using the Medicaid payment system. The payments are processed approximately the last month of the quarter. Overpayments and/or underpayments regarding provider and beneficiary eligibility are handled as debits or credits during the following quarter payment cycle.

POs are required to submit quarterly narrative and financial reports to assure that revenues spent are in alignment with the MiPCT Clinical Model. The report will include the progress of each practice and provide an accounting for the funds received and the distribution and use of those funds by participating Practices. The report will include an accounting of care manager activity according to the MiPCT reporting specifications.

State assurances for claiming administrative expenditures related to MiPCT can be found in Attachment 4.19-B, Appendix A, Page 1 of the State Plan.

The sunset date for MiPCT is December 31, 2016.
Rural Access Pool

The State will establish a Rural Access Pool beginning in State FY 2013 for hospitals that provide Medicaid services to low income rural residents. To be eligible for this pool, hospitals must be categorized by the Centers for Medicare & Medicaid Services as a sole community hospital, or meet both of the following criteria.

1. A hospital must have 50 or fewer staffed beds. The State will calculate staffed beds by dividing the total hospital days reported by the hospital on its Medicaid cost report with a fiscal year ending between October 1, 2010 and September 30, 2011, by the number of days covered in the cost report; and

2. A hospital must be located in a county with a population of not more than 165,000 and within a city, village, or township with a population of not more than 12,000. The population threshold will be measured against population counts from the 2000 federal decennial census.

Each hospital’s allocation from this pool will be calculated as the unreimbursed cost the hospital incurred providing outpatient services to Michigan Medicaid beneficiaries during its cost period that ended during the second previous fiscal year. For example, to calculate the 2013 pool, hospital cost reports with fiscal years ending between October 1, 2010 and September 30, 2011 will be used.

Provider costs will be determined using data reported on the following lines of the CMS 2552-96 or their equivalent lines on the CMS 2552-10: GME costs are determined. First, Total Medicaid Outpatient Program Charges (reported on Worksheet D, Part V, Column 5, Lines 37.00 through 65.99, excluding Lines 63.50 through 63.99 of the CMS 2552-96) are divided by Total Hospital Charges Net of Hospital Based Physicians, for all provider types (reported on Worksheet G2, Column 1, Lines 1, 2, 10-14, 17, and 18 of the CMS 2552-96). This ratio is then multiplied by the Intern and Resident Cost (reported on the Worksheet B, Part 1, Columns 22 and 23, Line 95 of the CMS 2552-96) to determine GME costs. Non-GME costs are obtained from Worksheet D, Part V, Column 9, Lines 37.00 through 65.99, excluding lines 63.50 through 63.99. GME and Non-GME costs are combined to determine total costs. The following gross Medicaid payments from this cost report period will be applied against cost to determine unreimbursed cost: operating, capital, graduate medical education, and Medicaid Access to Care Initiative, or any other supplemental payment.

Payments will be made within 45 days of the beginning of each quarter. The quarterly payments will be made in four equal installments based on the total annual amount the hospital is eligible to receive.

The total amount of the rural access pool payments is the sum of each hospital’s allocation from this pool described above.

In the aggregate, the State reimburses hospitals up to maximum allowable under the Federal upper payment limits for outpatient services provided to Medicaid beneficiaries. To keep total Medicaid fee-for-service payments to hospitals within the Federal upper payment limits, the State will reduce the size of the applicable year’s MACI Pool payments by the size of the Rural Access Pool.
MiPCT Administrative Claiming Assurances

The State of Michigan assures there is an agreement in place with the University of Michigan to perform administrative functions on behalf of the State Medicaid Agency and that this agreement was in effect prior to the State Medicaid Agency claiming federal matching funds for expenditures incurred under the agreement. Also identified in the agreement is the mechanism for the University of Michigan to file a claim with the State Medicaid Agency.

The agreement identifies the administrative activities and services the University of Michigan provides and includes provisions related to Medicaid reimbursement and funding mechanisms. Oversight activities and monitoring responsibilities are defined for the State of Michigan regarding the University of Michigan. Maintenance of records, participation in audits, designation of local project coordinators, training timetables and criteria, and submission of fiscal information are also described and defined.

The sunset date for MiPCT is December 31, 2016
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State  Michigan

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

XX 1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters “SP.”

For specific Medicare services that are not otherwise covered by this State Plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in Item _____ of this attachment (see 3 below).

___ 2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters “MR.”

___ 3. Payments are up the amount of a special rate, or according to a special method, described on Page 3 in item _____ of this attachment, for those groups and payments listed below and designated with the letters “NR.”

___ 4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item _____ of this attachment (see 3 above).

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TN NO. 97-024  
Approval Date 2/26/98  
Effective Date 10-01-97

Supersedes  
TN No. 96-17

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MICHIGAN

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Supersedes Approval Date 04-14-92

Effective Date 10-01-91

HCFA ID: 7982E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Payment for Reserved Beds
During a Patient’s Absence from an Inpatient Facility

I. Payment is not made for reserving a bed during a recipient’s absence from an acute care general hospital.

II. Payment for reserving a bed during a beneficiary’s absence from a Long Term Care Facility:

   A. Therapeutic Leave Days – payment is subject to the following conditions:

      1. The beneficiary is away for therapeutic and non-medical reasons (for example, home visits).

      2. Payment for reserving a bed for a beneficiary’s therapeutic leave days may not exceed payments for 18 days during a 365 – day period.

      3. The bed is reserved for the beneficiary during his/her absence.

      4. The beneficiary returns to the facility.

      5. The beneficiary’s written plan of care provides for “home visits” (defined as visits with friends and/or relatives, i.e., therapeutic leave days).

      6. Reimbursement for therapeutic leave days will be made at the facility’s current prospective rate. Therapeutic leave days must be included in the daily inpatient census.

______________________________________________________________________

TN NO.: 10-07 Approval Date: AUG 16 2010 Effective Date: 04/01/2010

Supersedes
TN No.: 05-07

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Payment for Reserved Beds
During a Patient’s Absence from an Inpatient Facility

1. Medicaid will pay to hold a beneficiary's bed only when the facility's total available bed occupancy is at 98 percent or more on the day the beneficiary leaves the facility. Facilities at 97.5 percent occupancy may round up to 98 percent.

2. Medicaid reimburses a nursing facility to hold a bed for up to ten days per hospital admission for emergency medical treatment (defined below), as documented by the attending physician in the resident’s medical record.

3. There must be a reasonable expectation by the attending physician that the resident will return by the tenth day.

4. The beneficiary must return to the nursing home in ten or fewer days for the facility to bill for hospital leave days. Otherwise, the nursing home is released from its obligation to hold the bed.

5. Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual in serious jeopardy; (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

6. Reimbursement for hospital leave days will be a single rate paid to all nursing facility providers regardless of the facility class. The hospital leave day rate is calculated as: the Class I average variable cost, times 95% (room & board portion), times 66% (salary and wage portion of the rate). The single hospital leave day rate will coincide with the State’s fiscal year of October 1 through September 30.

II. Notification of bed-hold policy and readmission is in accordance with CFR 483.12.

Attachment 4.19-C
Page 2
The State has in place a public process which complies with the requirement of Section 1902(a)(13)(A) of the Social Security Act.
1. Cost Finding, Cost Reporting and Records Maintenance

The specific methods of cost finding and cost reporting utilized by the single state agency are defined in the state agency’s cost reporting forms and instructions. Providers shall be notified of the cost reporting form or format and acceptable cost finding methods and notified promptly of change.

A. Beginning with cost reporting periods ending after September 1, 1973, all participating skilled nursing and intermediate care providers are required to submit to the state agency an annual cost report within 5 months of the close of the providers cost reporting period. The provider will be notified of the delinquency and given 15 calendar days to submit the cost report or, if the cost report is not submitted, the provider’s interim payments will be reduced by 100 percent. Restitution of withheld interim payments will be made by the state agency after receipt of an acceptable cost report. (Exception: A provider’s cost report is due 5 months after a sale of a facility or termination of the provider agreement.)

B. All cost reports must be submitted on the state agency’s uniform reporting form or an approved replica thereof, covering a 12 month cost reporting period. An exception is made for Class VII facilities; they are to submit the Medicare skilled nursing facility cost report in place of the state agency’s reporting form. Any changes in reporting periods or exceptions to the number of months covered must be approved by the state agency.

C. Each provider’s cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the provider.

D. The accrual method of accounting is mandated for providers and generally accepted accounting principles must be followed by providers of care under the plan.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

E. Each provider must maintain sufficient financial records and statistical data for proper
determination of costs as allowable, in accordance with Section III of this plan. This
may include pertinent records required by the Medicare Principles of Reimbursement in
42 CFR 413.20 and 42 CFR 413.24.

F. All of the provider’s accounting and related records, including the general ledger and
books of original entry and statistical data, are regarded as permanent records and
must be maintained for a period of not less than seven years.

G. All cost reports are retained by the state agency for not less than three years following
the date of filed receipt by RARSS or designee.

H. Non-allowable expenses are excluded from the total operating expenses in accordance
with procedures identified on the reporting form and defined in Section III of this plan.

I. Related organizations and costs to related organizations (as defined in 42 CFR 413.17)
shall be disclosed by the provider in the cost report.

J. Cost related to intergovernmental transfers: Class III nursing facilities owned by local
governments and any related transaction management fees associated with the
intergovernmental transfer will be recognized outside of the cost reporting process.

K. Revenue from the quality measure initiative described in Section IV must be adjusted
from the cost report as determined by the Michigan Department of Health and Human
Services.

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Supersedes
TN No.: 05-11

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
II. Auditing and Availability of Records

A. Each cost report submitted is verified for completeness, accuracy, reasonableness, and consistency through a desk audit and/or a computer check. It is expected that on-site audits will be conducted no less than once every four years.

B. Each provider must allow access, during on-site audits and/or reviews by the state agency auditors and representatives of the United State Department of Health and Human Services, to requisite financial records and statistical data specified in Section I of this plan. This access will include:

1. The complete records of related organizations

2. The record of lessors to determine underlying capital and operating costs of providers leasing facilities (per Section III.H).


4. Census records and numbers and types of leave days for each Medicaid beneficiary/resident (i.e. hospital, therapeutic).

C. If, upon audit or review, it is determined that a cost report contains incorrect data, the state agency shall use the corrected data to compute future rates and will retroactively change a previously applied rate if – audit adjustments to a filed cost report was used for setting an interim rate; the facility was approved for Plant Cost Certification due to capital cost changes, an approved non-available bed plan, or a plant rate affected by a DEFRA rate limitation for the cost report time period; audit adjustments that are required as a result of an appeal; Class I nursing facility was approved for Rate Relief for the rate year period. In cases of suspected fraud or failure to disclose required fiscal information, the state agency may retroactively adjust rates.

D. The audit process described under this section is not applicable to Class VII facilities.
Allowable costs are those costs related to patient care as permitted by the Medicare Principles of Reimbursement in 42 CFR, Chapter IV, Subchapter B, Part 413 regulatory sections as (regularly) amended, with any additional exceptions or Medicaid provisions included. Where the single state agency has incorporated a Medicare Principle of Reimbursement, PRM-15, interpretations will be used with any additional provisions included. Section IV, "Payment Determination," of this plan specifies the allowable costs to be used as a cost basis for calculating prospective rates.

A. Allowable costs will include the costs of meeting all standards for nursing care provider requirements as required by the state agency, by state law or by federal legislation or regulation.

B. Allowable costs include, but are not limited to, all items of expense which providers incur in the provision of routine services, such as: regular room; dietary; nursing services; minor medical and surgical supplies; administration of oxygen; hand feeding; incontinency care; tray service; enemas; patient gowns; water pitchers; basin; bed pans; bed rails; ice bags; canes; crutches; walkers; wheelchairs; traction equipment; and other durable medical equipment for multpatient use, special dietary services (including tube or oral feeding, special diets), laundry services, social services, patient activity services, transportation for medical and/or dental services, therapist services such as maintenance plan development through implementation and MDS assessments, and physician services of medical staff functioning in an administrative capacity. Socially acceptable personal clothing (Section IV.L) may be an allowable cost in Class IV Intermediate Care Facilities for the Mentally Retarded only. Excluded are personal physician fees, prescribed legend drugs and ancillary services (except as required in Section IV.F) and the costs of total parenteral nutrition solutions and related supplies and equipment.

C. The occupancy that will be used in per patient day cost determinations, for all but Class II facilities, is the greater of the paid occupancy including paid held-bed days excluding hospital leave days or 85 percent of (certified) bed days available during the cost reporting period for which cost information is reported, including new facilities. For facilities that voluntarily remove beds from service, through formal notification to and after obtaining approval for the temporary removal of beds from the Michigan Department of Community Health, occupancy percentages will be computed as a percent of bed days available in the cost reporting period.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Payment Rates – Long Term Care Facilities

period. Owner administrator compensation limits will be applied based on the reduced bed count. Payment determinations for Class II facilities will be based on actual occupancy.

D. Title XIX per patient day cost, for a designated cost component, is the total inpatient cost for that cost component, divided by total inpatient days, as determined from the provider's Medicaid cost report.

E. The Corporate Income Tax is an allowable expense.

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Supersedes
TN No.: 08-04

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Michigan

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(LONG TERM CARE FACILITIES)

F. The allowance for depreciation shall be determined in accordance with 42 CFR 413.134 through
413.149 (including section 413.134(f)) except that only the straight-line method (42 CFR 413.134
(b)(3)) shall be used and the useful life of the assets must be in compliance with subsection 104.17
of the Provider Reimbursement Manual (PRM) Part I. Subsequent to sales, the depreciation basis
will be held subject to the limitation on the revaluation of assets mandated by section
1861(v)(1)(A) of Title XVIII of the Social Security Act.

1. Consistent use of either component or composite asset depreciation schedules is required. Component
depreciation is permitted in the case of a newly constructed facility and for
recognized building improvements where the costs can be separated and acceptable useful
lives determined. Composite depreciation must be used in the case of a newly purchased
existing facility.

2. Depreciated replacement cost is defined as the current reproduction cost (42 CFR
413.134(b)(6)), adjusted for straight-line depreciation over the life of the asset to the time
of the sale (per PRM, Part I, subsection 104.14).

The depreciated replacement cost shall be determined by an independent appraiser chosen
and paid for by the provider in accordance with the "Appraisal Guidelines" in Part I
subsection 134 et seq of the PRM. Prior to the appraisal, the state agency must notify the
appraiser of the "Appraisal Guidelines" to be utilized in the determination of his/her
appraisal.

3. Class I and Class II facilities, paid in accordance with section IV.A., will not be paid
based upon depreciation expense.

G. The allowance for interest expense shall be determined using principle 1 or 2 below:

1. For Class I and Class II facilities, reimbursed in accordance with the methods in section
IV.A, interest expense will be determined in accordance with the Medicare Principles of
Reimbursement at 42 CFR 413.153 in effect as of July 17, 1984 (prior to the regulatory
changes associated with the mandates of the Deficit Reduction Act of 1984 and its
limitations on the revaluation of assets).

Exception: In cases where lessee/providers choose to forego increased reimbursement for
interest expense as a result of the requirements in section IV.A.5.b.2. below, the provider
must report, as an allowable cost, the interest expense from the schedule of borrowings
principal amortization and interest expense recognized for reimbursement by the Program
prior to that sale.

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Supersedes
TN No. 87-09

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
2. All other facilities will have interest expense determined in accordance with current Medicare Principles of Reimbursement, including the provisions at 42 CFR 413.153 and section 1861(v)(1)(O) of Title XVIII of the Social Security Act.

H. Allowable lease costs are determined using principle 1 or 2 below:

1. A provider who entered into a bona fide, arms-length lease prior to September 1, 1973 where the lessor refused to open his books, will be allowed an actual lease cost up to a maximum of $2.50 per patient day. This limit was developed from the average lease rental cost for facilities leased prior to September 1, 1973, at which time the current method of calculation was effected. The pre-September 1, 1973 lessee has the right of appeal for bona fide, arms-length lease agreements which exceed the $2.50 limit.

2. Providers who enter into or amend a bona fide arms-length lease agreement after August 31, 1973 will be reimbursed a plant cost component determined in accordance with sections IV. A. or B. as applicable to an owner-provider, if the lessee discloses the allowable cost information required or rate setting as outlined in section IV. A. 3. Without full disclosure lease expense will not be an allowable cost. The only exceptions to this disclosure rule shall be for lease expenses for pass through leases.

I. Bad debts, charity and courtesy allowances as defined in 42 CFR 413.80 are not recognized as allowable costs.

J. The cost of educational activities will be determined in accordance with 42 CFR 413.85, except the costs of educational activities outside the continental United States are not allowable.

K. The cost of research activities will be determined in accordance with 42 CFR 413.90.

L. The value of services of non-paid workers will be treated in accordance with 42 CFR 413.94.

M. Purchase discounts and allowances and refunds of expenses will be treated in accordance with 42 CFR 413.98.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

N. The cost for compensation to owners shall be determined in accordance with 42 CFR 413.102, except that the allowable cost for compensation to owner/administrators will be determined as follows:

1. Facilities with 50 or more beds are required to maintain a full-time administrator (per section 21702 of Public Act 493 of 1978).

2. The owner/administrator's salary shall not exceed amounts derived according to facility bed size.

3. Salary limitations are adjusted to reflect cost-of-living changes, as reflected by the Detroit Consumer Price Index, All Items For Urban Consumers. The owner/administrator's salary schedule covers only the position of administrator and assistants and does not include other owners' salaries employed in capacities other than the administration of the facility.

4. For the purposes of determining allowable cost compensation LIMITS INCLUDE WHAT that may be paid to a full owner/administrator, or the combined salary of the owner/administrator and any assistant administrator(s) and/or administrative assistant(s).

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Supersedes
TN No.: 90-34

Approval Date: MAR 15 2006
Effective Date: 04-01-2005

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
O. The cost to related organizations will be determined in accordance with 42 CFR 413.17.

P. Certain capital expenditures will be determined in accordance with 42 CFR 413.161.

Q. Costs related to patient care will be determined as allowable costs or non allowable costs in accordance with 42 CFR 413.9.

R. Providers shall be notified of changes to the Medicare Principles of Reimbursement as specifically amended by sections III.A. through III.Q. above.

6/10/93 Q. Costs related to intergovernmental transfers by Class III nursing facilities owned by local governments and any related transaction management fees associated with the intergovernmental transfer are allowable under this plan. These costs will not be counted in determining the lesser of costs or charges for billing purposes.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

IV. Payment Determination

For dates of service on or after June 1, 1981, providers of nursing care will be reimbursed
under this plan, except for Class VII providers, on the basis of the lower of customary charge
to the general public or a payment rate determined in accordance with this section of the State
Plan. Aside from specific exceptions, prospective rates are set prior to the provider’s rate-
setting/cost reporting period and are fixed for that period. There are seven classes of long
term care facilities and one special type of patient for which there are separate reimbursement
methods:

Class I  This class includes proprietary and nonprofit nursing facilities with payment rates
determined in accordance with Sections IV.A. through IV.F.

Class II  This class includes proprietary nursing facilities for the mentally ill or
developmentally disabled with prospective payment rates negotiated with the
Michigan Department of Health and Human Services, within individual facility
ceilings based on occupancy. Payments will be retrospectively cost settled in
accordance with Sections IV.B. through IV.G.

Class III  This class includes proprietary and nonprofit nursing facilities that are county
medical care facilities, hospital long term care units or state owned nursing
facilities with payment rates determined in accordance with Sections IV.B.
through IV.F.

Class IV  This class includes state owned and operated institutions certified as ICF/MR
facilities. Members of this class are reimbursed allowable costs determined in
accordance with the Medicare Principles of Reimbursement (42 CFR 413).

Class V  This class includes facilities that are a distinct part of special long term care
facilities for ventilator-dependent patients, with payment rates determined in
accordance with Section IV.G. of this plan.

Class VI: This class includes hospitals with programs for short-term nursing care (swing
beds). Class I and Class III average routine nursing care rate for a respective
period determines the prospective payment rate for these beds.

Class VII: This class includes state owned and operated veterans homes as defined in
Michigan Public Act 152 of 1885. Payment rates are based on patient acuity
groupings and determined in accordance with section IV.N.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(LONG-TERM-CARE FACILITIES)

Special Long Term Care Patients: If the single State agency has placed, in a nursing facility, a patient transferred from an acute care setting who requires specialized and concentrated nursing and support services, the provider shall have a negotiated payment rate determined in accordance with Section IV.H. of this plan.

A. Plant Cost Component (for Class I and Class II facilities) Effective for cost reporting periods beginning on or after April 1, 1985, the prospectively established plant cost component for Class I and Class II facilities will be the sum of four components: the tax component, the interest expense component, the lease/rental component and the return on current asset value component.

1. The tax component will be determined as per patient day tax cost, where tax cost consists of most recent, audited real estate and personal property taxes identified as an allowable cost under the Medicare Principles of Reimbursement as modified in Section III.

2. The interest expense component will be determined as per patient day interest expense, where all interest expense consists of most recent, audited interest expense and financing expense identified as an allowable cost as defined in Section III.G. above. Reimbursement for interest expense will not be based on any amount of borrowing which exceeds the lesser of the "current asset value" of that facility or the "current asset value upper limitation" (terms as defined in Section IV.A. 4. b. and c., respectively). Reimbursement for interest expense, subsequent to a sale or resale will be limited, as a result of the Title XIX Section 1902(a)(13)(B) limitation on increases in Medicaid Program reimbursement subsequent to sales, in accordance with Section IV.A.5.b. below.

3. The lease/rental component will be a per patient day amount determined in accordance with Section III.H. to be paid only to those providers with leases meeting the conditions in that section. All leases must have an accounting for the underlying initial owner's historical acquisition cost, and interest and property tax expense to obtain plant cost reimbursement for these assets, except for the lease costs for photocopiers, postage meters and telephone systems which will be included in the lease/rental component.

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Supersedes TN No. 90-07
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

4. The return on current asset value component will be determined as the per patient day return on value, where the return on value will be a "tenure factor" times the lesser of "current asset value" or the "current asset value upper limitation." Current asset value will not be allowed to diminish below the "current asset value floor" (terms as defined below).

a. The tenure factor is based upon a provider's number of years of continuous licensure determined at the beginning of the provider's rate year and the number of calendar days in the provider's cost reporting period from which asset values and patient days are determined. Beginning with rate years starting on or after October 1, 1990, the tenure factor will be 2.5 percent for less than two years of ownership tenure and increase 0.25 percent per year of tenure up to 5.25 percent for 12 or more years of tenure. The tenure factor is the percentage determined above, times the ratio of days in the provider's cost reporting period to 365 days. Licensure tenure will be based upon the number of full years that have elapsed from the effective date of a provider's license issued by the Michigan Department of Community Health to the beginning of the provider's rate year. Exception: In the situation where licensure has changed, but there has been no effective change in operator/provider and there has been no transaction which would affect Medicaid reimbursement other than the tenure factor, the provider may petition the State agency to recognize the continuous tenure (i.e., the licensure tenure schedule would not revert to zero years at the time of licensure change if the petition is approved).

b. The current asset value is determined by a formula using historical costs of capital assets times the difference between an inflationary index and an obsolescence factor. Assets purchased prior to 1960 will be treated as if they were brought into service in 1960.
1) The historical cost of capital assets will be based upon the initial owner's audited historical acquisition cost determined as allowable in accordance with Medicare Principles of Reimbursement as modified by Section III. It will be the responsibility of the current asset owner to provide the audited historical acquisition cost and purchase date information of the initial owner, otherwise the assets will be assumed obsolete for payment determination purposes (i.e., no current asset value). An exception to the historical acquisition cost basis is allowed for land which will be based upon the current owner's acquisition cost not to exceed the amount reported to the Internal Revenue Service for federal taxation purposes. Leased or rented assets, when the underlying audited historical acquisition cost to the initial owner has not been disclosed, will be treated as an obsolete asset for payment determination purposes.

At the discretion of the single State agency, in the determination of historical acquisition cost of capital assets, cost information from other sources will be considered. These sources include, but are not limited to Medicare or Blue Cross/Blue Shield reports or a provider's initial Medicaid report. To ensure the Program does not continue to pay for assets that no longer exist, the original acquisition costs of movable equipment and fixed building equipment items that are replaced will be removed from the determination of current asset value in the year the replacement was made. For other asset items, which have been replaced, renovated or improved and reported as a cost in cost report periods ending March 31, 1985 and thereafter, the original acquisition costs or an estimate thereof will also be removed from the determination of current asset value.

An exception to the above methods for capital assets may be made for the costs associated with the centralized facilities of related organizations. The plant and variable costs of such organizations will be treated as purchased services (variable costs) unless the related organizations' financial records assign the assets to the specific facilities. Another exception to the historical acquisition cost basis may be allowed for the occasional purchase of used movable equipment by ongoing operations when the purchase is not part of a change in facility ownership.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

2) The inflationary index utilized depends upon capital asset type: land improvements, building, building improvements and fixed building equipment will be updated using the Marshall Swift Valuation Service Construction Cost Index for Class A Buildings in the Central United States from the fiscal year the asset was brought into service until the most recent period for which data is available when the rate is determined; and land, moveable equipment and other assets will have an inflationary index of 1.00, i.e., no update factor.

3) The obsolescence factor utilized also depends upon the capital asset type: land improvements, building, building improvements and fixed building equipment will have an obsolescence factor of 3 percent per annum for each year the asset has been in service; moveable equipment and other capital assets will have an obsolescence factor of 10 percent per annum for each year the asset has been in service up to a maximum of 10 years (this factor will not be greater than 1.00); and land will have an obsolescence factor of zero. The number of years the asset has been in service will be based upon the number of years including the fiscal year after the year in which the asset was acquired through the most recent audited year.

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State of Michigan  

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(LONG-TERM-CARE FACILITIES)

4) The current asset value formula is the sum of current asset values for each distinct asset, where the current asset value of a distinct asset is the historical cost of that asset times the difference between the inflationary index and the obsolescence factor for the respective asset. Current asset values will be rebased annually based upon the most recent audited or reviewed cost report.

5) Only assets having a use related to patient care are to be included for reimbursement under the return on current asset value component. The cost finding and cost reporting methods, as defined in the State agency's cost reporting forms and instructions, apportion the provider's asset costs into the appropriate cost centers for reimbursement purposes.

6) Assets acquired after July 1, 1989 for training of nurse aides (as required by the Omnibus Reconciliation Act of 1987), are not included in the calculation of current asset values if the purchase of the asset was reimbursed as a nurse aide training expense.

c. The current asset value upper limitation is a limit placed upon current asset value per bed above which values are not recognized for reimbursement purposes. The per bed value of the upper limit is based upon a survey of construction and other purchase costs per bed of Class I and Class II nursing homes opened on or after January 1, 1975, with the historical costs updated through 1983 using the U.S. Department of Commerce Composite Construction Index. Annual updates subsequent to 1983 will be made using the Marshall Swift Index indicated in Section IV.A.4.b.2.

d. The current asset value floor is determined as 30 percent of the current asset value upper limit.
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5. Special Provisions: The plant cost component will be determined using special methods for Class I and Class II providers with either newly purchased facilities or newly participating facilities or existing providers with either a change of class or major additions, renovations, or new construction.

Special methods are required because there is no, or there is an inadequate, historical plant cost basis upon which to determine rates or rates are determined by different methods.

a. Plant Cost Certifications: Such providers are requested to certify and submit to the single State agency their expected allowable costs (in accordance with Medicare Principles of Reimbursement as modified by Section IV) for interest expense, property taxes, leases, and historical asset acquisition costs. If approved, the agency will determine the provider’s initial period plant cost component based upon the certified amounts using the principles described in Sections IV.A.1. through 4 above and IV.A.5.b. and c below. This rate will be retrospectively adjusted to reflect the facility’s actual audited allowable plant costs for each fiscal year until the facility’s rate is prospectively established from a cost reporting period which reflects a full cost reporting period of costs related to the original purpose of the plant cost certification. If, as a result of audit, the State agency finds a significant discrepancy between certified information and actual costs, all excess funds paid by the State agency to the facility as a result of that request will be recovered with a penalty factor (equal to the then current Medicare rate on net equity) applied to the discrepancy.
b. Sales and Resales: In the event of a sale occurring on or after July 18, 1984, but not the result of a binding agreement entered into prior to July 18, 1984, the changes in the plant cost component for a facility, attributable to the sale will be limited by the increase allowed by Section 1902(a)(13)(B) of Title XIX of the Social Security Act in effect prior to the Consolidated Omnibus Budget Reconciliation Act of 1985. In cases where the Title XIX Section 1902(a)(13)(B) limitation is applicable, a schedule of interest expense disallowance amounts will be developed to ensure the new owner's reimbursement does not increase by more than the amount the Title XIX Section 1902(a)(13)(B) limitation will allow. The schedule of disallowances will be based upon the initial year disallowance and the borrowing amortization schedule and interest expense amounts determined as allowable costs in accordance with Medicare Principles of Reimbursement as modified by Section III of this plan. Once the schedule is put in place, the disallowances will remain in effect regardless of the status of the loan. However, in no instance will the amount of interest expense allowable exceed net allowable interest expense.

1) In all cases of sale or resale, the seller must notify the State agency at least 90 days in advance of the sale. The sale will not be recognized for reimbursement purposes until 90 days after notification. Any exception must be approved by the state agency.

2) Exception: Where licensure does not change subsequent to a sale, the lessee/provider must choose either to retain his original licensure tenure schedule and forego increased reimbursement for interest expense or to receive increased reimbursement for interest expense and allow the licensure tenure schedule to revert to zero years and a tenure factor of 2.5 percent. Should the lessee/provider elect to retain the previous licensure tenure schedule, the Medicaid Program will not recognize for allowable cost determination purposes, interest expense beyond the schedule of borrowing principal amortization and interest expenses which would have been incurred were the seller's loans maintained or assumed by the new owner/lessor. This provision will apply to all property transactions between lessors, lessees and/or operators.

3) In the case of a sale between family members, there is no increase in nursing facility assets. The allowable asset value to the purchaser is limited to the allowable historical capital asset cost of the seller minus depreciation allowed and reimbursed by Medicaid.
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c. Change of Class: An existing provider becoming a Class I or Class II facility will be paid a plant cost component determined using the principles stated in Sections IV.A.1 through 4 above.

6. Grandfather Clause: Any provider who received a higher plant cost component under the reimbursement system in effect prior to April 1, 1985 may, at the option of the provider, be paid a plant cost component determined in accordance with Section IV.B below until facility fiscal years beginning on or after April 1, 1991. If a grandfathered facility is sold subsequent to April 1, 1985 and there is a change in licensure, then the grandfather clause will no longer be applicable and the new owner's rate will be determined utilizing the methods in Sections IV.A.1 through IV.A.5 above. If a grandfathered facility is sold subsequent to April 1, 1985, and there is no change in licensure, then the grandfather clause may continue to be applicable until facility fiscal years beginning on or after April 1, 1991.

7. Special Note on Recapture of Depreciation: In the event of a sale after March 31, 1985, there will be the application of 42 CFR 413.135(f) for any reimbursement received by the seller as depreciation expense from October 1, 1984 through the effective date of the sale and transfer of assets.

B. Plant Cost Component (for Class III facilities)

The prospectively established plant cost component for county medical care facilities, AND hospital long term care units and facilities grandfathered in Section IV.A.6. above is the lesser of allowable per patient day plant cost or the per patient day plant cost limit, as described below:

1. The allowable per patient day plant cost is the sum of depreciation expense, interest expense, property taxes, and recognized lease costs (as defined in Section III.H) divided by total patient days, as derived from the most recent audited cost report.
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2. The per patient day plant cost limit is the amount that would be paid for a recently constructed and prudently financed facility. The calculation of this amount is based on a survey of homes actually built between January 1, 1975, and December 31, 1977, updated to June 30, 1978, using the U.S. Department of Commerce Composite Construction Index Federal Housing Finance Board for Newly Built Homes. The value for depreciation expense is based on the mean of the surveyed values of depreciable assets and the mean depreciation rate for assets of similar type, determined by using straight-line depreciation with useful lives determined in accordance with 104.17 of the Provider Reimbursement Manual. The value for interest expense is based on the surveyed mean of interest rates paid and mean asset values for facilities constructed during the three years surveyed. The value for property taxes is based on the mean of property taxes of the surveyed tax-paying facilities. This plant cost limit is updated annually to reflect the rate of increase in property taxes and standards and regulations which affect plant costs.

3. Proprietary providers are permitted to retain as part of the plant cost component either:

a. Up to $.50 of the difference between allowable per patient day plant costs and the March 31, 1985, 80th percentile of Title XIX per patient day plant costs ($5.66 per patient day), or

b. The Medicare return on net invested equity defined in 42 CFR 413.157 to the extent that the plant cost component including the return on equity does not exceed the provider's plant cost limit.

Once option (b) is selected, a provider may not select option (a) for any future cost reporting periods.
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4. Special Provisions: The plant cost component will be determined using special methods for Class III providers with newly purchased facilities or newly participating facilities or a change of class. Special methods are also required for Class III and grandfathered Class I and Class II providers with major additions, renovations or new construction. Special methods are required because there is an inadequate historical plant cost basis upon which to determine rates or rates are determined utilizing different methods.

a. Plant Cost Certification: Such providers are requested to certify and submit to the State agency their expected plant costs. The State agency will use the certified expected dollar value of plant costs, when approved, in calculating the prospective rate, pending audit. This rate will be retroactively adjusted to reflect the facility's actual audited allowable plant costs for each fiscal year until the facility's rate is prospectively established from a cost reporting period which reflects a full cost reporting period of costs related to the original purpose of the plant cost certification. If, as a result of audit, the State agency finds a significant discrepancy between certified information and actual costs, all excess funds paid by the State agency to the facility as a result of that request will be recovered with a penalty factor applied to the discrepancy. The penalty will be 10 percent of the aggregate dollar amount difference between the overpayment and the plant cost settlement reimbursement. The penalty is waived if the aggregate dollar amount difference is equal to or less than 10 percent.

b. The plant cost limit (PCL) for these facilities will be calculated based on one or both of the following principles:

1) The per patient day plant cost limit will be updated to reflect changes in costs of construction and changes in standards and regulations which have a direct impact upon plant costs. Costs of construction will be updated using the Department of Commerce Composite Index Federal Housing Finance Board for Newly Built Homes

2) The per patient day plant cost limit will be updated to reflect changes in interest rates. The interest rate used to calculate the PCL will be updated by applying an index of change in interest rates for home mortgage loans (as reflected in conventional new home mortgage rates) Federal Housing Finance Board for Newly Built Homes to the interest rate used to calculate the original PCL (Section IV.B.3. above).

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B. Plant Cost Component for Class II AND CLASS III facilities

4. Special Provisions (continued)

c. New Facility: A “new facility” is defined as a LTC provider in a facility that does not have a Medicaid historical cost basis. The new provider’s initial-period plant cost component will be the provider’s certified and agency approved plant cost per patient day (per Section IV.B. 4.a.) up to the plant cost limit, where the plant cost limit is determined using update methods 1) and 2) of Section IV.B.4.a. above.

d. Additions, Renovations and Newly Constructed Facilities: The provider’s initial plant cost component subsequent to the changes in plant costs will be the provider’s certified and agency approved plant cost per patient day (per Section IV.B.4.a.) up to the plant cost limit, where the plant cost limit is the weighted average (using proportions of historical cost) of the historic PCL for the portion of the facility that remains unchanged, and the PCL applicable to the new portion determined using update methods 1) and 2) of Section IV.B.4.b. above.

e. Sales and Re-sales: Sales and re-sales will be recognized by the program. Reimbursement for providers with facilities purchased prior to July 18, 1984 will be determined in accordance with the State Plan methods applicable at the time of sale. Reimbursement for providers with facilities purchased on or after July 18, 1984, but not the result of a binding agreement entered into prior to July 18, 1984 will use as a plant cost basis, allowable cost as determined in accordance with the Medicare Principles of Reimbursement as modified in Section III. In all cases of sale or resale, the seller must notify the State agency at least 90 days in advance of purchase. The sale will not be recognized for reimbursement purposes until 90 days after notification. Provisions of 42 CFR 413.134 (f) will be retrospectively satisfied at this time. Any exception must be approved by the State agency. In the event of sale there will be an application of 42 CFR 413.134 (f) for any reimbursement received by the seller as depreciation expense from October 1, 1984 through the effective date of the sale and the transfer of assets.

The provider’s plant cost component subsequent to the sale will be the provider’s certified and agency approved plant cost per patient day (per Section IV.B.4.a.) up to the plant cost limit determined using update method 2) of Section IV.B.4.b. above (only the interest portion of the limit is updated).
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B. Plant Cost Component (CLASS II AND Class III facilities)
   4. Special Provisions (continued)

   f. Change of Class: An existing provider becoming a Class III facility will be paid a plant cost component determined using the principles stated in Section IV.B.2. of this plan.

C. Variable Cost Component

For Class II provider cost reporting periods, beginning on or after January 1, 1989, the variable cost component of the prospective rate will be based on a submitted cost report. Cost will be settled retrospectively against a fixed ceiling using allowable cost principles, as defined in Section III of this attachment. Fixed variable component ceilings will be determined for each facility based on the submitted budget.

For provider cost reporting periods beginning on or after April 1, 1986, the variable cost component for long term care facilities in Classes I and III will be determined in accordance with the following sections. Rate setting for prior periods will be made in accordance with the State plan in effect at the beginning of the provider's rate setting period.

1. Variable costs are defined as total allowable costs allocated to base and support costs in the routine service centers. Allowable costs and expenses are determined allowable in accordance with Medicare Principles of Reimbursement as modified by Section III of this attachment. The agency’s cost reporting forms specifically allocate routine service center costs into base, support, and plant costs. Costs of other services are also allocated on the cost reporting forms into ancillary service centers (retrospectively cost settled or paid fee-for-service), home for the aged service centers and other non-reimbursable service centers.

2. The variable cost component consists of two subcomponents — the base cost component and the support cost component. Base costs are generally defined as those costs which cover activities associated with direct patient care. Special add-ons to provide cash flow for anticipated costs that are not included in the cost base period may also be included in the rate. Special add-ons are calculated based on the same underlying methodology as the prospective payment rate, which is cost, and special add-ons are retrospectively settled. special add-ons apply to Class I and Class III
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providers to cover costs related to Nurse Aide Training and Testing (NAT&T) and to Class I providers for Special Dietary costs. Special add-ons provide reimbursement for costs that are not previously included in the variable cost component. Effective for cost reporting periods beginning on or after October 1, 1990, base costs include: 1) labor costs and related benefits and payroll taxes except medical records, medical director, general and administration, housekeeping and operation of plant cost categories; 2) raw and processed food costs; 3) the cost of all utilities; 4) consultant costs for base cost categories from a related organization; 5) the cost of contracted agency nursing personnel; 6) linen; 7) all worker compensation costs; and, 8) all other costs incurred in base cost categories except as specifically defined as support costs.

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C. Variable Cost Component

2. (continued) Effective for cost reporting periods beginning on or after October 1, 1990, support costs are considered to be all other variable costs, including administrative costs; consultant costs regardless of the department with which the cost is associated; all equipment repair and maintenance costs; and all materials and supplies except for those included in base costs. More specifically:

a. Base costs are defined as allowable costs (i.e., with related organization profit removed) for:

1) Payroll related costs (salaries, wages, related payroll taxes and fringe benefits) for core departments of nursing, dietary, activities, social services and laundry plus these other major cost items: raw and processed food; linen (does not include mattresses or springs); workers’ compensation; utility costs; consultant costs for base cost categories from related organizations; and supply costs incurred in all base cost departments.

2) Purchased services and contract labor from unrelated parties or from related organizations, except for nursing services, incurred in lieu of base costs as defined in Section 1, immediately above, are separated into base and support costs using the industry-wide average base-to-variable-cost ratio. The industry-wide average base-to-variable-cost ratio will be reviewed at least annually and revised when a change of 2% or greater occurs. The ratio will be based on cost reports filed in the calendar year that is two years prior to the end of the current fiscal year. The purchased services to be allocated using this method are exclusively limited to contracted services for costs incurred in base cost categories. All other purchased services are defined as support costs.

b. Support costs are defined as:

The payroll related costs of the departments of housekeeping and maintenance of plant operations; administrative costs; all consultant costs, all equipment maintenance and repair costs; and all other allowable variable costs, purchased services and contract labor not specified as base costs (i.e., variable costs minus base costs).

c. The allowability of costs shall be determined in accordance with Medicare Principles of Reimbursement as modified in Section III above.
C. Variable Cost Component (continued)

3. The rate determination methods using base and support costs to obtain the variable cost component are described below:

   a. A provider's indexed base cost component is determined as per patient day base costs taken from the provider's cost report ending in the previous calendar year indexed to October 1 of the year that is one year prior to the rate year being calculated. The base cost component will be rebased (recalculated) annually to reflect the more current costs of both the resource needs of patients and the business expenses associated with nursing care. The basis for the cost index is the Global Insight Health Care Cost Review, DRI-WEFA Skilled Nursing Facility Market Basket without Capital Care Cost Review.

      1. The annual economic inflationary rate for Class I and Class III facilities is 0%.

      2. If more than 20 percent of facilities in a class identify and document that new State or Federal requirements are anticipated to add more than 1 percent to the classwide average rates of facilities, the State will convene a work group that includes provider representatives to discuss and recommend adjustments to the prospective reimbursement system to meet those new costs. The state agency will act upon these recommendations within 90 days of their receipt.

   b. A provider's indexed support cost component is determined as the provider's indexed base cost component times the lesser of the provider's support-to-base (S/B) ratio or the support-to-base ratio for that facility's bed size group.

      For Class I and Class III facilities.

      1) The provider's S/B ratio is determined from the cost report ending in the previous calendar year.
C. Variable Cost Component (continued)

3. The rate determination methods using base and support costs to obtain variable cost component are described below:

b. A provider's indexed support cost component is determined (continued)

2) The provider's S/B ratio is limited to the 80th percentile S/B ratio for the provider's bed size group. The bed size groups shall be 0-50, 51-100, 101-150 and 151+ licensed nursing HFA beds and any other licensed beds in the facility or nursing complex.

3) The provider's S/B ratio is rebased annually regardless of ownership

4) An individual facility's support limit will be computed by multiplying the applicable annual ratio limit for the provider's facility size grouping times the provider's per patient day base cost for the period. If a provider's support component exceeds the bed size group limit, the provider will be paid the limit amount, which is based on the appropriate bed size grouping.

5) The 80th percentile support-to-base ratio limits will be determined annually from the cost reports ending in the previous calendar year for each size grouping. The 80th percentile support-to-base ratio limit will be determined in a like manner as the variable cost limit described in Section IV C.3.c.2 of this plan.

c. The provider's variable rate base is determined as the lesser of the calculated variable rate base or the provider's classwide variable cost limit (VCL), where

1) The classwide VCL is set at the 80th percentile of the indexed variable costs for nursing facilities in the class during the current calendar year.

2) To determine the classwide VCL, the State first rank orders providers from the lowest to the highest indexed Medicaid per patient day variable cost. The 80th percentile is then identified by accumulating Medicaid patient days of the rank ordered providers from the lowest indexed per patient day variable cost provider until 80 percent of the total Medicaid days for this class is reached. The indexed Medicaid per patient day variable cost of the facility in which the last patient day was accumulated is the variable cost limit for the class of providers.
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c. The provider’s variable rate base is determined as the lesser of the calculated variable rate base or the provider’s class wide variable cost limit (VCL), where (continued)

3) The variable cost limit for private institutions for the mentally ill and mentally retarded is computed by adding the VCL for Class I nursing facilities plus the cost of additional nursing hours per patient care day plus the cost of additional services as required by the Department, as outlined in the Supplement to Attachment 3.1-A.

4. Nursing Facility Class I Rate Relief

a. Criteria for Eligibility for NF Class I Rate Relief – A Class I nursing facility provider may apply for rate relief from the usual rate setting process if they meet the following eligibility criteria:

1) The provider must demonstrate that the current Medicaid reimbursement does not provide them with adequate funding to deliver the level of care to the Medicaid beneficiaries in the facility such that “each resident attains and maintains the highest practicable physical, mental and psycho-social well-being” as required by the Omnibus Budget Reconciliation Act (OBRA) of 1987.

2) The nursing facility Variable Rate Base amount meets the following criteria:

a) For a current provider – The facility’s Variable Rate Base is at or below the corresponding class Average Variable Cost. The class Average Variable Cost used for this determination is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested; or,

b) For a new provider in a Medicaid-enrolled nursing facility – The facility’s current Variable Rate Base is at or less than 80 percent of the corresponding class Average Variable Cost. The class Average Variable Cost used for this determination is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested. (A new facility with a Variable Rate Base between 80 and 100% of the corresponding class Average Variable Cost will be eligible for accelerated rebasing and will be treated as a current provider)

3) A current Medicaid provider agreement for the facility is in effect, except when applying under criteria 4) e). The rate relief period will be based on the facility, and not the owner, provider, or licensee. A change of ownership, provider, or licensee during the rate relief period would not end the agreement for rate relief under this policy, so long as the new owner, provider, or licensee fully complies with the requirements of the rate relief agreement.

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4) The provider must also meet at least one of the following 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 change 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.
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 receiving rate relief. Such citations would be for serious and immediate threat or substandard quality of care.

5. Special Previsions: 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
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 August 1, 2017, 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 August 1, 2017 and September 30, 2017, the QAS percentage is equal to 21.51% of the lesser of the facility’s variable rate base or the class variable rate 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 rate 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. Effective October 1, 2017 forward, the QAS percentage will be 21.76%.
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D. Incentive Component

1) If a Class II provider cost settles below the ceiling rate, they will be paid a per patient day efficiency incentive of 50 percent of the difference between actual per diem cost and the ceiling, not to exceed $2.50 per patient day. Class II providers will not be paid any other incentive.

2) Providers actively participating in the Facility Innovative Design Supplemental (FIDS) program on and after October 1, 2007 are eligible to receive a payment incentive not to exceed $5.00 per Medicaid day over a consecutive 20 year period. The FIDS payment will be terminated if it is determined the facility is not compliant with the culture change requirement.

The qualifying costs for FIDS are the capital costs for construction and/or renovation based on the approved project. The allowable capital costs incurred for land, land improvement, building, building improvement and equipment is based on current policy related to the allowance of those capital assets.

The reimbursement supplement only applies to qualifying FIDS costs above the nursing facility’s Capital Asset Value (CAV) Limit for Class I and the Plant Cost Limit (PCL) for Class III.

For Class I nursing facilities, MDCH reimbursement methodology for the FIDS program follows current Medicaid nursing facility reimbursement guidelines and policy with the exceptions noted below:

a. Up to five dollars ($5) per Medicaid day is added to the nursing facility’s return on current asset value.

b. The supplement amount is based on qualifying costs above the nursing facility’s current asset value limit determined by the Department either by plant cost certification or by cost reporting. When the plant cost certification estimate is used, the amount of the supplement is subject to an adjustment following the completion of an audit to the applicable period’s cost report in which the FIDS project is initially reported.

Under FIDS plant cost certification, providers apply for an interim capital reimbursement amount which is an estimate of the capital reimbursement amount a provider would be eligible to receive due to an increase in the reported capital asset value not present when the nursing facility rate was set.

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for the year. The cost report for the reporting period within which the capital value increased is used to adjust the plant cost certification estimate to an actual amount. The plant cost certification estimate is then replaced and reconciled.

Providers completing a FIDS project must plant cost certify or forgo reimbursement until the plant cost certification is approved. The plant cost certification interim payment amount is the FIDS payment amount until the provider completes 12 months of actual costs. During the interim rate period, for each cost reporting period, the plant cost certification interim amount for FIDS is reconciled to that period’s cost report to determine the interim supplement payment amount. The cost report is used after 12 months of actual costs to set the final rate for the next rate setting period. The difference between the interim payment amount for FIDS and the final payment amount for FIDS is recovered or reimburse to the provider for providers that complete a FIDS project before January 1, 2008, the cost report submitted in 2007 may be used to establish the interim rate.

c. To determine the amount of the FIDS supplement, the Department will utilize the following calculation:

Qualifying FIDS construction or renovation costs above the CAV Limit are divided by the number of FIDS beds in the project divided by the number of years remaining in the supplemental program divided by 365 days.

3. For Class III nursing facilities, MDCH reimbursement methodology for the FIDS program follows current MDCH nursing facility reimbursement guidelines and policy with the exceptions noted below:

a. Up to five dollars ($5) per Medicaid day is added to the nursing facility’s plant cost component.

b. The supplement amount is based on qualifying costs above the re-determined PCL determined by the Department either by plant cost certification or by cost reporting. When the plant cost certification estimate is used, the amount of the supplement is subject to an adjustment following the completion of an audit to the applicable period’s cost report in which the FIDS project is initially reported.

Under FIDS plant cost certification, providers apply for an interim capital reimbursement amount which is an estimate of the capital reimbursement amount a provider would be eligible to receive due to an increase in the

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reported capital asset value not present when the nursing facility rate was set for the year. The cost report for the reporting period within which the capital value increased is used to adjust the plant cost certification estimate to an actual amount. The plant cost certification estimate is then replaced and reconciled.

Providers completing a FIDS project must plant cost certify or forgo reimbursement until the plant cost certification is approved. The plant cost certification interim payment amount is the FIDS payment amount until the provider completes 12 months of actual costs. The cost report is used after 12 months of actual costs to set the rate for the next rate setting period. For each cost reporting period, the plant cost certification interim amount for FIDS is then reconciled to that period's cost report to determine the supplement payment amount. The difference between the interim payment amount for FIDS and final payment amount for FIDS is recovered or reimbursed to the provider. For providers that complete a FIDS project before January 1, 2008, the cost report submitted in 2007 may be used to establish the interim rate.

c. To determine the amount of the FIDS supplement, the Department will utilize the following calculation:

For FIDS renovation projects, the supplement is determined using qualifying costs to calculate the plant cost per resident day above the facility’s PCL per resident day. For a newly constructed facility, the calculation will be based on plant cost per resident day above the Class PCL per resident day effective the quarter the new construction is placed into service.

E. Husband and Wife Exception

Spouses or blood relatives residing in the same facility may share a room.

F. Payment Determination for Special Facilities

The payment rates for all special facilities for ventilator-dependent patients shall be a flat per patient day prospective rate determined by the single State agency. The special facility prospective rate shall not be subject to the provisions in Section IV.A. through IV.E. above, but instead the provisions within this section shall be used for payment determination.

1. Payment shall be made for prior authorized ventilator-dependent patients who have been transferred from an acute care inpatient hospital setting to a qualifying special facility. The prospective rate shall cover care requirements of the patients, including all the costs...
of benefits associated with Medicare Parts A and B services while the patient resides in the special facility. This includes but is not limited to all routine, ancillary, physician and other services related to ventilator care.

The purpose of the special rate is to provide the facility with payments meant to cover the cost of necessary physician’s services including services in the capacity of a case manager who will prescribe and monitor, on a case by case basis, habilitative and rehabilitative services necessary for management of the ventilator dependency. The ultimate goal is de-institutionalization of those ventilator-dependent patients who may gain an adequate level of independence.

2. Factors used by the single State agency in the determination of the per patient day prospective rate shall include audited costs at facilities providing similar services, expected increases in the appropriate inflationary adjustor over the effective period of the prospective rate, the supply response of providers and the number of patients for whom beds are demanded. The prospective rate will not exceed 85 percent nor fall below 15 percent of an estimate of the average.
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 I 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. Effective August 1, 2017, 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) percentage. 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. Between August 1, 2017 and September 30, 2017, the QAS percentage is equal to 21.51% of the Class I variable cost limit. Effective October 1, 2017 forward, the QAS percentage will be 21.76%.

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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availability of placement. Any authorized increase in the per diem rate represents the cost of the service. The negotiated prospective rate shall be re-evaluated in consideration of the recipient’s needs prior to the last day of the approval period.

3. Providers agree to remove from total costs, a dollar amount equal to the total difference between reimbursement at the special care rate and the established routine Medicaid rate, determined in accordance with other provisions of this plan.

H. Special Dietary Considerations

1. The Program will settle, outside of the 80th percentile Variable Cost Limit, actual costs to nonprofit nursing facilities resulting from raw food and food preparation costs associated with special dietary needs for religious reasons.

2. Facilities must apply to receive this special settlement consideration. In applying, facilities must document the reasons for special dietary consideration for religious reasons, and submit estimated cost data.

I. Payment Determination for Hospitals Providing Short Term Nursing Care (Swing Beds).

The payment for hospital swing bed services shall be a flat per patient day prospective rate determined by the Medical Services Administration. The following shall be used for payment determination.

1. The amount of payment is the weighted statewide routine nursing care per diem rate for the previous calendar year. The average nursing home per diem rate is calculated by dividing the sum of the Medicaid Class I and Class III amount approved for payment for routine nursing care days by the Medical Services Administration, by the sum of nursing care days paid for respective time period.

2. Payment will not be made for swing bed days which occur before the combined length of stay in the acute care hospital bed and the hospital swing bed exceeds the average length of stay for the Medicaid diagnosis related group (DRG) for the admission.

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J. Long Term Care Facility Proportionate Share Pool

A proportionate share pool is created for state fiscal year 2006, in the amount of $8,218,356.00, subject to the upper payment limits in accordance with 42 CFR 447.272. The pool is funded at a level not to exceed the Medicare upper payment limit for State fiscal year 2006. Eligible providers are those nursing facilities and hospital long term care units owned by local units of government and in operation at the time of payment. Payment to each facility is in proportion to the facility’s number of Medicaid Program inpatient days for the most recent calendar year. The inpatient days will be determined from the Medicaid program Invoice Processing payment data nine months after the end of the calendar year.

K. Personal Clothing for Recipients in Class IV Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

Class IV facilities are reimbursed for allowable costs determined in accordance with the Medicare Principles of Reimbursement (42 CFR 413), with the following additions:

To enable the normalization of recipients in ICFs/MR, street clothing supplied by the facility and/or required by the patient’s plan of care will be considered an allowable cost for Medicaid patients residing in ICFs/MR who do not own or have other access to the clothing required.
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L. Special Payments to County Medical Care Facilities (CMCF) for Un-reimbursed Medicaid Costs

A special payment to county government-owned nursing facilities will be established and renewed annually. The purpose of the payment is to compensate CMCFs for incurred un-reimbursed routine costs. Allocations for individual facilities will be determined based upon un-reimbursed routine costs certified as public expenditures in accordance with 42 CFR 433.51.

To be eligible for the special payment the following apply:

1. The county medical care facility must meet minimum federal requirements for Medicaid payments; and
2. The nursing facility must be county-owned and operated.

Data Sources Utilized for the Calculation of Medicaid Loss

Routine cost and revenue data reported on Worksheet 1 of the filed Michigan Medicaid Cost Report are the basis of all calculations, allocations, and adjustments used to calculate Medicaid loss. Allowable costs are defined by the Michigan State Plan. Michigan reimbursement policy follows Medicare reimbursement principles. Only audited cost report values are used in the final settlement calculations. WS 2-G reports allowable routine costs, including base, plant, and support costs for the routine unit and column 1a shows allowable total routine cost per patient day.

The following Michigan Medicaid cost report worksheets contain the data used. Each is defined by the relevant Michigan State Plan section:

- Patient days from worksheet b.
- Total revenue from worksheet 1.
- Base costs from worksheet WS 2-G as defined on Attachment 4.19-D, Section IV, page 13, C 2.
- Support costs from worksheet WS 2-G as defined on Attachment 4.19-D, Section IV, Page 13, C 2.
- Base /support – payroll related from worksheet WS 2-G as defined on Attachment 4.19-D, Section IV, Pages 15 and 16.
- Plant costs from worksheet WS 2-G as defined on Attachment 4.19-D, Section IV, Page 2.

The Michigan Medicaid Program is claiming Medicaid loss as the difference between allowable total Medicaid routine costs before formula limitations and total routine revenue received (as accrued) for Medicaid services for that same time period. Routine services revenue total is defined as the sum of lines 2 (routine services – nursing, Medicaid) and line 4 (routine services – nursing, Medicaid MOU), of Worksheet 1, taking into account any reclassifications and adjustments. No facility will receive payment greater than its cost for Medicaid services.
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Interim Payment of Medicaid Loss

The interim Medicaid loss will be calculated in the first quarter of the State fiscal year using each facility's latest available as-filed cost report and the patient day and payment data pertaining to that cost reporting period. The total interim Medicaid loss amount will be distributed in four quarterly payments in the months of December, March, June, and September.

Total routine costs for each facility are based on Worksheet 2-G, Line 35, Column 1 of the Cost Report. Total patient days for the routine unit are reported on Worksheet B.

The facility's routine cost per day is computed by dividing total allowable routine costs by total patient days and is reported on Worksheet 2-G, Line 35, Column 1a. Medicaid routine cost is equal to the routine cost per day multiplied by the number of Medicaid days for the cost reporting period. The quality assurance assessment is not included in costs per Worksheet 2-G.

Medicaid routine services revenue total is listed on Worksheet 1. Total revenue includes net Quality Assurance Supplemental (QAS) payments.

3. QAS payment is defined as the product of the number of Medicaid days multiplied by 21.76 percent of the variable cost component limited to variable cost limit for class one facilities.

4. Quality Assurance Assessment Program (QAAP) assessment is the product of the difference of total inpatient days minus the sum of Medicare days and Medicare HMO days multiplied by the approved QAAP rate. The QAAP rate is the approved QAAP tax rate charged to each facility.

5. Net QAS is the difference between QAS payment and QAAP assessment if this difference is a positive number. Any negative net QAS is disregarded from further consideration in the calculation of Medicaid loss. As such, a negative net QAS cannot increase the Medicaid loss for any participating facility.

Medicaid loss is defined as total Medicaid routine costs minus total routine revenue received for the same Medicaid routine services. The routine revenues that are offset to arrive at Medicaid loss must include all revenues received for the Medicaid routine services even if they are reported outside of Worksheet 1, including Medicaid base and other supplemental/enhanced payments (if applicable) from the State and all payments received by the facility from patients and other payers for the same Medicaid routine services.

Initial Settlement Calculation:

For each facility, an initial settlement of the interim Medicaid loss payments made will be calculated each year. The initial settlement will be done once the cost report for the expenditure period is accepted into the state’s rate setting database. The Medicaid loss will be calculated using the methodology described above but utilizing each expenditure period cost report once it has been accepted with initial audit adjustments and reclassifications, actual patient days from the cost report, actual Medicaid days for the period and actual Medicaid rate payments and other applicable payments. The Medicaid loss calculated at initial settlement is reconciled with the interim Medicaid loss payments made for the cost reporting period. The Federal share of any overpayment is credited to the Federal government.

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Final Settlement Calculation:

For each facility, final settlement calculations will be conducted upon completion of the final audit of the facility’s cost report.

The Medicaid loss will be calculated using the methodology described above but utilizing each audited expenditure period cost report, actual patient days from the cost report, actual Medicaid days for the period, and actual Medicaid rate payments and other applicable payments. The Medicaid loss calculated at final settlement is reconciled with the initial settlement Medicaid loss payments made for the cost reporting period.

All adjustments to the initial payment will be done via gross adjustment and processed through Michigan’s claims processing system. The Federal share of any overpayment is credited to the Federal government.
M. Quality Measure Initiative

Effective October 1, 2017, a Quality Measure Initiative (QMI) payment is established for class I and class III nursing facilities. Payments to individual nursing facilities will be determined by their yearly average 5-star quality measure rating from the Centers for Medicare & Medicaid Services Nursing Home Compare (NHC) website, Medicaid utilization rate, number of licensed nursing facility beds, and resident satisfaction survey data as described in this section.

1) To be eligible for a QMI payment, a provider must meet the following conditions:
   a. The provider must have a 1, 2, 3, 4 or 5-star quality measure rating on the NHC compare website.
   b. The provider must be a Medicaid-certified nursing facility.
   c. The provider must deliver at least one day of Medicaid nursing facility services during the state fiscal year in which they receive QMI payments and in their immediate prior year-end cost reporting period. QMI payments made to a provider found to have no days of Medicaid nursing facility services shall be recouped by MDHHS after the end of the state fiscal year.
   d. The provider must not be closed for business.
   e. The provider must not be designated as a special focus facility by the Centers for Medicare & Medicaid Services.
   f. If the provider has an average quality measure rating below 2.5 stars, they must submit an action plan to the Michigan Department of Health and Human Services. The action plan must meet the requirements determined by the Michigan Department of Health and Human Services and must be submitted by the due date specified by the department.

2) The average NHC 5-star quality measure rating will be based upon the average rating from July of the prior calendar year to June of the current calendar year. The NHC quality measure rating will determine a per-bed QMI amount based on available funding. The per-bed QMI amount will be larger for higher average quality measure ratings.

3) The Medicaid utilization rate will be determined from the immediate prior year-end cost report covering a time period of at least 7 months. A nursing facility that did not file a cost report in the prior year or a cost report covering a period of at least 7 months must submit their utilization data in a format determined by the Michigan Department of Health and Human Services, or they will be assumed to have no Medicaid utilization. The per-bed QMI amount is multiplied by the Medicaid utilization scale. The Medicaid utilization scale is determined by the Medicaid utilization rate and is applied as follows:
   a. For nursing facilities with a Medicaid utilization rate of above 63%, the facility shall receive 100% of the QMI amount.
   b. For nursing facilities with a Medicaid utilization rate between 50% and 63%, the facility shall receive 75% of the QMI amount.
   c. For nursing facilities with a Medicaid utilization rate below 50%, the facility QMI amount is multiplied by the facility's Medicaid utilization rate.
4) Licensed beds will be determined using the number of licensed nursing facility beds identified by the Michigan Department of Health and Human Services as of a date determined by the department. Only licensed nursing facility beds count towards the total, but the bed count includes nursing facility beds that have Medicare only certification, Medicaid only certification, dual Medicare and Medicaid certification, or are licensed only. The per-bed QMI amount is multiplied by the number of licensed beds.

5) Effective October 1, 2018, an adjustment is made to the per-bed QMI amount based on the submission of resident satisfaction survey data and documentation to the Michigan Department of Health and Human Services. Per-bed QMI amounts will be multiplied by 100% for nursing facilities that submit acceptable resident satisfaction survey data and documentation, but payments will be multiplied by a percentage set by the Michigan Department of Health and Human Services for nursing facilities that do not submit the data and documentation. The resident satisfaction survey must not be more than 12 months old, and survey data used for prior year QMI payments will not be accepted.

6) QMI payments will be calculated to be effective at the beginning of the state fiscal year unless otherwise determined by the Michigan Department of Health and Human Services. The QMI payments will be distributed on a monthly basis. In cases of a change of ownership, the new owner’s QMI payment will continue to be calculated based off of the prior owner’s average quality measure rating, Medicaid utilization rate, number of licensed beds and resident satisfaction survey data. If a facility closes or is designated as a special focus facility, the Michigan Department of Health and Human Services may recalculate some or all QMI payments.

7) The following formula demonstrates how monthly QMI payments are calculated (for rate years prior to October 1, 2018 the resident satisfaction survey factor is not included in the formula):

\[
\text{Monthly QMI payment} = \frac{([\text{per-bed QMI amount}] \times [\text{Medicaid utilization scale percentage}] \times [\text{resident satisfaction survey adjustment percentage}] \times [\text{number of licensed nursing facility beds}])}{[\text{number of eligible payment months}]}
\]
N. Payment Determination for State Veterans Homes

The payment rates to State Veterans Homes shall be prospective, per patient day, and based on patient acuity groupings. The rates for these facilities shall not be subject to the provisions in sections IV.A. through IV.M. above, but instead the following provisions shall be used for payment determination:

1. The single state agency shall utilize Resource Utilization Groups (RUGS) to set payment rates. The Minimum Data Set (MDS) shall be employed to calculate a RUG score which will be used to determine a patient’s acuity.
2. The payment rates associated with an individual RUG category shall be set as a percentage of what the Centers for Medicare and Medicaid Services would pay under the Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS). The percentage shall not exceed 100% of the Medicare rate.
   a. Payment = (percentage * Medicare SNF PPS RUG rate) * billed XIX days.
3. The patient’s RUG score shall be reported on any claim submitted to the single state agency and based on the applicable MDS assessment(s) to the billing period.
4. Participating providers shall not receive any supplemental payments from the single state agency.
5. Allowable cost identification for cost reporting and upper payment limit purposes will not follow section III of this attachment, but will follow the Medicare principles of reimbursement in 42 CFR, Chapter IV, Subchapter B, Part 413 and the PRM-15.
V. Payment Assurance

As a condition of participation, when signing the provider agreement, the provider agrees to accept, as payment in full, the rate paid by the State agency in accordance with the reimbursement formula detailed above.
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VI. Notice of Limits to be Imposed

Each provider shall receive a notice of the methods to be imposed at least 30 days prior to the date under which that provider shall receive reimbursement under this plan.

The state agency will give public notice of any significant proposed change in methods and standards for setting payment rates for services, in compliance with the conditions established by 42 CFR 447.205.
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VII. Exception Procedure

A Class I, II, or III provider may file with the State agency a petition for emergency relief, either at the time of the emergency by filing an interim rate certification or at the time of submission of the cost report covering the time period of the emergency. For purposes of this section, an emergency exists when the lives, well being, or continuation of care of Medicaid recipients is placed in jeopardy. Emergency relief may be granted if the provider can show to the satisfaction of the State agency that a change in law or regulation, a fire or natural disaster, with a substantial effect on operating costs caused the emergency for which the relief is requested.

Emergency relief shall consist of a rate add-on based on the expected added cost of the change. The rate add-on shall be determined from a cost certification form submitted by the provider and shall be subject to approval by the single State agency pending unit.

Emergency relief will require a retrospective cost settlement of the provider’s cost reporting period(s) commencing with the period for which the emergency relief was filed and continuing until such time as the provider’s cost data base appropriately reflects the cost of the operational changes for which relief was given. Rebasin of the provider’s prospective rate will occur when this costs data base is available. The cost settlement shall be made utilizing the principles and guidelines stated in Sections I, II, and III above and shall not exceed the appropriate cost limitations in Section IV above. In addition, if applicable, a retrospective profit factor may be added to the rate based on the principles outlined in Sections IV.B.3. Also, if applicable, a retrospective adjustment to the incentive component may be added to the rate based on the principles outlined in Section IV.D. To determine allowable per patient day variable costs for the latter adjustment, the principles and definitions contained in Section IV.C.Q. & 2. apply.

If, upon audit, the agency finds a discrepancy between certified information and actual costs, all excess funds paid by the State to the facility as a result of that certification will be recovered with a penalty factor (equal to the then current Medicare rate on net invested equity) applied to the discrepancy.
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VIII. Appeals Procedure

The appeals procedure can be initiated by a provider upon receipt of a notice of adverse action, for an informal or formal review or hearing. Procedure I contains provisions for the informal review of an adverse action that is contained in the final summary of audit findings issued by the State agency. This procedure is available to Class I, II and III providers and is effective for cost reporting periods ending on or after September 30, 2000. Procedure II contains provisions for: 1) all classes of providers for formal hearings; 2) all classes of providers for informal reviews which pertain to such adverse action issues as cost settlement determinations, rate determinations, and incentives; and 3) Class IV and V providers for informal reviews of audit findings, if applicable.

A. Procedure I – Informal Review of the Final Summary of Audit Findings

A Class I or Class III provider can request an area office conference for the purpose of review of an adverse action that is contained in the preliminary summary of audit findings issued by the State agency. The election to participate in an area office conference does not result in the waiver of the provider's right to any further administrative processes contained in these provisions and in administrative hearing rules R400.3405 through R400.3424. The following provisions will apply:

1. Provision 1. As used in these provisions:
   a. Adverse action means the audit adjustments contained in the final summary of audit findings that is issued by the appropriate audit representative(s) of the department
   b. Administration means the Medical Services Administration of the Michigan Department of Community Health
   c. Appropriate audit representative(s) means that individual(s) employed or contracted by the Michigan Department of Community Health to conduct audits of provider cost reports.
   d. Days, as used herein, refer exclusively to calendar days unless otherwise specified.
   e. Department means the Michigan Department of Community Health, its officials or agents.
   f. Final determination notice means a notice of an adverse action which includes the action to be taken; the date of the proposed action; the reason for the action; the statute, rule or guideline under which the action is taken; and the right to a hearing.
   g. Provider means an individual, firm corporation, association, agency, institution or other legal entity which is providing, has formerly provided, or has been approved to provide, medical assistance to a recipient pursuant to the medical assistance program.
h. Receipt of as used herein is either on the day of personal delivery or will be presumed on the third day subsequent to the postmark date if the article of mail containing the referenced document is: deposited in Michigan in the United State mail; mailed first class; and properly addressed with postage pre-paid.

2. Provision 2. Audit Review and Area Office Conference:
   a. The appropriate audit representative(s), after completion of the field (desk) audit, will issue a preliminary summary of audit findings to the provider.
   b. If the provider or its representative desires to contest the findings required by Provision 2.a), the provider or its representative must respond to the appropriate audit representative(s) within 10 business days of the date of the preliminary summary of audit findings, and indicate which findings it contests.
   c. If no timely request for an area office conference is made by a provider or its representative, the provider will receive a final summary of audit adjustments notice. The notice advises the provider of subsequent appeal rights, up to and including an administrative hearing. The provider or its representative has 30 calendar days from the date of the final summary of audit adjustments notice to request a formal hearing in accordance with MDCH rules for hearings.
   d. The appropriate audit representative(s) must schedule and conduct a conference to discuss the preliminary summary of audit findings. This conference will be called the area office conference. The provider or its representative must present the appropriate audit representative(s) with the documents and arguments it feels support its position relative to the issue(s) it is contesting. Likewise, the appropriate audit representative(s) shall explain to the provider his/her basis for the findings which the provider is contesting.
   e. The appropriate audit representative(s) will issue a final summary of audit findings to the provider. The Final Summary of Audit Findings advises the provider of subsequent appeal rights, up to and including an administrative hearing. The provider or its representative has 30 calendar days from the date of the final summary of audit adjustments notice to request a formal hearing in accordance with MDCH rules for hearings. This is the final step in the audit review process.
   f. If no timely request for an administration conference is made by a provider or its representative, the audited data as outlined in the final summary of audit findings will be submitted for the rate determination process. The provider will be deemed to have waived its right to any further administrative processes contained in these provisions and in administrative hearing rules R400.3405 through R400.3424. The findings as outlined in the final summary of audit findings will be implemented.

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3. Provision 3 – In computing any period of time prescribed or allowed, the day of the act, event or default after which the designated period of time begins to run is not included. The last day of the period so computed is included, unless it is a Saturday, Sunday or legal holiday in which event the period runs until 5 pm of the next business day which is not a Saturday, Sunday or legal holiday.

B. Procedure II

1. Once a notice of adverse action is issued, a provider may invoke Procedure II by submitting its application in writing to the State agency. The written request shall include an identification of the issue(s) for which resolution is being sought and a description of why the provider believes the determination on these matters is incorrect.

2. Appeals which are allowable under this plan through this procedure will be conducted in accordance with the procedures outlined in the rules, filed on March 4, 1978, as amended, and adopted into Administrative Rules, R400.3401 through R400.3424.

3. A written application for a formal hearing (that is, a hearing conducted by an administrative law judge) must be received within 30 calendar days of the date of notice of an adverse action or a final determination notice. Exceptions: 1) A written request for a formal hearing pertaining to a notification of intent to terminate shall be made in accordance with sub rule 6(4) of Administrative Rule R400.3406. 2) A written application for a formal hearing following an administration conference conducted under Provision 4(c) of Procedure II shall be made in accordance with Provision 4(e) of Procedure II and 3) as otherwise provided in Section VIII.A.1 above.

C. Specific Situation Provisions for Procedure I

1. If the State agency is responsible for a delay in the procedures and either an area office conference or administration conference is in progress, or the potential for an area office conference or an administration conference is still open, at the beginning of the rate year that begins the start of the state fiscal year the following calendar year, the provider will be given a provisional rate for the new rate year. For this purpose, “delay in the procedures” means, if applicable: 1) the State agency failed to issue the preliminary summary of audit adjustments timely (that is, in accordance with Provision 2(a) or as amended in accordance with specific situation 1); 2) the State agency failed to conduct the area office conference timely (that is, in accordance with Provision 2(d) or as amended pursuant to specific situation 1); 3) the State agency failed to issue the final summary of audit findings timely (that is, in accordance with Provision 2(e) or as amended pursuant to specific situation 1); and/or 4) the State agency failed to issue a final determination notice timely (that is, in accordance with Provision 4(c) or as amended pursuant to specific situation 1).

The provisional rate will be established by updating the payment rate for the immediately preceding state fiscal rate year using the provider’s filed cost data. Upon the completion of the audit appeal process, an adjustment, retroactive to the beginning of the new rate year, will be made.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

D. Non-appealable Elements

Elements of the reimbursement program for which an administrative remedy, if permitted for a single provider, would imply or necessitate a change in the program for all providers or for all providers in a class may not be appealed through administrative rules or provisions but may be appealed to a court of appropriate jurisdiction. These elements include, but are not limited to: 1) the determination of the selection and use of inflationary adjustors (Section IV.C.3.); 2) the principles of reimbursement and guidelines which define allowable costs (Section III.); 3) non-Medical Assistance Program issues; 4) the cost limits, unless otherwise specifically provided (Sections IV.B.2., and the appropriate subsections of IV.C.3. and IV.B.4.); and 5) the State agency determination of the allowability of items certified under this plan (until such time as an audit is completed).

E. Adjustments

If the results of an appeal require a change in a provider's rate, the change will be effected through an aggregate adjustment.
State of MICHIGAN

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

e) Within 30 days of the date of the preliminary determination notice, the provider or its representative(s) may request a formal hearing before an administrative law judge. The formal hearing will be conducted in accordance with the Michigan Department of Community Health Medicaid provider reviews and hearings rules, R400.3401 and R400.3406 through R400.3424.

f) If no timely request for an administrative hearing is made by a provider or its representative(s), the provider will be deemed to have waived its rights to an administrative hearing. No further administrative appeal rights will be afforded the provider under these provisions. The action as outlined in the final determination notice will be implemented.

5. Provision 5 – In computing any period of time prescribed or allowed, the day of the act, event or default after which the designated period of time begins to run is not included. The last day of the period so computed is included, unless it is a Saturday, Sunday or legal holiday in which event the period runs until 5 pm of the next business day which is not a Saturday, Sunday or legal holiday.

C. Specific Situation Provisions for Procedure II

1. If the cost report of a provider is not filed timely (that is, in accordance with Provision 2), the State agency will have the option to distribute "late days" into any segment of the time frame for which the State agency is the responsible entity. For this purpose, "late days" means the number of calendar days that have elapsed from the day after the cost report was due through the day the cost report is accepted by the State agency as being correct and complete. The State agency will notify the provider of the date of acceptance, the number of late days the State agency has available for distribution and the number of these days, if any, the State agency has chosen to distribute to the audit process.

2. If the cost report of a provider is not correct or complete, the "clock" for the audit segment of the cycle (that is, the process that is conducted in accordance with Provision 3(a) will be stopped. The clock will be set for recommencement of the 135 day period on the day the resubmitted cost report is accepted by the State agency as being correct and complete. The State agency will notify the provider of the date of acceptance.

3. If the State agency is responsible for a delay in the procedures and either an area office conference or administration conference is in progress, or the
potential for an area office conference or an administration conference is still open, at the beginning of the rate year that begins a year and a day after the end of the fiscal year that is being processed the provider will be given a provisional rate for the new rate year. For this purpose, “delay in the procedures” means, if applicable: 1) the State agency failed to issue the preliminary summary of audit adjustments timely (that is, in accordance with Provision 3(a) or as amended in accordance with specific situation 1); 2) the State agency failed to conduct the area office conference timely (that is, in accordance with Provision 3(d) or as amended pursuant to specific situation 1); 3) the State agency failed to issue the final summary of audit findings timely (that is, in accordance with Provision 3(e) or as amended pursuant to specific situation 1); and/or 4) the State agency failed to issue a final determination notice timely (that is, in accordance with Provision 4(c) or as amended pursuant to specific situation 1). The provisional rate will be established by updating the payment rate for the immediately preceding rate year with an appropriate nursing home cost factor adjustment for the new rate year. Upon the completion of the audit appeal process, an adjustment, retroactive to the beginning of the new rate year, will be made.

D. Nonappealable Elements

Elements of the reimbursement program for which an administrative remedy, if permitted for a single provider, would imply or necessitate a change in the program for all providers or for all providers in a class may not be appealed through administrative rules or provisions but may be appealed to a court of appropriate jurisdiction. These elements include, but are not limited to: 1) the determination of the selection and use of inflationary adjustors (Section IV.C.3.); 2) the principles of reimbursement and guidelines which define allowable costs (Section III.); 3) non-Medical Assistance Program issues; 4) the cost limits, unless otherwise specifically provided (Sections IV.B.2., and the appropriate subsections of IV.C.3. and IV.B.4.); and 5) the State agency determination of the allowability of items certified under this plan (until such time as an audit is completed).

E. Adjustments

If the results of an appeal require a change in a provider’s rate, the change will be effected through an aggregate adjustment.
IX. Overpayments

Overpayments which have been made to individual providers will be assessed against, and recovered from, providers consistent with 42 CFR Section 447.
DEPARTMENT OF SOCIAL SERVICES
MEDICAID PROVIDER REVIEWS AND HEARINGS

Filed with the Secretary of State on March 7, 1978
These rules take effect 15 days after filing with the Secretary of State

(By authority conferred on the director of the department of social services by sections 6 and 9 of Act No. 280 of the Public Acts of 1939, as amended, being §§400.6 and 400.9 of the Michigan Compiled Laws)

R400.3401. Definitions.
   Rule 1. As used in these rules:
   (a) "Adverse action" includes, but is not limited to:
      (i) A suspension or termination of provider participation in the medical assistance program.
      (ii) A denial of an applicant's request for participation in the medical assistance program.
      (iii) A denial, revocation, or suspension of a license or certification issued by the department to allow a facility to operate.
      (iv) The reduction, suspension, or adjustment of provider payments.
      (v) Retroactive adjustments following the audit or review and determination of the daily reimbursement rates for institutional providers.
   (b) "Applicant" means an individual, firm, corporation, association, agency, institution, or other legal entity that has made formal application to participate in the medical assistance program as a provider.
   (c) "Bureau" means the bureau of medical assistance of the Michigan department of social services.
   (d) "Bureau director" means the director of the bureau of medical assistance, Michigan department of social services.
   (e) "Bureau representative" means a person, agency, or entity which is authorized to review the patient care rendered by a provider or applicant or which is authorized to make audits and reviews of the records, procedures, reports, accounting methods, and billing practices of the provider or applicant, as well as the propriety of same.
   (f) "Delegate" means a person who is authorized to act on behalf of the bureau director.
   (g) "Department" means the Michigan department of social services, its officials, or agents.
   (h) "Director" means the director of the Michigan department of social services.
   (i) "Final determination notice" means a notice of an adverse action which includes the action to be taken; the date of the proposed action; the reason for the action; the statute, rule, or guideline under which the action is taken; and the right to a hearing.
(j) "Hearing authority" means the person appointed by the director to decide appeals from decisions of an administrative law judge.

(k) "Medical assistance program" means the department's program to provide for medical assistance established by section 105 of Act No. 280 of the Public Acts of 1939, as amended, being $ 400.105 of the Michigan Compiled Laws, and title XIX of the federal social security act, 42 U.S.C. § 1396 et seq.

(1) "Notice", when notification by the department is indicated or required, means notice which meets the requirement of section 7H(2) of Act No. 306 of the Public Acts of 1969, being $ 24.271(2) of the Michigan Compiled Laws. Notification shall be by certified or registered mail, with return receipt requested, to the last address of the provider or other party on file with the department.

(m) "Provider" means an individual, firm, corporation, association, agency, institution, or other legal entity which is providing, or has been approved to provide, medical assistance to a recipient pursuant to the medical assistance program.

(n) "Recipient" means an individual receiving medical assistance through the department.

R 400.3402. Preliminary conference; initial findings; request for bureau conference; final determination letter.

Rule 2. (l) The bureau shall, prior to the taking of an adverse action, hold a preliminary conference with the provider or applicant, or with the representative thereof, to discuss the results of the investigation. The provider or applicant shall be advised of the preliminary conference in writing. The provider or applicant may submit any additional information which the provider or applicant wishes to be considered prior to the closing of the investigation.

(2) Within 10 calendar days of the completion of the preliminary conference, the bureau representative shall inform the provider or applicant, in written form, of his initial findings including copies of all written reports which influenced the findings. At the same time, the bureau representative shall inform the provider or applicant of the right to a conference with the bureau director or his delegate.

(3) Within 20 calendar days of receipt of the initial findings by the provider or applicant, the provider or applicant may request, in writing, a bureau conference. If the provider or applicant makes a timely request for a bureau conference, the provider or applicant shall, at the same time, submit a written response to the initial findings.

(4) If no timely request for a bureau conference is made by a provider or applicant, a final determination letter shall be mailed pursuant to rule 5.

R 400.3403. Bureau conference.

Rule 3. (l) The bureau director or his delegate shall hold a conference with a provider or applicant prior to the determination of an adverse action upon request of the provider or applicant. The bureau director or his delegate shall review the initial findings and the written statements or oral statements, or both, of the provider or applicant.
(2) If the bureau conference is held by a delegate, the delegate shall make a recommendation to the bureau director. The recommendation shall be prepared and shall address itself to the initial findings and the written or oral statements of the provider or applicant. A copy of that recommendation shall be forwarded to the provider or applicant within 10 calendar days after the end of the conference.

R 400.3404. Decision to take an adverse action.

Rule 4. (1) The bureau director shall, within 30 days after the completion of the bureau conference, decide whether to take an adverse action against an applicant or provider.

(2) The bureau director may, in his discretion, consult with independent professional personnel in the applicable field, as long as the recommendations of such professionals are in writing, are made available to all parties of the hearings, and are incorporated in the record.

R 400.3405. Final determination notice.

Rule 5. Prior to the taking of an adverse action, the provider shall receive a final determination notice.

R 400.3406. Formal hearing.

Rule 6. (1) A provider or applicant is entitled to a hearing pursuant to chapter 4 of Act No. 306 of the Public Acts of 1969, being § 24.271 et seq. of the Michigan Compiled Law, in any case in which there has been a final determination of an adverse action as defined in rule 1, except where that action is predicated upon the situation described in rule 6(2).

(2) A request for a formal hearing shall not be granted if the adverse action is the result of the revocation, suspension, or termination, by an authority other than the department, of the provider's license or certification to practice in the provider's profession or to operate a nursing home, hospital, or other such medical facility, and if the department is in receipt of a certified copy or formal notification of such revocation, suspension, or termination.

(3) A formal hearing shall be granted if the revocation, suspension, or termination of the provider's license, certification, or authorization is the result of a department action, unless the provider previously had an opportunity to have that action reviewed.

(4) Unless a written request for a formal hearing is received within 30 calendar days of notification of intent to terminate, the providers' participation shall automatically terminate as of the 30th calendar day after date of notification. Such termination shall then be a final and binding administrative determination.

(5) The request shall identify those aspects of the determination with which the provider or applicant is dissatisfied; shall explain why the provider or applicant believes the determination on those matters is incorrect; shall set out the dollar amount involved, if any; and shall be submitted with any documentary evidence the provider or applicant considers necessary to support its position.
R 400.3407. Suspension and adjustment of program payments.

Rule 7. (1) Regardless of any request for a hearing, payments on pending and subsequently submitted bills may be immediately suspended, in whole or in part, if the bureau director determines that the practice set out in the final determination requires immediate action to protect the health, safety, or welfare of recipients or the general public. This subrule does not prejudice the provider's right to a hearing as provided in rule 6. Any hearing requested pursuant to this subrule shall be commenced forthwith if requested by the provider.

(2) The final determination notice shall constitute the basis for making retroactive adjustment of any program payments made to the provider during the period to which the determination applies, including the suspension of further payments to the provider, in order to recover, or to aid in the recovery of, an overpayment identified in the determination to have been made to the provider or applicant. If the provider or applicant requests a hearing, adjustments and recovery shall not be made, except as provided in rule 7(1), until 10 days after the mailing of the hearing decision as provided in rule 24.

R 400.3408. Filing final determination notice with bureau of administrative hearings.

Rule 8. The bureau of medical assistance shall file with the bureau of administrative hearings, within 30 days after receipt by the department of the hearing request, a copy of the final determination notice and supporting documentation.

R 400.3409. Notice of hearing.

Rule 9. Notice of the time, date, place of hearing, and name of the administrative law judge shall be mailed to the parties, or their designated representative, not less than 10 days before the date of the hearing.

R 400.3410. Appearance and representation.

Rule 10. In any pending procedure:
   (a) A natural person may appear and be heard on that person's own behalf, through an attorney at law, or through a designated representative.
   (b) A corporation may appear and present evidence by any bona fide officer or employee, through an attorney at law, or through a designated representative. All persons appearing in proceedings before the department shall conform to the standards of conduct practiced by attorneys before the courts of this state. If a person does not conform to the standards, the administrative law judge may decline to permit the person to appear in the proceeding, or may exclude the person from the proceeding.

R 400.3411. Notice of appearance.

Rule 11. A person appearing in a representative capacity shall file a written notice of appearance on behalf of a provider or applicant, identifying himself by name, address, and telephone number, and identifying the party represented, and shall have a written authorization to appear on behalf of the provider or applicant. The department shall notify the bureau of administrative hearings and the provider or applicant of the name and telephone number of its representative.
R 400.3412. Papers filed in proceeding; formal requirements.
   Rule 12. (1) All papers filed in a proceeding shall be typewritten and double-
   spaced on standard legal sized white paper, using 1 side of the paper only. The
   papers shall have a cover sheet, with a caption clearly showing the title of the
   proceeding in connection with which such papers are filed, together with the
   register number, if any.
   (2) All papers shall be signed by the party attorney, or a designated repre-
   sentative, and shall contain the signer's business address and telephone number.
   The original shall be filed with the bureau of administrative hearings.

R 400.3413. Service and proof of service.
   Rule 13. (1) All papers, notices, and other documents shall be served by the
   party filing them upon all parties to the proceeding. Proof of that service upon
   all parties shall be filed with the bureau of administrative hearings.
   (2) Service shall be made by delivering in person, or by depositing in the
   United States mail, properly addressed with postage prepaid, 1 copy to each
   party entitled thereto. When any party has appeared by attorney, service upon
   the attorney shall be deemed service upon the party.
   (3) Proof of service of a paper shall be by affidavit or acknowledgment.

R 400.3414. Computation of time periods.
   Rule 14. In computing any period of time prescribed or allowed, the day of
   the act, event, or default after which the designated period of time begins to
   run is not included. The last day of the period so computed is included, unless
   it is a Saturday, Sunday, or legal holiday, in which event the period runs until 5
   p.m. of the next business day which is neither a Saturday, Sunday, nor holiday.
   When the period of time prescribed is 7 days or less, intermediate Saturdays,
   Sundays, and holidays shall be excluded in the computation.

R 400.3415. Certification of documents.
   Rule 15. The signature of a person signing a document constitutes a certifi-
   cation that he has read the document and that, to the best of his knowledge,
   information, and belief, every statement contained in the instrument is true.

R 400.3416. Hearing extensions and postponements.
   Rule 16. Upon good cause shown, the administrative law judge may grant
   extensions of time or postponements of a hearing.

R 400.3417. Prehearing conference.
   Rule 17. The administrative law judge, on his own motion or at the request
   of a party, may hold a prehearing conference, to be held in an office or place
   designated by the bureau of administrative hearings before an administrative law
   judge. The conference shall be convened for, but not limited to, the following
   purposes:
   (a) The simplification of factual and legal issues.
   (b) The necessity or desirability of amendments to the pleadings.
   (c) The making of admissions or stipulations of fact, including all material
   facts that are pertinent to the dispute.

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(d) The identification of witnesses and exchange of information regarding the subject matter of their testimony.

(e) The identification and exchange of documentary evidence to be introduced at the hearing.

(f) The consideration of the possibilities for settlement of the issues.

(g) The discussion of such other matters as may aid in the simplification and disposition of the proceedings.

R 400.3418. Administrative law judge; powers.

Rule 18. In addition to the powers granted in chapter 4 of Act No. 306 of the Public Acts of 1969, an administrative law judge shall have the power to:

(a) Administer oaths or affirmations.

(b) Sign and issue subpoenas in the name of the agency, requiring attendance and the giving of testimony by witnesses.

(c) Sign and issue subpoenas in the name of the agency for the production of books, papers, and other documentary evidence to the extent permitted by law.

(d) Regulate the course of a hearing, set the time and place for continued hearings, and fix the time for filing of briefs and other documents.

(e) Provide for the taking of testimony by depositions.

(f) Rule upon offers of proof and to receive evidence.

(g) Hold conferences before or during the hearing for the purpose of simplification of issues and for such other purposes as the demands of justice require.

(h) Rule on motions and to dispose of procedural requests or similar matters.

(i)Prescribe general rules of hearing decision or conduct.

(j) Determine any and all issues presented at the hearing including the denial of an application or termination of a provider from the medical assistance program.

R 400.3419. Rules of discovery.

Rule 19. Insofar as is practical, the administrative law judge shall follow the rules of discovery as applied in a nonjury civil case, as contained in the Michigan general court rules.

R 400.3420. Hearing procedure, generally; evidence; filing of written statements.

Rule 20. (1) Procedure shall be in accordance with chapter 4 of Act No. 306 of the Public Acts of 1969. The hearing shall be open to the parties, their designated representatives, and to such other persons as the administrative law judge deems proper. The administrative law judge shall receive in evidence the relevant testimony of witnesses and any documents which are relevant and material to the subject of the hearing, pursuant to section 75 of Act No. 306 of the Public Acts of 1969. The order in which evidence and allegations are presented, and the procedure at the hearing, shall be at the discretion of the administrative law judge, and shall be of such a nature as to afford the parties due process.

(2) The parties, upon their request, shall be allowed a reasonable time, not to exceed 15 days after the close of the hearing, for the filing of written statements in support of their positions.

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R 400.3421. Confidentiality.
Rule 21. At all times during the procedures outlined in these rules, measures shall be taken to insure the confidentiality of all privileged medical information and to safeguard the disclosure and use of information regarding recipients of medical assistance.

R 400.3422. Record of proceedings.
Rule 22. A complete record of the proceedings at the hearing shall be made. The testimony shall be transcribed and copies of other documentary evidence shall be reproduced in any case when directed by the administrative law judge. The record shall also be transcribed and reproduced at the request of a party to the review, if that party bears the cost thereof.

R 400.3423. Recommended decision of administrative law judge; exceptions.
Rule 23. (1) As soon as practicable after the close of a hearing, the administrative law judge shall prepare a recommended decision in the case, which shall be based upon the evidence adduced at the hearing or otherwise included in the record. The recommended decision shall be made in writing and shall contain findings of fact and conclusions of law. A copy of the recommended decision shall be mailed to each party to the hearing at that party's last known address.

(2) Any party may, within 10 days of the administrative law judge's decision, file exceptions for the consideration of the director or hearing authority. The exceptions shall be mailed to all parties and shall be made a part of the record.

R 400.3424. Final decision of director or hearing authority.
Rule 24. The director or hearing authority shall render a final decision in each case based upon the evidence in the record, not later than 45 days after the administrative law judge makes his recommendation. The decision shall be made in writing. A copy of the decision shall be mailed to each party at the party's last known address. Copies of all decisions of the director or hearing authority shall be accessible to the public at the state office of the department. Copies may be obtained at actual cost.

R 400.3425. Nonapplicability of rules to alternate method of hospital reimbursement.
Rule 25. Rules 1 to 23 do not apply to the alternate method of hospital reimbursement. That method shall follow the procedures in the approved state medical assistance plan.

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PART I - GENERAL

1. NAMES AND ADDRESSES PROVIDER NUMBERS DATES CERTIFIED

HOSPITAL

SUBPROVIDER I

SUBPROVIDER II

SKILLED NURSING FACILITY

HOME HEALTH AGENCY

SPECIAL PROVIDER-CONTROLLED FACILITY

2. COST REPORTING PERIOD

FROM TO

3. TYPE OF CONTROL

0. VOLUNTARY NONPROFIT
   □ CHURCH
   □ OTHER (Specify)

L. PROPRIETARY
   □ INDIVIDUAL
   □ CORPORATION
   □ PARTNERSHIP
   □ OTHER (Specify)

G. GOVERNMENT
   □ FEDERAL
   □ STATE
   □ COUNTY
   □ CITY
   □ CITY-COUNTY
   □ HOSPITAL DISTRICT
   □ OTHER (Specify)

4. TYPE OF HOSPITAL

G. GENERAL - SHORT TERM
   □ PSYCHIATRIC
   □ SPECIALTY - LONG TERM

L. GENERAL - LONG TERM
   □ CHRONIC DISEASE
   □ SPECIALTY - SHORT TERM
   □ TUBERCULOSIS
   □ OTHER (Specify)

D. MEDICARE CERTIFIED KIDNEY TRANSPLANT HOSPITAL
   □ YES □ NO

5. HEALTH CARE PROGRAMS

□ TITLE V □ TITLE XVIII □ TITLE XIX

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN
THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL
LAW.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying
Statement of Reimbursable Cost and the Balance Sheet and Statement of Revenue and Expense
prepared by ____________________________

(Provider name[s] and number[s]) for the cost report period beginning __________ and
ending __________, and that to the best of my knowledge and belief, it is a true, correct,
and complete statement prepared from the books and records of the provider(s) in accordance with
applicable instructions, except as noted.

(Signed) ____________________________
Officer or Administrator of Provider(s)

Title ____________________________

Date ____________________________

5/1/80
### PART II - HOSPITAL STATISTICS

#### INPATIENT - ALL PATIENTS

<table>
<thead>
<tr>
<th>Provider No.</th>
<th>Period: From</th>
<th>To</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Inpatient - All Patients</th>
<th>General Service</th>
<th>ICU</th>
<th>CCU</th>
<th>Other, Specify</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Beds (excluding newborn) available at beginning of period</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Beds (excluding newborn) available at end of period</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Total beds available (excluding newborn)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Aged, pediatric and maternity inpatient days</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>Other than aged, pediatric and maternity inpatient days (excl. newborn)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>Total inpatient days (excluding newborn) (Sum of lines 4 and 5)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Percent occupancy (line 6 divided by line 3)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>Total newborn inpatient days</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

#### INPATIENT - HEALTH CARE PROGRAMS

| Title V | | | | |
|---------|---|---|---|
| a. Inpatient days (excluding newborn) | 1 | 2 | 3 |
| b. Newborn inpatient days | 1 | 2 | 3 |

| Title XVIII | | | | |
|------------|---|---|---|
| a. Aged, pediatric and maternity inpatient days (excluding kidney acquisition days) | 1 | 2 | 3 |
| b. Kidney acquisition days (aged, pediatric and maternity) | 1 | 2 | 3 |
| c. Total aged, pediatric and maternity inpatient days (Sum of lines 10a and 10b) | 1 | 2 | 3 |
| d. Other than aged, pediatric and maternity inpatient days (excluding kidney acquisition days) | 1 | 2 | 3 |
| e. Kidney acquisition days (other than aged, pediatric and maternity) | 1 | 2 | 3 |
| f. Total other than aged, pediatric and maternity inpatient days (Sum of lines 10a and 10b) | 1 | 2 | 3 |
| g. Total inpatient days (excluding kidney acquisition days) (Sum of lines 10a and 10b) | 1 | 2 | 3 |
| h. Total kidney acquisition days (Sum of lines 10a and 10b) | 1 | 2 | 3 |
| i. Total Part A inpatient days (Sum of lines 10a and 10b) | 1 | 2 | 3 |
| j. Total Part B inpatient days (SEE INSTRUCTIONS) | 1 | 2 | 3 |
| k. Part B inpatient days when Part A benefits are not available (SEE INSTRUCTIONS) | 1 | 2 | 3 |

#### OUTPATIENT - HEALTH CARE PROGRAMS

<table>
<thead>
<tr>
<th>Title V</th>
<th>Title XVIII</th>
<th>Title XIX</th>
<th>All Other</th>
<th>Total Sum of Cols</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Inpatient days (excluding newborn)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. Newborn inpatient days</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### PART III - OTHER HOSPITAL DATA

1. Amount of accelerated payments outstanding on or after date of last remittance period - title XVIII
2. Average number of employees on payroll for the period (full-time equivalent) - excludes resident physicians
3. Average number of employed workers for the period (full-time equivalent) for which remuneration is claimed
4. Number of renal dialysis treatments (inpatients and outpatients):
   - a. Total - All Hospital Patients
   - b. Title V
   - c. Title XVIII
   - d. Title XIX

5. Number of admissions (excluding newborns):
   - a. Total - All Hospital Inpatients
   - b. Title V
   - c. Title XVIII
   - d. Title XIX

6. Number of discharges including deaths (excluding newborns):
   - a. Total - All Hospital Inpatients
   - b. Title V
   - c. Title XVIII
   - d. Title XIX

7. Average length of stay:
   - a. Total (Part II, line 6a + sum of cols 1-5) / Part III, line 6d
   - b. Title V (Part II, line 6a + sum of cols 1-5) / Part III, line 6d
   - c. Title XVIII (Part II, line 6a + sum of cols 1-5) / Part III, line 6d
   - d. Title XIX (Part II, line 6a + sum of cols 1-5) / Part III, line 6d

**Form SSA-2552 (3-71)**

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
## PART V - OTHER SUBPROVIDER AND SKILLED NURSING FACILITY DATA

### INPUT PATIENT - ALL PATIENTS

<table>
<thead>
<tr>
<th>Description</th>
<th>SUBPROVIDER</th>
<th>SKILLED NURSING FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1 Beds (excluding newborn) available at beginning of period</td>
<td></td>
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</tr>
<tr>
<td>2 Beds (excluding newborn) available at end of period</td>
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</tr>
<tr>
<td>3 Total beds available (excluding newborn)</td>
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</tr>
<tr>
<td>4 Aged, pediatric and maternity inpatient days</td>
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<tr>
<td>5 Other than aged, pediatric and maternity inpatient days (excluding newborn)</td>
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<td>6 Total inpatient days (excluding newborn)</td>
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<tr>
<td>7 Percent occupancy (lines 4 and 5)</td>
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<td>8 Total newborn inpatient days</td>
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### INPUT PATIENT - HEALTH CARE PROGRAMS

<table>
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<td>VIII</td>
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### PART V - OTHER SUBPROVIDER AND SKILLED NURSING FACILITY DATA

<table>
<thead>
<tr>
<th>Description</th>
<th>SUBPROVIDER</th>
<th>SKILLED NURSING FACILITY</th>
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</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>Amount of Medicare payments outstanding as of end of most reporting period</td>
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<tr>
<td>Average number of employees on payroll for the period (full-time equivalent) excluding nonpaid workers</td>
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<tr>
<td>Average number of nonpaid workers for the period (full-time equivalent) for which reimbursement is claimed</td>
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<tr>
<td>Number of renal dialysis treatments</td>
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</tr>
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<td>a. Total</td>
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</tr>
<tr>
<td>b. Title V</td>
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<tr>
<td>c. Title VIII</td>
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<td></td>
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<tr>
<td>d. Title XIX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of admissions (excluding newborn)</td>
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<tr>
<td>a. Total</td>
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<tr>
<td>b. Title V</td>
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<tr>
<td>c. Title VIII</td>
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<tr>
<td>d. Title XIX</td>
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<tr>
<td>Number of discharges including deaths (excluding newborn)</td>
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<tr>
<td>a. Total</td>
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<tr>
<td>b. Title V</td>
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<td>c. Title VIII</td>
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<td>d. Title XIX</td>
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<tr>
<td>Average length of stay</td>
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<tr>
<td>a. Total (Part IV, line 4 + Part V, line 6a)</td>
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<tr>
<td>b. Title V (Part IV, line 9a + Part V, line 6b)</td>
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<tr>
<td>c. Title VIII (Part IV, line 10a + Part V, line 6c)</td>
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<tr>
<td>d. Title XIX (Part IV, line 11a + Part V, line 6d)</td>
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</table>

Fonn SSA-2552 (1-73) 3
## RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

<table>
<thead>
<tr>
<th>COST CENTER</th>
<th>SALARIES</th>
<th>OTHER</th>
<th>TOTAL (COL 1 + 2)</th>
<th>RECLASSIFICATIONS (FR WKSST A-1 - A-6)</th>
<th>RECLASSIFIED TRIAL BALANCE (COL 5 + 4)</th>
<th>ADJUSTMENTS TO EXPENSES (INCREASES &amp; DECREASES) (FR WKSST A-8)</th>
<th>NET EXPENSES FOR COST ALLOCATION (COL 5 + 4)</th>
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<tbody>
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</tbody>
</table>

**RECLASSIFICATIONS AFFECTING ADMINISTRATIVE AND GENERAL EXPENSES**

**ITEM**

1. Employee Health & Welfare benefits included in Administrative and General
2. Personnel Department
3. Employee Health Service
4. Hospitalization Insurance
5. Workmen's Compensation
6. Employee Group Insurance
7. Social Security Taxes
8. Unemployment Taxes
9. Annuity Premiums, Post Service Benefits, Pensions
10. 
11. 
12. 
13. Total employee benefit costs included in Administrative & General (Sum of lines 2-12)
14. Insurance
15. Interest
16. Rent
17. Taxes (Real Property Taxes) (Personal Property Taxes)
18. Utilization Review - SNF
19. TOTAL RECLASSIFICATIONS

(Total of lines 13-18)

(Total of columns 1-6, line 19, should equal 0)

**TRANSFER TO WORKSHEET A**

**COL 4, LINE 2**

**TRANSFER TO WORKSHEET A**

**COL 4, LINE 3**

**TRANSFER TO WORKSHEET A**

**COL 4, LINE 4**

**TRANSFER TO WORKSHEET A**

**COL 4, LINE 5**

**TRANSFER TO WORKSHEET A**

**COL 4, LINE 6**

**TRANSFER TO WORKSHEET A**

**COL 4, LINE 7**

**TRANSFER TO WORKSHEET A**

**COL 4, LINE 8**

**TRANSFER TO WORKSHEET A**

**COL 4, LINE 9**
### PART I - RECLASSIFICATION OF EXPENSES

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>TOTAL EXPENSES (FROM WORKSHEET A, COL 3, LINE AS INDICATED)</th>
<th>ANALYSIS OF DIETARY EXPENSES</th>
<th>TOTAL (SUM OF COLS 1 &amp; 2)</th>
<th>ALLOCATION OF TOTAL UNIDENTIFIED DIETARY EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1 Dietary (From Worksheet A, col 3, line 10)</td>
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<tr>
<td>Identified Expenses (1)</td>
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<tr>
<td>2 Dietary (2)</td>
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</tr>
<tr>
<td>3 Cafeteria</td>
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</tr>
<tr>
<td>4 Nursery</td>
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<tr>
<td>5 Total (Sum of lines 2-5)</td>
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<td>6 Unidentified Dietary Expenses (line 1 minus line 6)</td>
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### PART II - TRANSFER OF RECLASSIFIED EXPENSES

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<th>ITEM</th>
<th>AMOUNT</th>
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<tbody>
<tr>
<td>1 Cafeteria (line 3, sum of columns 2 and 5) (Add on Worksheet A, column 4, line 11)</td>
<td>$</td>
</tr>
<tr>
<td>2 Nursery (line 4, sum of columns 2 and 5) (Add on Worksheet A, column 4, line 51)</td>
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</tr>
<tr>
<td>3 (line 5, sum of columns 2 and 5) (Add on Worksheet A, column 4, line as appropriate)</td>
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</tr>
<tr>
<td>4 TOTAL (Sum of lines 1-3) (Deduct on Worksheet A, column 4, line 10)</td>
<td>$</td>
</tr>
</tbody>
</table>

(1) These amounts must be specifically identifiable in the accounting records or by analysis.

(2) Include in the dietary cost center all activities served directly from the dietary department; e.g., hospital inpatients, skilled nursing facility inpatients. If no cafeteria exists and employees and student nurses are served meals directly from the dietary department, costs for these items should be included in the dietary cost center and allocated to the proper departments on Worksheet B.
### RECLASSIFICATION OF CENTRAL SERVICES & SUPPLY

<table>
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<th>AMOUNT</th>
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<tbody>
<tr>
<td>1</td>
<td>Intern-Resident Service - (in approved teaching program) (Add on Worksheet A, column 4, line 19)</td>
</tr>
<tr>
<td>2</td>
<td>Intern-Resident Service - (not in approved teaching program) (Add on Worksheet A, column 4, line 61)</td>
</tr>
<tr>
<td>3</td>
<td>Intravenous Therapy (Add on Worksheet A, column 4, line 32)</td>
</tr>
<tr>
<td>4</td>
<td>Oxygen (Inhalation) Therapy (Add on Worksheet A, column 4, line 33)</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>TOTAL (Sum of lines 1-6) (Deduct on Worksheet A, col. 4, line 14)</td>
</tr>
</tbody>
</table>

### RECLASSIFICATION OF LABORATORY EXPENSE

<table>
<thead>
<tr>
<th>ITEM</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Blood (Add on Worksheet A, column 4, line 30)</td>
</tr>
<tr>
<td>2</td>
<td>Blood Storing, Processing, &amp; Administration (Add on Worksheet A, column 4, line 31)</td>
</tr>
<tr>
<td>3</td>
<td>Electrocardiography (Add on Worksheet A, column 4, line 37)</td>
</tr>
<tr>
<td>4</td>
<td>Electroencephalography (Add on Worksheet A, column 4, line 38)</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>TOTAL (Sum of lines 1-6) (Deduct on Worksheet A, col. 4, line 29)</td>
</tr>
</tbody>
</table>

### RECLASSIFICATION OF RADIOLOGY - DIAGNOSTIC

<table>
<thead>
<tr>
<th>ITEM</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Radiology-Therapeutic (Add on Worksheet A, column 4, line 27)</td>
</tr>
<tr>
<td>2</td>
<td>Radioisotope (Add on Worksheet A, column 4, line 28)</td>
</tr>
<tr>
<td>3</td>
<td>Electrocardiography (Add on Worksheet A, column 4, line 37)</td>
</tr>
<tr>
<td>4</td>
<td>Electroencephalography (Add on Worksheet A, column 4, line 38)</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>TOTAL (Sum of lines 1-6) (Deduct on Worksheet A, col. 4, line 26)</td>
</tr>
</tbody>
</table>
### Worksheet A.4

<table>
<thead>
<tr>
<th>Code</th>
<th>Period</th>
<th>Cost Center</th>
<th>Description</th>
<th>Amount</th>
<th>Line No.</th>
<th>Increase</th>
<th>Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Explanation:**

(1) All reclassification entries must be entered on each line to identify each reclassification entry.

(2) Transfer to Worksheet A.1, line as appropriate.

*Note: This page contains a table with data entries that are not clearly visible due to distortion or blurriness.*
**LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES QUESTIONNAIRE**

**PROVIDER NO.: [Enter applicable number]**

**PERIOD:**

**HOSPITAL WORKSHEET A.7**

### Worksheet A.7

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BEGINNING BALANCE</th>
<th>ACQUISITIONS</th>
<th>DISPOSALS AND RETIREMENTS</th>
<th>ENDING BALANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$ 1 $ $ 2 $</td>
<td>$ 3 $ $ 4 $ $ 5 $ $ 6 $ $ 7 $ $ 8 $</td>
<td>$ 9 $</td>
</tr>
<tr>
<td><strong>Land</strong></td>
<td>$</td>
<td>$ 1 $ $ 2 $</td>
<td>$ 3 $ $ 4 $ $ 5 $ $ 6 $ $ 7 $ $ 8 $</td>
<td>$ 9 $</td>
</tr>
<tr>
<td><strong>Land Improvements</strong></td>
<td>$</td>
<td>$ 1 $ $ 2 $</td>
<td>$ 3 $ $ 4 $ $ 5 $ $ 6 $ $ 7 $ $ 8 $</td>
<td>$ 9 $</td>
</tr>
<tr>
<td><strong>Buildings &amp; Fixtures</strong></td>
<td>$</td>
<td>$ 1 $ $ 2 $</td>
<td>$ 3 $ $ 4 $ $ 5 $ $ 6 $ $ 7 $ $ 8 $</td>
<td>$ 9 $</td>
</tr>
<tr>
<td><strong>Building Improvements</strong></td>
<td>$</td>
<td>$ 1 $ $ 2 $</td>
<td>$ 3 $ $ 4 $ $ 5 $ $ 6 $ $ 7 $ $ 8 $</td>
<td>$ 9 $</td>
</tr>
<tr>
<td><strong>Equipment</strong></td>
<td>$</td>
<td>$ 1 $ $ 2 $</td>
<td>$ 3 $ $ 4 $ $ 5 $ $ 6 $ $ 7 $ $ 8 $</td>
<td>$ 9 $</td>
</tr>
<tr>
<td><strong>Fixed</strong></td>
<td>$</td>
<td>$ 1 $ $ 2 $</td>
<td>$ 3 $ $ 4 $ $ 5 $ $ 6 $ $ 7 $ $ 8 $</td>
<td>$ 9 $</td>
</tr>
<tr>
<td><strong>Movable</strong></td>
<td>$</td>
<td>$ 1 $ $ 2 $</td>
<td>$ 3 $ $ 4 $ $ 5 $ $ 6 $ $ 7 $ $ 8 $</td>
<td>$ 9 $</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$</td>
<td>$ 1 $ $ 2 $</td>
<td>$ 3 $ $ 4 $ $ 5 $ $ 6 $ $ 7 $ $ 8 $</td>
<td>$ 9 $</td>
</tr>
</tbody>
</table>

2. Were there any obligations and/or expenditures incurred for capital expenditures (as defined in Provider Reimbursement Manual Part I, chapter 24) by or on behalf of the provider during the period to which this cost report applies and subsequent to (1) December 31, 1972, or (2) the effective date of the agreement between the State and the Secretary, whichever is later.

- [ ] YES
- [ ] NO

If "No", DO NOT COMPLETE THE REMAINDER OF THIS WORKSHEET.

3. Enter the following data relative to each capital expenditure (as defined in Provider Reimbursement Manual Part I, chapter 24) made by or on behalf of the provider during the period to which this cost report applies and subsequent to (1) December 31, 1972, or (2) the effective date of the agreement between the State and the Secretary, whichever is later.

| DESCRIPTION | HOW ACQUIRED SYMBOL(1) | DATE OBLIGATION INCURRED | COST | DEPRECIATION | INTEREST | RENT | OTHER | EXPENSE | OTHER | AMOUNT | TOTAL | ISSUE COLS A.A.A.M |
|-------------|------------------------|--------------------------|------|--------------|----------|------|-------|---------|-------|--------|-------|
|             |                        |                          |      |              |          |      |       |         |       |        |       |                 |
| a.          |                        |                          |      |              |          |      |       |         |       |        |       |                 |
| b.          |                        |                          |      |              |          |      |       |         |       |        |       |                 |
| c.          |                        |                          |      |              |          |      |       |         |       |        |       |                 |
| d.          |                        |                          |      |              |          |      |       |         |       |        |       |                 |

4. Enter the following data with regard to the provider's written notice of intention to make each capital expenditure described in item 3 above. The capital expenditures should be listed in the same chronological order as those listed in item 3.

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>DATE WRITTEN NOTICE SUBMITTED</th>
<th>DATE APPROVED</th>
<th>DATE OF NOTICE OF DISAPPROVAL RECEIVED</th>
<th>DATE OF APPEAL</th>
<th>APPEAL OF DENIAL</th>
<th>STATUS OF APPEAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

(1) Use the following symbols to indicate how the asset was acquired.

- A - Purchase on the open market
- B - Donation or transfer
- C - Lease or comparable arrangement

FORM SSA-2552 (8-75)
### ADJUSTMENTS TO EXPENSES

**WORKSHEET A-8**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>BASIS FOR ADJUSTMENT</th>
<th>AMOUNT</th>
<th>COST CENTER</th>
<th>LINE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Investment income on commingled restricted and unrestricted funds (chapter 2)</td>
<td></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Transfers, loans, leases, and discounts on purchases (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Reimbursements and refunds of expenses (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Rent of provider space by suppliers (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Telephone service (pay stations excluded) (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Television and radio service (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Parking lot (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Remuneration applicable to provider-based radiologists for professional services (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Remuneration applicable to provider-based pathologists for professional services (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Remuneration applicable to provider-based anesthesiologists for professional services (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Remuneration applicable to provider-based cardiologists for professional services (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Remuneration applicable to provider-based neurologists for professional services (chapter 2)</td>
<td></td>
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<tr>
<td>13.</td>
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<tr>
<td>14.</td>
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<td>15.</td>
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<tr>
<td>16.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Home office costs (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Sale of scrap, waste, etc. (chapter 2)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19. Nonallowable costs related to certain capital expenditures (chapter 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Adjustment resulting from transactions with related organizations (chapter 10)</td>
<td>Fr Wtt A-8-1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Laundry and linen services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Cafeteria - employees, guests, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Rental of living quarters to employees and others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Sale of medical and surgical supplies to other than patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Sale of drugs to other than patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Sale of medical records and abstracts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Nursing school (tuition, fees, textbooks, uniforms, etc.)</td>
<td></td>
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</tr>
<tr>
<td>28. Vending machines</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>29. Income from imposition of interest, finance or penalty charges (chapter 21)</td>
<td></td>
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</tr>
<tr>
<td>30.</td>
<td></td>
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</tr>
<tr>
<td>31.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. SUBTOTAL (Sum of lines 1-31) (Carry forward to page 11, Worksheet A-4, line 32)</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(1) Description - all line references in this column pertain to the Provider Reimbursement Manual, Part 1.

(2) Basis for adjustment (SEE INSTRUCTIONS):

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.
### ADJUSTMENTS TO EXPENSES

<table>
<thead>
<tr>
<th>DESCRIPTION (1)</th>
<th>BASIS FOR ADJUSTMENT (2)</th>
<th>AMOUNT</th>
<th>EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. SUBTOTAL</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td></td>
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<td>35.</td>
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<td>36.</td>
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<td>37.</td>
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<td>38.</td>
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<td>39.</td>
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<td>40.</td>
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<td>41.</td>
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<td>42.</td>
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<td>43.</td>
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<td>44.</td>
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<td>45.</td>
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<td>46.</td>
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<td>47.</td>
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<td>48.</td>
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<td>49.</td>
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<td>50.</td>
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<td>51.</td>
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<td>52.</td>
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<td>53.</td>
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<tr>
<td>54.</td>
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<td>55.</td>
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<tr>
<td>56.</td>
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<tr>
<td>57.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58. SUBTOTAL</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>59. Grants, gifts, and income designated by donor for specific expenses (chapter 6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60. Utilization Review - physicians' compensation (chapter 21)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61. Depreciation - buildings and fixtures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62. Depreciation - movable equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63. TOTAL (line 58 plus or minus the sum of lines 59-62) (Transfer to Worksheet A, column 6, line 72)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(1) Description - all descriptions in this column pertain to the Provider Reimbursement Manual Part I.

(2) Basis for adjustment (SEE INSTRUCTIONS):

A. Cost - if cost, including applicable overhead, can be determined.
B. Amount Receivable - if cost cannot be determined.

**FORM SSA-2552 (2-79)**
A. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in the Provider Reimbursement Manual, Part I, chapter 10?

☐ Yes  ☐ No  (If “Yes,” complete Parts B and C)

B. Costs incurred and adjustment required as result of transactions with related organizations:

<table>
<thead>
<tr>
<th>LOCATION AND AMOUNT INCLUDED ON WORKSHEET A, COLUMN 5</th>
<th>AMOUNT ALLOWABLE IN COST</th>
<th>NET ADJUSTMENT (COL. 4 MINUS COL. 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LINE NO.</td>
<td>COST CENTER</td>
<td>EXPENSE ITEMS</td>
</tr>
<tr>
<td>1</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>2</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>3</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>4</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>5</td>
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<td>[ ]</td>
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<tr>
<td>6</td>
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<tr>
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<tr>
<td>8</td>
<td>[ ]</td>
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<tr>
<td>9</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>10</td>
<td>TOTALS (Sum of lines 1-9) (Transfer col. 6, lines 1-9 to Wast A, col. 6, lines as appropriate)</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

C. Interrelationship of provider to related organization(s):

The Secretary, by virtue of authority granted under Section 1814(b)(1) of the Health Insurance for the Aged and Disabled Act, requires the provider to furnish the information requested on Part C of this worksheet.

The information will be used by the Social Security Administration and its intermediaries in determining that the costs applicable to services, facilities and supplies furnished by organizations related to the provider by common ownership or control, represent reasonable costs as determined under Section 1861 of the Health Insurance for the Aged and Disabled Act. If the provider does not provide all or any of the requested information, the cost report will be considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

<table>
<thead>
<tr>
<th>SYMBOL (1)</th>
<th>NAME</th>
<th>PERCENT OWNERSHIP OF PROVIDER</th>
<th>RELATED ORGANIZATION(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>2</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
<tr>
<td>3</td>
<td>[ ]</td>
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<td>4</td>
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<td>5</td>
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<td>10</td>
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</tr>
<tr>
<td>11</td>
<td>[ ]</td>
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</tr>
<tr>
<td>12</td>
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</table>

(1) Use the following symbols to indicate the interrelationship of the provider to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial or non-financial) interest.
**DEPRECIATION**

**PART I - QUESTIONNAIRE**

1. Depreciation reported in cost statement:
   - A. Straight-Line $__________
   - B. Declining Balance
   - C. Sum-of-the-Years’ Digits
   - D. Optional Allowance
   - E. Depreciation reported on Worksheet A, column 7 (Sum of A, B, C, and D) $__________

2. Is Depreciation Funded? (If Yes: Balance in Fund At End of Period $__________)

3. Were There Any Disposals of Capital Assets During Period?

4. Was Accelerated Depreciation Claimed On Any Assets In The Current Or Any Prior Cost Reporting Period?
   - B. Did Provider Cease To Participate In The Medicare Program At End Of Period To Which This Cost Report Applies? (See Provider Reimbursement Manual, Part I, chapter 1)
   - C. Was There Substantive Decrease In Health Insurance Proceeds Of Allowable Costs From Prior Cost Reporting Periods? (See Provider Reimbursement Manual, Part I, chapter 1)

**PART II - COMPUTATION OF THE OPTIONAL ALLOWANCE FOR DEPRECIATION**

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1965 Operating Cost Related to Patient Care $__________</td>
</tr>
<tr>
<td>2</td>
<td>Less: Actual Depreciation – included on line 1 $__________</td>
</tr>
<tr>
<td>3</td>
<td>Lower of rental charge or estimated straight-line depreciation on rented depreciable type assets (col 1, lines 2 + 3) $__________</td>
</tr>
<tr>
<td>4</td>
<td>Adjusted 1965 Operating Cost (line 1 minus line 3, column 2) $__________</td>
</tr>
<tr>
<td>5</td>
<td>Current Year’s Allowable Cost (SEE INSTRUCTIONS) $__________</td>
</tr>
<tr>
<td>6</td>
<td>Less: Actual Depreciation – included on line 5 $__________</td>
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<tr>
<td>7</td>
<td>Lower of rental charge or estimated straight-line depreciation on rented depreciable type assets (col 1, lines 6 + 7) $__________</td>
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<tr>
<td>8</td>
<td>Adjusted Current Year’s Allowable Cost (line 5 minus line 7, column 2) $__________</td>
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<tr>
<td>9</td>
<td>Lower of lines 4 or 8 above $__________</td>
</tr>
<tr>
<td>10</td>
<td>Percentage Allowance (SEE INSTRUCTIONS) %</td>
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<tr>
<td>11</td>
<td>Gross Allowance (line 9 x line 10) $__________</td>
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<tr>
<td>12</td>
<td>Less: Estimated depreciation on assets rented in 1965 (Some fiscal period for which cost is reported on line 1) $__________</td>
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<tr>
<td>13</td>
<td>Adjusted Allowance (line 11 minus line 12) $__________</td>
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</tbody>
</table>

**COMPUTATION OF THE LIMITATION OF THE OPTIONAL ALLOWANCE**

14. Adjusted Allowance (line 13) $__________
15. Add: Depreciation on owned assets acquired after 1965 (Computed on a straight-line basis) $__________
16. Estimated straight-line depreciation on all depreciable type assets rented in the current year $__________
17. Total (Sum of lines 14, 15, and 16) $__________
18. Less: 6% of adjusted current year’s allowable cost (line 8 above) $__________
19. Deduction in Allowance (Only when line 17 exceeds 18) $__________
20. Net Allowance (line 14 minus line 19) $__________

**PART III - COMPUTATION OF ADJUSTMENT TO DEPRECIATION ON OWNED ASSETS**

1. Net Optional Allowance (line 20) $__________
2. Add: Depreciation on assets acquired after 1965 (computed in accordance with Medicare Principles of Reimbursement) $__________
3. Total Allowable Depreciation on Owned Assets (Optional Allowance Claimed-Sum of lines 1 and 2) (Optional Allowance Not Claimed – SEE INSTRUCTIONS) $__________
4. Less: Depreciation recorded on the provider’s books (From Worksheet A, column 8) (SEE INSTRUCTIONS) $__________
5. Adjustment to Depreciation on Owned Assets (line 3 minus line 4) (Transfer to Worksheet A-E, lines 61 and 62, as appropriate) $__________

(1) If Part II is completed, providers should complete lines 1 through 5. If Part II is not completed, providers will only complete lines 3 through 5.
### COST ALLOCATION - GENERAL SERVICE COSTS

<table>
<thead>
<tr>
<th>COST CENTER (OMIT CENTS)</th>
<th>NET EXPENSES FOR COST ALLOCATION (FROM WSKT A, COLUMN 7)</th>
<th>DEPRECIATION BUILDINGS &amp; FIXTURES (FROM WSKT A, COLUMN 7)</th>
<th>DEPRECIATION MOVABLE EQUIPMENT (FROM WSKT A, COLUMN 7)</th>
<th>EMPLOYEE HEALTH &amp; WELFARE (FROM WSKT A, COLUMN 7)</th>
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<tbody>
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<td>1 GENERAL SERVICE COST CENTERS</td>
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<td>58 OTHER REIMBURSABLE COST CENTERS</td>
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<td>61 Inpatient Resident Service (not in approved teaching program)</td>
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<td>62 SUBTOTALS (Sum of lines 2-61)</td>
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<td>63 NONREIMBURSABLE COST CENTERS</td>
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<td>65 Research</td>
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<td>66 Physicians' Private Offices</td>
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<td>67 Nongpaid Workers</td>
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<td>69 TOTAL EXPENSES (Sum of lines 62-68)</td>
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**Form SSA 2552 (8/08)**

5/1/80
### COST ALLOCATION - GENERAL SERVICE COSTS

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<th>COST CENTER (UNIT CENT)</th>
<th>CAFETERIA</th>
<th>MAINTENANCE OF PERSONNEL</th>
<th>NURSING ADMINISTRATION</th>
<th>CENTRAL SERVICES &amp; SUPPLY</th>
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<td>3 Depreciation - Moveable Equipment</td>
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<td>19 Interns Resident Service (in approved teaching program)</td>
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**Form SSA-2552 (5-79)**
# COST ALLOCATION - STATISTICAL BASIS

## PROVIDER NO.: HOSPITAL

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*Form SSA-2552-B-11*

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
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Note: This plan is provided for informational use only and does not replace the original version.
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(1) Cost centers from Worksheet A, columns 21, lines 23-61, lines 43 and 44, lines 55-57, and line 91. (See special instructions for line 21)

Columns 2-10 (Total cost distributed)

b - Column 1 (Cost charged all patients in provider component from provider records)
Column 3-10 (Cost charged all patients in indicated provider component from provider records)
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</tr>
<tr>
<td>18 Electromyography</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Medical Supplies Charged to Patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Drugs Charged to Patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Blood Analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Outpatient Service Cost Centers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 Clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 Emergency</td>
<td></td>
<td></td>
<td></td>
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<td>26</td>
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<td></td>
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<td>27</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 TOTAL</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(1) Transfer the amounts in column 6 and column 9, line 20, to Worksheet E-5, Part I, column as appropriate, line 1.

(2) Transfer the amounts in column 7 and column 8, line 20, to Worksheet E, Part I, column as appropriate, line 1.
## General Inpatient Care Units (Excluding Nursery) Cost

### Inpatient Days

1. Total aged, pediatric and maternity inpatient days (From page 2, Part II, line 4 or page 3, Part IV, line 4, as applicable)
2. Total other than aged, pediatric and maternity inpatient days (excluding newborn) (From page 2, Part II, line 5 or page 3, Part IV, line 5, as applicable)
3. Total inpatient days - all patients (excluding newborn) (Sum of lines 1 and 2; must agree with page 2, Part II, line 6 or page 3, Part IV, line 6, as applicable)
4. Aged, pediatric and maternity inpatient days plus 85% (line 1 x 1.085)
5. Total adjusted inpatient days (Sum of lines 2 and 4)
6. Aged, pediatric and maternity inpatient days applicable to title XVIII, Part A (Medicare) (From page 2, Part II, line 10c or page 3, Part IV, line 10c, as applicable)
7. Other than aged, pediatric and maternity inpatient days-applicable to title XVIII, Part A (Medicare) (From page 2, Part II, line 10f or page 3, Part IV, line 10f, as applicable)
8. Total inpatient days applicable to title XVIII, Part A (Medicare) (Sum of lines 6 and 7; must agree with page 2, Part II, line 10i or page 3, Part IV, line 10i, as applicable)

### Inpatient Routine Costs

9. Total inpatient routine nursing salary cost (excluding nursery)
10. Total inpatient routine service cost (excluding inpatient routine nursing salary cost on line 9)
11. Total inpatient routine service cost (Sum of lines 9 and 10)
12. Inpatient routine nursing salary cost plus 85% (line 9 x 1.085)

### Medicare General Inpatient Care Per Diem Costs

13. Adjusted average per diem inpatient routine nursing salary cost applicable to aged, pediatric and maternity patients including the inpatient routine nursing salary cost differential adjustment factor (line 12 + line 5)
14. Average per diem inpatient routine service cost (excluding inpatient routine nursing salary cost) (line 10 + line 3)
15. Adjusted average per diem inpatient routine service cost applicable to aged, pediatric and maternity patients including the inpatient routine nursing salary cost differential adjustment factor (Sum of lines 13 and 14)
16. Total inpatient routine service cost (line 11)
17. Inpatient routine service cost applicable to all aged, pediatric and maternity patients (line 1 x line 15)
18. Inpatient routine service cost applicable to all patients, other than aged, pediatric and maternity (line 16 minus line 17)
19. Average per diem inpatient routine service cost applicable to all patients - other than aged, pediatric and maternity (line 18 + line 2)

### Medicare General Inpatient Routine Service Cost

20. Medicare general inpatient routine service cost applicable to aged, pediatric and maternity patients (line 6 x line 15)
21. Medicare general inpatient routine service cost applicable to all patients - other than aged, pediatric and maternity (line 2 x line 19)
22. Total Medicare general inpatient routine service cost before reasonable cost limitation (Sum of lines 20 and 21)
23. Aggregate charges to beneficiaries for excess costs (From provider records) (SEE INSTRUCTIONS)
24. TOTAL (line 23 minus line 22)
25. General inpatient routine service cost limitation (line 8 x $ per diem limitation)
26. Aggregate charges for excess costs applicable to kidney acquisition days (From page 2, Part II, line 10h or page 3, Part IV, line 10h x $ per diem charge)
27. TOTAL (Sum of lines 25 and 26)
28. Reimbursable general inpatient routine service cost (lesser of line 24 or line 27)

### Special Care Units (Excluding Nursery)

<table>
<thead>
<tr>
<th>Special Care Unit</th>
<th>Total Inpatient Days</th>
<th>Average Per Diem Cost (Col 1 x 2)</th>
<th>Medicare Days</th>
<th>Cost Applicable to Medicare (Col 3 x 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive Care Unit</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Total Medicare Inpatient Routine and Special Care Service Cost (Sum of lines 20-28, col 5) (Transfer to Wks 1 E, Part I, line 3)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

**Form SSA-2552 (Rev 9/91)**

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
**Worksheet D-1**

**COMPUTATION OF INPATIENT ROUTINE SERVICE COST**

**PART II - TITLES V AND XIX**

**GENERAL PATIENT CARE UNITS (EXCLUDING NURSERY) PER DIEM COST**

| 34 | Total inpatient routine service costs (From line 11) | $ |
| 35 | Total general inpatient routine service cost applicable to Medicare including nursing salary cost differential adjustment factor (line 22) | $ |
| 36 | Inpatient routine service cost applicable to outpatient renal dialysis services (From Supplemental Wkst D-7, Part 1, col 2, lines 1 & 2, or 7 & 8, or 9 & 10) | $ |
| 37 | Allowable general inpatient routine service cost subject to apportionment under titles V and XIX (line 34 minus sum of lines 35 and 36) | $ |
| 38 | Total inpatient days - all patients (line 3) | $ |
| 39 | Inpatient days applicable to title XVIII, Part A (Medicare) (line 8) | $ |
| 40 | Inpatient days applicable to outpatient renal dialysis services (From Supplemental Wkst D-7, Part 1, col 2, lines 1 & 2, or 7 & 8, or 9 & 10) | $ |
| 41 | Net inpatient days (line 38 minus sum of lines 39 and 40) | $ |
| 42 | Average per diem cost (line 37 + line 41) | $ |

**NURSERY PER DIEM COST**

| 43 | Total inpatient cost of nursery (From Wkst B, col 21, line 51) | $ |
| 44 | Total newborn days - nursery (From page 2, Part II, line 8 or page 3, Part IV, col 1 or 2, as applicable, line 8) | $ |
| 45 | Average per diem cost - nursery (line 43 + line 44) | $ |

**INPATIENT ROUTINE SERVICE COST**

| 46 | Inpatient days applicable to title V and title XIX (From page 2, Part II, lines 9a and 11a, or page 3, Part IV, lines 9a and 11a) | $ |
| 47 | General inpatient routine service cost before reasonable cost limitation (line 42 x line 46) | $ |
| 48 | Aggregate charges to beneficiaries for excess costs (From provider records) (SEE INSTRUCTIONS) | $ |
| 49 | TOTAL (line 47 minus line 48) | $ |
| 50 | General inpatient routine service cost limitation (line 46 x $ per diem limitation) | $ |
| 51 | Reimbursable general inpatient routine service cost (lesser of line 49 or line 50) | $ |

**NURSERY AND SPECIAL CARE UNITS**

<table>
<thead>
<tr>
<th>COST CENTERS</th>
<th>DAYS</th>
<th>AVERAGE PER DIEM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NURSERY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SPECIAL CARE UNITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intensive Care Unit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coronary Care Unit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL INPATIENT GENERAL ROUTINE, NURSERY AND SPECIAL CARE COSTS</strong> (Sum of lines 51 [col 1 or col 2, as applicable] and 52-56 [col 4 or col 5, as applicable]) (Transfer to Wkst E-5, Part 1, line 2)</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

---

**Form SSA-2552 (10-75)**

5/1/80
### APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

#### PROVIDER NO.:
**HOSPITAL**

#### PART I - NOT IN APPROVED TEACHING PROGRAM

<table>
<thead>
<tr>
<th>COST CENTER</th>
<th>PERCENT OF ASSIGNED TIME</th>
<th>EXPENSE ALLOCATION</th>
<th>TOTAL INPATIENT DAYS - ALL PATIENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>100%</td>
<td>$ 1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Hospital Inpatient Routine Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Adult &amp; Pediatrics (General Routine Care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Intensive Care Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Coronary Care Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Nursery</td>
<td></td>
<td>$ 16</td>
</tr>
<tr>
<td>9</td>
<td>SUBTOTAL (Sum of lines 3-8)</td>
<td>$ 1</td>
<td>$ 16</td>
</tr>
<tr>
<td>10</td>
<td>Subprovider I - Inpatient Routine Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Subprovider II - Inpatient Routine Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Skilled Nursing Facility - Certified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Skilled Nursing Facility - Uncertified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Home Health Agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>SUBTOTAL (Sum of lines 9-14)</td>
<td>$ 1</td>
<td>$ 15</td>
</tr>
<tr>
<td>16</td>
<td>Hospital Outpatient Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Clinic</td>
<td></td>
<td>$ 17</td>
</tr>
<tr>
<td>18</td>
<td>Emergency</td>
<td></td>
<td>$ 19</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td>$ 19</td>
</tr>
<tr>
<td>20</td>
<td>SUBTOTAL (Sum of lines 17-19)</td>
<td>$ 1</td>
<td>$ 20</td>
</tr>
<tr>
<td>21</td>
<td>TOTAL (Sum of lines 15 and 20)</td>
<td>100%</td>
<td>$ 20</td>
</tr>
</tbody>
</table>

#### PART II - IN AN APPROVED TEACHING PROGRAM (PART B INPATIENT ROUTINE COSTS ONLY)

<table>
<thead>
<tr>
<th>COST CENTERS</th>
<th>EXPENSES ALLOCATED TO COST CENTERS ON WEST B, COL 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hospital Inpatient Routine Services</td>
</tr>
<tr>
<td>2</td>
<td>Adult &amp; Pediatrics (General Routine Care)</td>
</tr>
<tr>
<td>3</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>4</td>
<td>Coronary Care Unit</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>SUBTOTAL (Sum of lines 2-6)</td>
</tr>
<tr>
<td>8</td>
<td>Subprovider I - Inpatient Routine Service</td>
</tr>
<tr>
<td>9</td>
<td>Subprovider II - Inpatient Routine Service</td>
</tr>
<tr>
<td>10</td>
<td>Skilled Nursing Facility - Certified</td>
</tr>
<tr>
<td>11</td>
<td>TOTAL (Sum of lines 7-10)</td>
</tr>
</tbody>
</table>

#### PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)

<table>
<thead>
<tr>
<th>COST CENTERS</th>
<th>REFERENCE (FROM) PART I, COL 9 LINE</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hospital</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Inpatient</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Outpatient</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>TOTAL Hospital (Sum of lines 2 and 3)</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Subprovider I</td>
<td>10</td>
</tr>
<tr>
<td>6</td>
<td>Subprovider II</td>
<td>11</td>
</tr>
<tr>
<td>7</td>
<td>Skilled Nursing Facility - Certified</td>
<td>12</td>
</tr>
<tr>
<td>8</td>
<td>TOTALS (Sum of lines 4-7)</td>
<td>$ 21</td>
</tr>
</tbody>
</table>

**FORM SSA-2552 (B-73)**

**5/1/80**
<table>
<thead>
<tr>
<th>MEDICAL SPECIALTY DEPARTMENT</th>
<th>TOTAL CHARGES - ALL PATIENTS (1)</th>
<th>RATIO OF REMUNERATION TO CHARGES (COL. 1 X 2)</th>
<th>HEALTH CARE PROGRAM CHARGES</th>
<th>PROFESSIONAL SERVICE REMUNERATION APPLICABLE TO HEALTH CARE PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Radiology - Diagnostic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Radiology - Therapeutic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Radialhotograph</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Pathology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Anesthesiology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Electrocardiology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Electroencephalography</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
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<tr>
<td>9.</td>
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<tr>
<td>10.</td>
<td></td>
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</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. TOTAL (Sum of lines 1-11)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(1) If the medical specialty department services the hospital and each subprovider, do not complete columns 1 and 2 on the subprovider worksheets. Enter in column 3 the same ratios developed on the hospital worksheet. Gross charges for professional and provider components are used on Worksheet C; gross charges must be used in column 2 and in columns 4 through 6. Gross charges for professional component only must be used in column 4 and in columns 6 through 6.

(2) Transfer the amounts on line 12, column(s):
- 4a
- 5 and 5d
- 5b
- 5c
- 5s

TO:
- Supplemental Worksheet D-6, Part II, line 2 (Professional Component Charges Only)
- The respective title V and title XIX Worksheet E-5, Part I, line 9
- Worksheet E, Part I, column as appropriate, line 22
- Worksheet E, Part I, column 2, line 17
- Supplemental Worksheet D-6, Part I, line 4
## CALCULATION OF REIMBURSEMENT SETTLEMENT - TITLE XVIII
### PART A AND PART B SERVICES

<table>
<thead>
<tr>
<th>Description</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inpatient ancillary services (From Work D, col 7 &amp; 8, line 20)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>2. Outpatient services (From Work D, col 7, line 20)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>3. Inpatient routine services (From Work D, Part 1, Part 3, line 20)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>4. Interm and resident services (From Work D, Part 1, Part 3, col 9, Part 2, col 9, Part 1, col 9, or Part III, col 4, as appropriate)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>5. Utilization review-physicians' compensation (From provider records)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>6. Hospital-based pathologists remuneration - SHF inpatients (From Supplemental Work D-4, line 3)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>7. Ambulance services (From Supplemental Work D-5, col 3, line 5)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>8. Kidney acquisition costs-supplementary to inpatient routine and inpatient ancillary service costs (From Supplemental Work D-4, Part 1, line 6)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
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</tr>
<tr>
<td>10.</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>11.SUBTOTAL (Sum of lines 1-10)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>12. Differential in charges between semiprivate accommodations and less than semiprivate accommodations</td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
</tr>
<tr>
<td>13. Total kidney acquisition charges billed to Medicare under Part B (From provider records)</td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
</tr>
<tr>
<td>14. SUBTOTAL (Part A - line 11 minus sum of lines 12 and 13)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>15. Amounts paid and payable by Medicare's Compensation</td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
</tr>
<tr>
<td>16. Total revenue received for kidneys furnished to other providers, kidney procurement organizations, and others and for kidneys transplanted in non-Medicare patients (From provider records)</td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
</tr>
<tr>
<td>17. Outpatient professional services rendered by hospital-based physicians - Combined Billing (From Work D-3, col 5e, line 12)</td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
</tr>
<tr>
<td>18. SUBTOTAL (Part A - line 14 minus sum of lines 15 and 16)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>19. Part B deductibles billed to Medicare patients (exclude coinsurance units)</td>
<td>(</td>
<td></td>
<td>(</td>
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<td>(</td>
<td></td>
<td>(</td>
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</tr>
<tr>
<td>20. Net Cost - Part B (line 18 minus line 19)</td>
<td>$</td>
<td></td>
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<td>$</td>
<td></td>
<td>$</td>
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</tr>
<tr>
<td>21. 80% of Net Cost (line 20) - reimbursable expenses</td>
<td>(</td>
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<td>(</td>
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<td>(</td>
<td></td>
<td>(</td>
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<td></td>
</tr>
<tr>
<td>22. Inpatient professional services rendered by hospital-based pathologists and pathologists - Combined Billing (From Work D-3, col 5e, line 12)</td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
</tr>
<tr>
<td>23. Part A deductibles and coinsurance billed to Medicare patients</td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
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</tr>
<tr>
<td>24. Bad debts for deductibles and coinsurance, net of bad debt recoveries</td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
<td>(</td>
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</tr>
<tr>
<td>25. Net deductibles and coinsurance billed to Medicare patients (line 23 minus line 24)</td>
<td>(</td>
<td></td>
<td>(</td>
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<td>(</td>
<td></td>
<td>(</td>
<td></td>
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</tr>
<tr>
<td>26. Net Cost of Medicare covered services, excluding return on equity capital and adjustments for Part B costs (Part A - line 18 minus line 25) (Part B - sum of lines 21 and 22)</td>
<td>(</td>
<td></td>
<td>(</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

**FORM SSA-2552 10-73**

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
## PART II - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>PROVIDER NO.</th>
<th>PERIOD:</th>
<th>WORKSHEET E</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART A AND PART B SERVICES</td>
<td>HOSPITAL</td>
<td>FROM</td>
<td>TO</td>
</tr>
</tbody>
</table>

| DATE |  |  |  |
|------|  |  |  |

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasonable cost of title XVIII - Part A and Part B services</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cost of services (From Part I, line 18)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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<td>$</td>
</tr>
<tr>
<td>Allowable return on equity capital (From Supplemental Vol F, Part III, col 3, line 5)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Renal dialysis cost in excess of limitation (From Supplemental Vol E-3, sum of cols. 1-3, line 11)</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL reasonable cost of title XVIII - Part A and Part B services (Sum of lines 2 and 3 minus line 4)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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<td>$</td>
</tr>
<tr>
<td>Ratio of Part A and Part B cost to total cost for each provider component</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Charges for title XVIII - Part A and Part B services</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
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</tr>
<tr>
<td>Inpatient ancillary services (SEE INSTRUCTIONS)</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
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<td>6</td>
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<tr>
<td>Outpatient services (SEE INSTRUCTIONS)</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Inpatient routine services (From provider records)</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Expenditures related to inpatient and outpatient services (From provider records)</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Hospital-based pathologists professional charges - SNF Inpatients (From Supplemental Vol D-4, line 4, EXCL. PROVIDER COMPONENT IF COMBINED CHG)</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Ambulance services (From Supplemental Vol D-4, line 4, EXCL. PROVIDER COMPONENT IF COMBINED CHG)</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
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<td>11</td>
</tr>
<tr>
<td>Kidney acquisition charges - supplementary to inpatient and outpatient ancillary services charges (From Supplemental Vol E-5, Part II, line 1)</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>TOTAL charges for title XVIII - Part A and Part B services (Sum of lines 8-17)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Customary charges</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Aggregate amount actually collected from patients liable for payment for services on a charge basis (From provider records)</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
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</tr>
<tr>
<td>Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with Health Insurance Regulaton section 405.550(a) (From provider records)</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
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<td>15</td>
</tr>
<tr>
<td>Ratio of line 16 to line 17 (cost to exceed 1,0000)</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
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<td>16</td>
</tr>
<tr>
<td>TOTAL customary charges (line 16 x line 20)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>Excess of customary charges over reasonable cost (line 21 minus the sum of Part A and Part B costs on line 5) (Transfer to Supplemental Vol E-5, Part I, line 5, or E-5.1, Part I, line 5, if appropriate)</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Excess of reasonable cost over customary charges (Sum of Part A and Part B costs on line 2 minus line 21) (Transfer to Supplemental Vol E-5, Part II, line 5, or E-5.1, Part II, line 5, if appropriate)</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Excess reasonable cost applicable to Part A and Part B (line 6 each column x line 23)</td>
<td>$</td>
<td>$</td>
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</tr>
</tbody>
</table>

**FORM SSA-2552 (5-75)**
### PART III - COMPUTATION OF REIMBURSEMENT SETTLEMENT

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
<th>PART A</th>
<th>PART B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Net cost of Medicare covered services, excluding return on equity capital and adjustments for Part B costs (From Part I, line 26)</td>
<td>$</td>
<td>$</td>
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<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>3. Renal dialysis cost in excess of limitation (From Supplemental Wkst E-3, sum of cols 1-3, line 12)</td>
<td>$</td>
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</tr>
<tr>
<td>4. SUBTOTAL (Sum of lines 1 and 2 minus line 3)</td>
<td>$</td>
<td>$</td>
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<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>5. Excess reasonable cost (Part A - from Part I, line 24) (Part B - from Part II, line 24 x .80)</td>
<td>$</td>
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</tr>
<tr>
<td>6. SUBTOTAL (line 4 minus line 5)</td>
<td>$</td>
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</tr>
<tr>
<td>7. Reimbursable bad debts (From Wkst E-2, line 12)</td>
<td>$</td>
<td>$</td>
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<td>$</td>
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</tr>
<tr>
<td>8. Amount exceeding total Part B costs collected from Medicare including deductibles and coinsurance (Not to exceed Part I, line 24) (From Wkst E-2, line 9)</td>
<td>$</td>
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</tr>
<tr>
<td>9. TOTAL COST - current cost reporting period (Sum of lines 5 and 7 minus line 9)</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>10. Recovery of unreimbursed cost under cost limits (From Supplemental Wkst E-4-1, Part II, line 5)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>11. Recovery of unreimbursed cost under lower of cost or charges (From Supplemental Wkst E-4, Part III, cols 2b and 3b, line 4, or Supplemental Wkst E-4-1, Part IV, cols 2b and 3b, line 5, as appropriate)</td>
<td>$</td>
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<td>$</td>
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</tr>
<tr>
<td>12. 80% of recovery of unreimbursed cost under lower of cost or charges (line 11) - Part B</td>
<td>$</td>
<td>$</td>
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<td>$</td>
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<td>$</td>
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<td>$</td>
</tr>
<tr>
<td>13. Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets</td>
<td>$</td>
<td>$</td>
<td>$</td>
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<td>$</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>14. Recovery of excess depreciation resulting from provider termination or a decrease in Medicare utilization</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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<td>$</td>
</tr>
<tr>
<td>15. Unrefunded charges to beneficiaries for excess costs erroneously collected, based on correction of cost limit</td>
<td>$</td>
<td>$</td>
<td>$</td>
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<td>$</td>
<td>$</td>
<td>$</td>
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<td>$</td>
</tr>
<tr>
<td>16. TOTAL COST - reimbursable to provider (Part A - sum of lines 9-11 plus/minus line 13 minus sum of lines 14 and 15) (Part B - sum of lines 9 and 12 plus/minus line 13 minus line 14)</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>17. Total interim payments (From Wkst E-1, line 4)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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</tr>
<tr>
<td>18. Balance due provider/Medicare program (line 16 minus line 17)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
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</tr>
</tbody>
</table>
### ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED TO TITLE XVIII (MEDICARE) BENEFICIARIES

#### CHECK ONE:
- [ ] HOSPITAL
- [ ] SUBPROVIDER I
- [ ] SUBPROVIDER II
- [ ] SKILLED NURSING FACILITY

#### WORKSHEET E-1

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CATEGORY 1 INPATIENT</th>
<th>CATEGORY 2 INPATIENT</th>
<th>CATEGORY 3 OUTPATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MO. DAY. YR</td>
<td>AMOUNT</td>
<td>MO. DAY. YR</td>
</tr>
<tr>
<td>1 Total interim payments paid to provider</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write &quot;NONE.&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write &quot;NONE.&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### TO BE COMPLETED BY INTERMEDIARY

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>CATEGORY 1 INPATIENT</th>
<th>CATEGORY 2 INPATIENT</th>
<th>CATEGORY 3 OUTPATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MO. DAY. YR</td>
<td>AMOUNT</td>
<td>MO. DAY. YR</td>
</tr>
<tr>
<td>5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write &quot;NONE.&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### TOTAL MEDICARE PROGRAM LIABILITY (Reimbursable cost, net of deductibles and coinsurance) (line 4 plus/minus lines 5g and 6) (Should equal amounts entered on Wkst E, Part III, column as appropriate, line 16)

#### NAME OF INTERMEDIARY

<table>
<thead>
<tr>
<th>INTERMEDIARY NUMBER</th>
<th>SIGNATURE OF AUTHORIZED PERSON</th>
<th>DATE (MO. DAY. YR)</th>
</tr>
</thead>
</table>

(1) On lines 3, 5, and 6, where an amount is due "Provider to Program", show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

---

**Form Approved OMB No. 72-R1010**

**October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.**
## CALCULATION OF REIMBURSABLE BAD DEBTS

**TITLE XVIII - PART B**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>HOSPITAL</th>
<th>SUBPROVIDER I</th>
<th>SUBPROVIDER II</th>
<th>SKILLED NURSING FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Total cost applicable to Medicare (Col 1 - From Wkst E, Part I, col 2, line 18 minus Part II, col 2, line 4; cols 2, 3, and 4 - From Wkst E, Part I, cols 4, 6, 8, as appropriate, line 18)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>2</strong> Allowable return on equity capital (Col 1 - Amount $ entered in cal 1, line 1 x ratio from Wkst F, Part III, line 3) (Cols 2-4 - From Wkst E, Part II, cols 4, 6, 8, as appropriate, line 3)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>3</strong> SUBTOTAL (Sum of lines 1 and 2)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>4</strong> Reimbursable expenses (Col 1 - From Wkst E, sum of Part I, col 2, line 21 and Part III, col 2, line 2 minus line 3; cols 2, 3, and 4 - From Wkst E, sum of Part I, cols 4, 6, 8, as appropriate, line 21, and Part III, cols 4, 6, 8, as appropriate, line 2)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>5</strong> Balance to be recovered from Medicare (Part B) patients (line 3 minus line 4)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>6</strong> Deductibles and coinsurance billed to Medicare (Part B) patients</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>7</strong> Bad debts for deductibles and coinsurance, net of bad debt recoveries</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>8</strong> Net deductibles and coinsurance billed to Medicare (Part B) patients (line 6 minus line 7)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>9</strong> Unrecovered from Medicare (Part B) patients (line 5 minus line 6) (If line 8 exceeds line 5, transfer excess to Wkst E, Part III, cols 1, 3, 5, 7, as appropriate, line 8 and do not complete the balance of this worksheet)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>10</strong> Gross bad debts (lesser of line 7 or line 9)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>11</strong> Bad debts applicable to professional component and unallowable under title XVIII (line 10 x ratio on line 15)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>12</strong> Reimbursable bad debts (line 10 minus line 11) (Transfer to Wkst E, Part III, cols 2, 4, 6, 8, as appropriate, line 7)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

## CALCULATION OF PERCENTAGE OF BAD DEBTS FOR OUTPATIENT SERVICES APPLICABLE TO PROFESSIONAL COMPONENT OF HOSPITAL-BASED PHYSICIANS - COMBINED BILLING

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>HOSPITAL</th>
<th>SUBPROVIDER I</th>
<th>SUBPROVIDER II</th>
<th>SKILLED NURSING FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>13</strong> Professional component charges of hospital-based physicians included in deductibles and coinsurance on line 6</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>14</strong> Deductibles and coinsurance (professional component and provider component) billed to Medicare (Part B) patients (From line 6)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>15</strong> Ratio of line 13 + line 14 (Multiply ratio times line 10 and enter results on line 11)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
# PART I - COMPUTATION OF NET COST OF COVERED SERVICES

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>HOSPITAL</th>
<th>SUBPROVIDER I</th>
<th>SUBPROVIDER II</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Inpatient ancillary services (From Wkst D, col 6 or 9, line 28)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2 Inpatient routine services (From Wkst D-1, Part II, line 57)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3 Intern and resident services (From Wkst D-2, Part I, col 8 or 10, lines 9, 10, and 11)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4 Ambulance Services (From Supplemental Wkst D-5, col 2, line 4 or 6)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>6 SUBTOTAL (Sum of lines 1-5)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>7 Differential in charges between semiprivate accommodations and less than semiprivate accommodations</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>8 SUBTOTAL (line 6 minus line 7)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>9 Inpatient professional services rendered by hospital-based physicians - Combined Billing (From Wkst D-3, col 50 or 51, line 12)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>10 Amounts paid and payable by Workmen’s Compensation</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>11 SUBTOTAL (Sum of lines 8 and 9 minus line 10)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>12 Deductibles and coinsurance billed to health care program inpatients</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>13 Bad debts for deductibles and coinsurance, net of bad debt recoveries.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>14 Net deductibles and coinsurance billed to health care program inpatients (line 12 minus line 13)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>15 Net cost of covered services to health care program inpatients, excluding return on equity capital (line 11 minus line 14)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

# PART II - COMPUTATION OF LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>HOSPITAL</th>
<th>SUBPROVIDER I</th>
<th>SUBPROVIDER II</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Reasonable cost of inpatient services</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2 Cost of services (From Part I, line 8)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3 Allowable return on equity capital (From Supplemental Wkst F, Part III, line 4 or line 6)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4 TOTAL reasonable cost of inpatient services (Sum of lines 2 and 3)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5 Charges for inpatient services</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>6 Inpatient ancillary services (SEE INSTRUCTIONS)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>7 Inpatient routine services (From provider records)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>8 Ambulance services (From Supplemental Wkst D-5, col 1, line 4 or 6)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>9</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>10 TOTAL charges for inpatient services (Sum of lines 6-9)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>11 Customary charges</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>12 Aggregate amount actually collected from patients liable for payment for services on a charge basis (From provider records)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>13 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with Health Insurance Regulation Section 405.455(b) (From provider records)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>14 Ratio of line 12 to line 13 (Not to exceed 1.000%)</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>15 TOTAL customary charges (line 10 x line 14)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>16 Excess of customary charges over reasonable cost (line 15 minus line 4) (Transfer to Supplemental Wksts E-4, Part I, line 1, or E-4-1, Part I, line 2, as appropriate)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>17 Excess of reasonable cost over customary charges (line 4 minus line 15) (Transfer to Supplemental Wksts E-4, Part II, line 3, or E-4-1, Part III, line 3, as appropriate)</td>
<td>$</td>
<td>$</td>
<td>$</td>
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</tbody>
</table>
### CALCULATION OF REIMBURSEMENT SETTLEMENT

#### PART III - COMPUTATION OF REIMBURSEMENT SETTLEMENT

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>HOSPITAL</th>
<th>SUBPROVIDER 1</th>
<th>SUBPROVIDER 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Net cost of covered services to health care program inpatients, excluding return on equity capital (From Part I, line 15)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2  Reimbursable return on equity capital (From Part II, line 3)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3  SUBTOTAL (Sum of lines 1 and 2)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4  Excess reasonable cost (From Part II, line 17)</td>
<td>(</td>
<td>(</td>
<td>(</td>
</tr>
<tr>
<td>5  Recovery of unreimbursed costs under cost limits (From Supplemental Wkst E-4-1, Part II, line 5)</td>
<td>(</td>
<td>(</td>
<td>(</td>
</tr>
<tr>
<td>6  Recovery of unreimbursed costs under lower of cost or charges (From Supplemental Wkst E-4, Part II, col 5, line 2, or Supplemental Wkst E-4-1, Part III, col 6, line 2)</td>
<td>(</td>
<td>(</td>
<td>(</td>
</tr>
<tr>
<td>7  Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets</td>
<td>(</td>
<td>(</td>
<td>(</td>
</tr>
<tr>
<td>8  Recovery of excess depreciation resulting from provider termination or a decrease in Medicare utilization</td>
<td>(</td>
<td>(</td>
<td>(</td>
</tr>
<tr>
<td>9  Unrefunded charges to beneficiaries for excess costs erroneously collected, based on correction of cost limit</td>
<td>(</td>
<td>(</td>
<td>(</td>
</tr>
<tr>
<td>10 TOTAL COST - reimbursable to provider (Sum of lines 3, 5, and 6 minus sum of lines 4, 8, and 9 plus or minus line 7)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>11 Amount received and receivable from intermediary or State agency for current fiscal year on accrual basis (Exclude accelerated payments; include lump sum interim payments)</td>
<td>(</td>
<td>(</td>
<td>(</td>
</tr>
<tr>
<td>12 Balance due provider/health care program (line 10 minus line 11) (Indicate over-payment in brackets)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>ASSETS</td>
<td>GENERAL FUND</td>
<td>PLANT FUND</td>
<td>EQUIPMENT FUND</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Cash on Hand &amp; in Bank</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Investments</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Less: Allowance for Uncollectible Accounts</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Land</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Less: Accumulated Amortization</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Buildings</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Less: Accumulated Amortization</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Fixtures &amp; Furniture</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Less: Accumulated Amortization</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Vehicles &amp; Equipment</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Less: Accumulated Amortization</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Other Equipment</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Less: Accumulated Amortization</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Land &amp; Fixtures &amp; Furniture</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Less: Accumulated Amortization</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total Assets</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total Liabilities</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Long-Term Liabilities</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total Long-Term Liabilities</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Capital Account</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>General Fund Balance</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Plant Fund Balance</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Equipment Fund Balance</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total Liabilities and Fund Balance</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total Other Assets</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total Assets &amp; Liabilities</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>STATEMENT OF CHANGES IN FUND BALANCES</td>
<td>PROVIDER NO.</td>
<td>HOSPITAL</td>
<td>PERIOD:</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------</td>
<td>----------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>GENERAL FUND</td>
<td>SPECIFIC PURPOSE FUND</td>
<td>ENDOWMENT FUND</td>
</tr>
<tr>
<td>1 Fund balance at beginning of period</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2 Net income (loss) (From Worksheet G.3, line 32)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3 Total (Sum of line 1 and line 2)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4 Additions (Credit adjustments) (Specify)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Total Additions (Sum of lines 4-9)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>11 Subtotal (line 3 plus line 10)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>12 Deductions (Debit adjustments) (Specify)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Total Deductions (Sum of lines 12-17)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>19 Fund balance at end of period per balance sheet (line 11 minus line 18)</td>
<td>$</td>
<td>$</td>
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</tbody>
</table>
## PART I - PATIENT REVENUES

<table>
<thead>
<tr>
<th>REVENUE CENTER</th>
<th>INPATIENT</th>
<th>OUTPATIENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. GENERAL INPATIENT ROUTINE CARE SERVICE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Hospital</td>
<td>$</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>3. Subprovider I</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Subprovider II</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Skilled Nursing Facility - Certified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Skilled Nursing Facility - Noncertified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. TOTAL General Inpatient Routine Care Service (Sum of lines 2-6)</td>
<td>$</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>8. SPECIAL INPATIENT CARE SERVICE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Intensive Care Unit</td>
<td>$</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>10. Convalescent Care Unit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. TOTAL Special Care Service (Sum of lines 9-11)</td>
<td>$</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>13. TOTAL Inpatient Routine Care Service (Sum of lines 7 &amp; 12)</td>
<td>$</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>14. Ancillary Service</td>
<td>$</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>15. Outpatient Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Home Health Agency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Ambulance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. TOTAL Patient Revenues (Sum of lines 14-20)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

(Transfer col 3 to Worksheet G-3, line 1)

## PART II - OPERATING EXPENSES

<table>
<thead>
<tr>
<th>EXPENSES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Operating Expenses (Per Worksheet A, col 3, line 72)</td>
<td>$</td>
</tr>
<tr>
<td>2. Add (Specify)</td>
<td>$</td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
</tr>
<tr>
<td>8. TOTAL Additions (Sum of lines 2-7)</td>
<td></td>
</tr>
<tr>
<td>9. Deduct (Specify)</td>
<td>$</td>
</tr>
<tr>
<td>10.</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
</tr>
<tr>
<td>14. TOTAL Deductions (Sum of lines 9-13)</td>
<td></td>
</tr>
<tr>
<td>15. TOTAL Operating Expenses (Sum of lines 1 and 8 minus line 14)</td>
<td></td>
</tr>
<tr>
<td>(Transfer to Worksheet G-3, line 4)</td>
<td></td>
</tr>
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</table>

(Transfer to Worksheet G-3, line 4)
### STATEMENT OF REVENUE AND EXPENSES

<table>
<thead>
<tr>
<th>PROVIDER NO.:</th>
<th>PERIOD:</th>
<th>WORKSHEET G-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOSPITAL</td>
<td>FROM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total patient revenues (From Wkst G-2, Part I, col 3, line 21)</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>Less - Allowances and discounts on patients' accounts</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Net patient revenues (line 1 minus line 2)</td>
<td>$</td>
</tr>
<tr>
<td>4</td>
<td>Less - Total operating expenses (From Wkst G-2, Part II, line 15)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Net income from service to patients (line 3 minus line 4)</td>
<td>$</td>
</tr>
<tr>
<td>6</td>
<td>Other income:</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Contributions, donations, bequests, etc.</td>
<td>$</td>
</tr>
<tr>
<td>8</td>
<td>Income from investments</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Revenue from telephone and telegraph service</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Revenue from television and radio service</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Purchase discounts</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Rebates and refunds of expenses</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Parking lot receipts</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Revenue from laundry and linen service</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Revenue from meals sold to employees and guests</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Revenue from rental of living quarters</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Revenue from sale of medical and surgical supplies to other than patients</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Revenue from sale of drugs to other than patients</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Revenue from sale of medical records and abstracts</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Tuition (Fees, sale of textbooks, uniforms, etc.)</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Revenue from gifts, flower, coffee shops, and canteen</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Revenue from vending machines</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Rental of hospital space</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Other (Specify)</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Other (Specify)</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Total other income (Sum of lines 7 - 25)</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Total (line 5 plus line 26)</td>
<td>$</td>
</tr>
<tr>
<td>28</td>
<td>Other expenses (Specify):</td>
<td>$</td>
</tr>
<tr>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Total other expenses (Sum of lines 26 - 30)</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Net income (or loss) for the period (line 27 minus line 31)</td>
<td>$</td>
</tr>
</tbody>
</table>
I. General

Nursing Care Facility as used in these instructions refers to all institutions caring for patients or clients in licensed nursing homes (basic and/or skilled nursing care facilities) and in licensed homes for the aged (supervised residential care facilities).

Under the programs for the aged, the amount paid to a nursing care facility for services furnished eligible clients under the Social Security Act is the "reasonable cost" for such services. The Michigan "Principles of Reimbursement" as approved by the Auditor General on November 29, 1973, must be used in arriving at allowable nursing home care expenses in the reimbursement formula.

A significant number of the facilities participating in the intermediate care and medical assistance programs use accounting methods and procedures which are adequate for the purposes of management but may not provide cost center expense distribution. The Statistical and Operating Cost Report schedules which accompany these instructions are designed to accommodate the reporting capabilities of homes maintaining basic bookkeeping records only. Since the report provides a minimum of information to the State, each schedule in the report must be completed prior to filing.

All reports are subject to audit. Each provider, therefore, is cautioned to retain all supporting documents (trial balances, grouping sheets, schedules and working papers) and have them available to the State auditor at the time he visits the facility. If you wish to file supporting documents with the report, it may help reduce the time you spend reviewing your records with the auditor.

Routine Nursing Care Services

Routine nursing care service includes room and board, nursing services and supplies, recreational and diversional activities and other services related to the day to day care of the client in nursing care or in residential care facilities.

Routine nursing care services does not include those services provided by the patients' physicians, nor does it include the cost of prescription drugs, restorative physical or occupational therapies, laboratory, x-ray or similar health services. These exclusions are normally regarded in hospitals and larger extended care facilities as separate income producing divisions, and are referred to as "ancillary" services. For the purpose of the Michigan Nursing Care Facility Statistical and Operating Cost Report, all ancillary service costs (salaries, supplies and overhead allocation) are to be excluded from nursing home costs to arrive at a proper cost for routine nursing care service (see Schedule B).
Reporting Periods

Cost information is to be submitted within ninety days of the close of each facility's accounting year. Legislation requires the completion of all schedules in the annual cost report as the "...director shall not authorize reimbursement to any facility which refuses...." [Section 23 (6)] of Enrolled House Bill 4445, Public Acts of 1975.

Accounting Basis

The cost data submitted is acceptable only on the accrual basis of accounting.

Data and Cost Information Forms

Enclosed are three sets of forms to be used in determining the cost of routine nursing care services provided during the accounting year. Each nursing care facility will complete Schedules A through F and submit two properly signed copies within ninety days of the close of its accounting year.

II. Instructions

Statistical and Operating Cost Report

The schedules attached, consisting of Schedules A, B, C, D (5 parts), E and F and the Certification by Officer on page 8 must be completed by all providers participating in the intermediate care and medical assistance programs.

Schedule A - Statistical and Operating Cost Report

Explanation of terms:

(1) Provider Number:

The code number assigned to a particular facility for a specific level of care. Should a given facility have been issued two or more provider numbers, a separate report must be filed for each provider number (distinct part) provided separate cost center accounting is maintained in the general ledger.

(2) For Year Ended:

Record the last date in the nursing home's accounting year. For example, a nursing home whose accounting year started April 1, 1975 and ends March 31, 1976 will show "for the year ended March 31, 1976".

(3) Report of an "entire facility" or a "distinct part":

A facility licensed and certified as a provider of one level of care only, will check the line preceding "entire facility".

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A "distinct part" is defined in the Rules and Regulations as "a clearly identifiable area or section within a licensed home consisting of at least a nursing unit, wing, floor or building containing contiguous rooms providing a specific type or level of care and service. Appropriate personnel are regularly assigned and working in the distinct part under qualified direction. The distinct part may share services such as management services, building maintenance and laundry with other units".

In view of the above, a single facility having "distinct part" operations and if the facility maintains in its general ledger separate cost centers for each distinct part in which direct expenses are recorded routinely throughout the accounting year, that facility will be expected to file for the accounting year a separate Statistical and Operating Cost Report for each certified "distinct part". Each distinct part report will include a separate Schedule A, B, D (1-5), E, F and owner's certification; duplicate copies of Schedule C may be filed for the "entire facility" and will contain identical data for each distinct part report.

(4) Licensed as:

Please check the appropriate box(es) to designate the certification which has been issued as the level or intensity of care authorized under the Intermediate Care and Medical Assistance Programs (State) and/or the Health Insurance for the Aged Act (Medicare - Federal).

(5) Type Control:

Please check the category that describes the nature of the ownership and the type control under which the facility operates.

Schedule A - Total Expenses and Adjustments to Expenses

Line 1 - TOTAL EXPENSES refers to the total expenses listed on Line 27 of Schedule D, Section 2, and reflects the gross cost of operating the facility (or distinct part). Total expenses on Line 27, Schedule D, Section 2, for a "distinct part" must represent only those expenses which have been allocated to and are a part of "distinct part" operation; therefore, each line item in the Schedule D, Section 2, must reflect that portion of expense only which relates to the distinct part operation.

Facilities having "distinct part" certificates may enter their Schedule A Adjustments to Expenses in accordance with one of the following:

(1) Prorate each item (Lines 2 through 25) on the basis of the income earned by the specific distinct part for which the report is prepared to the facility's total income, or

(2) Prorate each item (Lines 2 through 25) on the basis of the expense of operating the specific distinct part for which the report is prepared to the facility's total expense, or

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(3) Other methods which will arrive at reasonable values to portray the cost of operations for the total facility and for each of its distinct parts.

Please identify by footnote to Page 1 of the report the method used in allocating "distinct part" Adjustments to Expenses on Schedule A.

Line 2 - INCOME FROM TELEPHONE SERVICE:

All client or patient charges for bedside telephone and long distance fees are properly a reduction of total expenses (line 1) whenever line 1 includes the cost of client's telephone extension and/or long distance toll fees. Normally, income from telephone service (whether at a rate per line, fee per call, and/or fee per long distance call) is recorded as a charge to the client's account receivable and as a credit to an income category (see Schedule D, Section 1).

Line 3 - EMPLOYEE AND GUEST MEALS:

Revenue realized from the sale of meals is properly a reduction of expenses as raw food and cost of food preparation is included in dietary expenses. (see revenue from meals, Schedule D, Section 1, line 20).

Line 5 - SALE OF MEDICAL ABSTRACTS, ETC.:

Represents income frequently realized from insurance companies, attorneys and others in payment for abstracts from medical records. The income is properly a reduction of expense as all costs relating to the service producing the revenue are included in the total expenses for the facility.

Line 6 - SALE OF SCRAP, WASTE, ETC.:

Miscellaneous income whether realized from the sale of scrap metal, by-products of food, recovery of silver in x-ray, or other salvage are properly a reduction of total expense since the cost for the items from which scrap is obtained has been recorded as an expense.

Line 7 - RENTAL INCOME:

Where expenses (heat, light, depreciation, etc.) are shared between client service areas and rental income areas, the rental income received (or the cost, if determined by appropriate cost finding methods) may be used in the absence of a more sophisticated cost determination method to reduce total expenses and arrive at a fair cost of operation for client care.

Line 8 - CASH, TRADE, QUANTITY AND OTHER DISCOUNTS ON PURCHASES:

Treatment of trade and quantity discounts as a reduction of expense is the generally accepted accounting procedure. This treatment reflects departmental expense accounts correctly at net cost only.

Some accountants record "cash discounts" as "other income" in the income statement. If the treatment of discounts is other than as a reduction of expense, the discounts must be shown on Line 8 as a reduction of total operating expenses.
Line 9 - PURCHASE REBATES, REFUNDS; RECOVERY ON INSURED LOSS OF EXPENSES:

Refunds and/or rebates represent additional purchase allowances and as such are a reduction in the purchase price of a product. If rebates are permitted to be recorded as income items, then the expenses are shown at inflated values. The purpose of Line 9, therefore, is to correct such inflated costs by properly reducing expenses by the amount of rebates, refunds or recovery on insured losses.

Line 10 - ALLOWANCE FOR ADMINISTRATIVE SERVICES RENDERED SPECIALISTS:

By agreement, a facility may process billings or make collections, etc., for selected "specialists" and receive a fee for the service. As this is a non-patient related service, the cost must be deducted from operating costs. Nursing homes that share such services may elect to either:

(a) Compute the cost of providing the services for the specialists and record the cost on line 10. Calculations must recognize direct costs and provide overhead allocations and will be expected to satisfy the "test of reasonableness". Or,

(b) Assume the income received approximates the cost for the services provided specialists. Homes exercising this option will record such income (or fees received) on line 10 as costs shared with specialists (e.g., radiologists, therapists, etc.), and may be required by the field auditor to document if such income is significantly less than the cost to provide the services.

Whichever option is used, the allowable operating cost must be reduced by an appropriate value for all non-client (patient or resident) expense.

Line 11 - INTEREST INCOME ON CO-MINGLED UNRESTRICTED FUNDS:

Interest earned through investment of nursing home funds (other than from endowment funds) must be used to reduce interest expenses. If interest is a recognized operating expense, only the net interest expense should be reflected as an allowable operating expense for purposes of cost determination.

Interest earned from funds received as gifts and grants and where such monies are co-mingled with other operating funds, the interest earned should be used as a reduction of allowable interest expense in the same manner as required under the federal Medicare program.

Line 12 - GRANTS, GIFTS AND INCOME:

Such items designated by the donor for paying specific operating costs should be deducted from the particular operating cost of the program so endowed. The same interpretation will be found in the Medicare regulations.

Line 13 - FUND RAISING EXPENSES:

Expenses attributed to fund raising are not directly or indirectly related to the cost of providing client care. Therefore, costs for fund raising must be eliminated from expenses to arrive at a corrected net operating expense.
Line 14 - ANCILLARY SERVICE EXPENSES:

All non-bed clients' service (outpatient and/or residential care facility) expenses must be eliminated from total facility expense to arrive at a reasonable net operating expense for routine nursing service care for nursing home bed patients. Ancillary costs (salaries, supplies, and overhead) must be deducted from total operating expenses to arrive at the cost for "routine nursing services". Therefore, all direct expenses (salaries and supplies) relating to outpatient and ancillary services plus an appropriate overhead allocation for indirect expenses must be withdrawn from total expenses. (See Schedule B for specific details).

Lines 15-25 -

These spaces are provided for the recording of additional items of expense or income which should be disclosed in order to arrive at the proper net cost for routine nursing care services for the facility or "distinct part".

Line 28 - TOTAL NUMBER OF RESIDENT OR PATIENT DAYS OF CARE:

See page 2, Schedule B, Statistical Data, line 4, column 3 for the total number of days of care.

Schedule B - Schedule of Other Than Residential or Routine Nursing Service Expenses

The type facility will determine the lines in Schedule B which must be completed. The list shown in this schedule will serve as a checklist to assist in identifying those ancillary and other services which through oversight might remain in total expenses. Failure to remove ancillary costs from operating expenses would have the effect of inflating routine nursing care costs.

Ancillary services as used in these instructions are defined as those nursing home cost centers designed to generate income for services which are other than routine nursing care services (see definition on page 1 of these instructions). Simply stated: ancillary services are separate income producing divisions.

Lines 1 through 4 identify some of the ancillary services whose departmental costs must be excluded from total expenses. Each ancillary department will record its direct costs (salaries, supplies and other departmental expenses) as shown in the departmental accounts in the general ledger.

A second line entitled "overhead allocation" is provided for each ancillary department. Overhead allocation represents the reasonable share of overhead costs (light, heat, insurance, administrative, etc.) consumed by each ancillary service center as determined by the nursing home's auditor or by others. Overhead allocations must be supported by working schedules which are kept on file in the business office of each facility for the State auditor's review.

Lines numbered 6 through 14 are reserved for those other-than-routine nursing care services purchased from outside vendors by the facility for its clientele. If the cost of such purchased services has been included in total expense (line 1 of Schedule A), it must be disclosed in Schedule B.

Schedule B's Total Ancillary Service Expenses (line 15) is then transferred to Schedule A, line 14, as discussed earlier (see page 6 above).
Where applicable, record the requested data in each of the three (basic, skilled and total facility) columns.

Single nursing care facility reports that are "certified" skilled nursing homes (one level of care) may properly record days of care in both the skilled care column and in the basic care column if basic nursing care patients were admitted during the accounting year. Under these circumstances, all three columns (skilled, basic, total facility) would be used by a single certificate holding facility. However, the level of care authorized for a particular patient (basic, skilled or other) is not to be determined from the patient’s rate of reimbursement.

Lines 1 and 2 -
State the number of beds available for use by patients. Temporary changes due to alterations, painting, etc., do not affect the facility's bed capacity.

Line 3 -
Total bed days available are determined by multiplying the number of beds available during a period by the number of days in that period. Take into account increases or decreases in the number of beds available and the number of days elapsed since the increase or decrease.

Line 4 -
A patient day is the care of one patient during the period between the census-taking hour on two successive days. The day of admission is to be counted and the day of discharge is not to be counted. Do not include both. When a patient is admitted and discharged on the same day, this period must be counted as one patient day.

Line 5 - Percentage of Occupancy:
Percentage of occupancy is the proportion of the total patient days to the total possible patient days during a selected period of time. The total possible patient days are the bed days determined in item 3 above.

Line 6 -
A patient discharge, including death, is a formal release of a patient. However, when a patient has a leave of absence and the patient's bed is held pending his return, the day on which the patient begins such leave of absence is treated as a day of discharge and is not counted as a patient day unless he returns to the facility by midnight of the same day. The day the patient returns to the facility from a leave of absence is treated as a day of admission and is counted as a patient day if he is present at midnight of that day.

Line 7 -
A patient admission is the formal acceptance of a person by a facility for nursing care as a patient or as a resident.
Statistics requested in items 8a, 8b, and 8c refer only to patients who received benefits under the medical assistance programs. Use care to record data in the correct column.

Schedule C - Balance Sheet Accounts

The information requested on the balance sheet statement is in simple condensed form.

Most nursing homes will find the format used in Schedule C compatible with those used for routine financial statements prepared for internal purposes. The information furnished in the report must reflect year-end balances after facility's auditor adjustments have been recorded in the general ledger.

These abbreviated instructions are considered adequate, as all nursing care facilities (profit and non-profit) now file comparable annual balance sheet reports with federal and state agencies. The balance sheet schedule should include dollar values representing all assets, all liabilities and the value of the capital section as of the last day of the facility's accounting year.

The balance sheet schedule must be completed for all facilities whether corporation, partnership or proprietary. For the single facility having "distinct part" operations, duplicate copies of Schedule C representing the balance sheet for the entire facility may be used for each distinct part cost report.

ASSETS:

"Cash on hand and in bank" includes all funds actually on hand or in bank accounts subject to immediate withdrawal. Savings, deposits, certificates of deposit, etc., are to be classified under investments.

"Accounts and notes receivable" represent monies due the facility for services rendered clients or amounts due from creditors (i.e., notes receivable, interest receivable, advances, etc.) as of balance sheet date. The dollar amount recorded on the schedule will represent gross accounts and notes receivable less, if so recorded, an allowance for uncollectible accounts and notes receivable.

"Investments" are normally permanent or long-term securities with value, but which are normally not available for immediate withdrawal. Investments include stocks and bonds, savings accounts, certificates of deposit, etc.

"Inventories" designates those goods awaiting sale or use, and excludes those long-term assets subject to depreciation. Inventories are normally conservatively priced at the lower of "cost or market" values. Inventories may include dietary supplies, housekeeping and linen, general stores and others in accordance with the practice in each individual home.

"Prepaid Expenses" represent that portion of the expenditures which will be carried forward into the next accounting period as a proper expense in some future period. Examples of prepaid expenses include membership dues, insurance premiums, rent, service contracts, etc.
"Fixed Assets" may include several classifications of plant and equipment used in the operation of nursing homes: land, buildings, leasehold improvements and equipment are listed on Schedule C. If needed, other categories may be added by footnote to Schedule C.

Fixed asset classifications should be recorded at cost. The accumulated reserve for depreciation for each category should be shown in the "reserve" column. The sum of the net book values is extended to the asset column. It is essential supporting data be maintained in the home's business office to substantiate all figures reported.

"Accounts Payable" represents liabilities on routine transactions normally kept on open account and limited to amounts owing specific creditors for goods and/or services purchased.

"Notes Payable" represents amounts due creditors, normally evidenced by written instruments and may be of short-term or long-term duration.

"Accrued salaries, wages payable" represents the salaries and wages earned by employees but not paid during the accounting period. To be recognized as an allowable expense, salaries accrued at the end of the accounting year must be paid within ninety days of the year end.

"Deferred Income" is a liability if revenue is received before it has been earned. Services which will be rendered in a future accounting period for which monies have been collected is an example of deferred income.

"Long-term Liabilities" include mortgages payable, long-term notes payable and contracts payable.

"Capital" includes the investments made in the home by the owners (proprietary, partnership or corporation). If capital stock is involved, the amount outstanding at the balance sheet date will be shown.

"Surplus" accounts result from a variety of transactions. The most common surplus account is "retained earnings" - the accumulation of undistributed earnings over the life of the corporation.

The surplus section of the balance sheet is designed to disclose the surplus balance at the beginning of the year, the increases or decreases during the year and the end of the year balance.

Schedule D - Analyses of Income and Expenses

Section 1 of Schedule D - Selected patient revenue and other income accounts

This schedule identifies all patient revenue by category of service. In addition, income derived from non-patient activities is also shown in appropriate revenue accounts. All sources of income must be recorded in this schedule.

Section 2 of Schedule D - Operating Expenses

Individual costs as recorded in the home's general ledger are normally grouped by departmental function in the health care facility chart of accounts. This schedule identifies most of the departmental functions in nursing homes. Total expenses (line 27) is also recorded on line 1, Schedule A.
To illustrate the composition and type of expenses which are normally included in a few representative departments in the schedule -

**Line 1 - NURSING WAGES**

The total salaries and wages paid in the nursing services department for (1) bedside nursing care and (2) for recreational activity salaries during the accounting period. Included in salaries and wages for line 1 are: compensation for hours worked in providing care to the resident patient, sick pay, vacation pay, holiday pay and shift differential pay.

**Line 2 - NURSING WAGE FRINGES AND PAYROLL TAXES**

That portion of the payroll fringe benefit package which is allowable to the nursing and recreational salaries and wages recorded on line 1 should be recorded on line 2, Schedule D, Section 2.

Nursing's fringe benefits include the nursing department's fair share of payroll taxes (FICA, federal and state unemployment), insurance (hospitalization, health and accident and life), workmen's compensation, income replacement, etc.

**Line 3 - RAW FOOD COSTS**

Includes only the costs of unprocessed food. Costs of preparation and serving are to be recorded on line 5.

**Line 5 - OTHER DIETARY EXPENSES**

Salaries - Cooks, dietitian, kitchen and cafeteria help

Supplies - All purchases used in the department: includes meats, dairy products, vegetables, staples, etc.

Other - Maintenance cost of dietary equipment, replacement of dishes and silverware, and/or contracted dietary services, etc.

**Line 6 - ADMINISTRATIVE AND GENERAL**

The sum of: Salaries - administration and clerical

Supplies - all office and administrative supplies including magazine subscriptions, postage, dues, etc.

Other - Advertising, telephone and telegraph, insurance, repair and maintenance of office equipment, legal and audit expense, all employee fringe benefits, etc.

For purposes of determining allowable operating costs, the maximum amount of compensation that may be paid full-time (40-hour work week) administrator(s) (viz: combined salary for the administrator, assistant administrator, and/or administrative assistant) may not exceed:

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Paragraph 405.426 "Principles of Reimbursement for Provider Costs" defines a reasonable allowance of compensation for services of owners. To be reasonable, an owner's compensation must "be such an amount as would ordinarily be paid for comparable services by comparable institutions."

Salary ranges for administrators and assistant administrators developed by the Social Security Administration, Bureau of Health Insurance as reasonable 1971 (most recent data available) compensation for Michigan are as follows:

<table>
<thead>
<tr>
<th>Bed Size</th>
<th>Administrators</th>
<th>Median Administrators</th>
<th>Assistant Administrators</th>
<th>Median Assistant Administrators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 25</td>
<td>$7,000-11,000</td>
<td>$11,786</td>
<td>$4,000-7,000</td>
<td>$4,977</td>
</tr>
<tr>
<td>25 - 49</td>
<td>$7,000-15,000</td>
<td>$12,400</td>
<td>$4,000-10,000</td>
<td>$7,408</td>
</tr>
<tr>
<td>50 - 74</td>
<td>$7,000-17,000</td>
<td>$13,521</td>
<td>$5,000-10,000</td>
<td>$7,800</td>
</tr>
<tr>
<td>75 - 99</td>
<td>$8,000-22,000</td>
<td>$12,000</td>
<td>$5,000-13,000</td>
<td>$9,750</td>
</tr>
<tr>
<td>100 - 149</td>
<td>$9,000-23,000</td>
<td>$15,000</td>
<td>$7,000-15,000</td>
<td>$10,800</td>
</tr>
<tr>
<td>150 - 199</td>
<td>$10,000-25,000</td>
<td>$16,719</td>
<td>$10,000-16,000</td>
<td>$12,095</td>
</tr>
<tr>
<td>200 - 249</td>
<td>$12,000-26,000</td>
<td>$20,350</td>
<td>$12,000-18,000</td>
<td>$15,500</td>
</tr>
<tr>
<td>250 and over</td>
<td>$12,000-27,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To interpret the above guidelines, one must use Medicare's point system for placing owner/administrator compensation within the appropriate range: experience formal education, and other considerations are assigned values, the resulting total determines the relative position an owner has within the range and becomes his maximum allowable compensation.

The dollar values used in the schedule above represent 1971 survey results. To update the values, the following percentages are used:

- For 1973, 1.088 is applied to above values
- 1974, 1.138 is applied to above values
- 1975 as estimated, 1.188 is applied to above values

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Line 9 - OPERATION AND MAINTENANCE OF PLANT

Salaries - Building engineer and maintenance personnel
Supplies - Utilities (gas, oil, electric, water), small tools, paint, etc.
Other - Purchased repair services, etc.

Line 11 - PHARMACY

Salaries - Registered pharmacist(s)
Supplies - Drugs and medications

Line 15 or Lines 24-26 -

Normally, general ledger account balances are grouped with other ledger account balances and appear on one of the appropriate lines printed in Schedule D, Section 2. However, unusual expense categories which are significant in amount, may be recorded separately in one of the lines identified by this paragraph.

Lines 17 and 18 - DEPRECIATION

The allowable depreciation expense is restricted to the straight-line method of calculation. Amounts claimed must be supported by appropriate records in the home's accounting department. For further instructions, see Schedule D, Section 3 below.

Line 19 - PURCHASED SERVICES

This line is reserved for those special services or supplies a nursing home may purchase for individual clients, pay with nursing home funds and recover its cost through collections from the client or patient. Purchased service expenses which would be used on line 21 include:

X-ray, laboratory, physical therapy, occupational therapy, braces, individual wheelchairs and/or physician-prescribed non-routine nursing care type expenditures.

Section 3 of Schedule D - Depreciation

Include all depreciable assets using for asset cost the values reported for income tax purposes during the period covered by this report. Use the straight-line method for determining the amount of depreciation allowance claimed for the accounting year, and apply the reasonable life for each depreciable asset (normally asset life acceptable to the Internal Revenue Service would be acceptable for the Medicaid/Medicare program).

The assessed valuation which appears on your most recent real estate tax bill should be shown in the space requested. It is the intent of the schedule to exclude land values from the real property assessed valuation.
Section 4, Schedule D - Salaries and Wages

This schedule is for informational purposes only. The data requested is readily available from schedules contained in your federal report on employee earnings (viz: W-2's). The schedule's total represents the total salary and wages paid during the calendar year.

Section 5, Schedule D - Fixed Asset Schedule

The Fixed Asset Schedule is designed to summarize the cost data contained in the facility's "lapse schedule", "plant ledger" or similar record of fixed assets by category (building, equipment, etc.) and by year of acquisition. The data recorded in this schedule should conform with cost values used in column 3 "Cost or other basis" of Schedule D, Section 3.

The remaining portion of D-5 is devoted to identifying the number of square feet within the facility that is used for:

- Line 1 - patient areas (bed areas, day rooms, etc.)
- Line 2 - offices - administrative areas
- Line 3 - residence - living quarters assigned personnel
- Line 4 - service areas - self-explanatory

Schedule E - Statement of Provider Transactions with Businesses Having Common Ownership (Related Organizations)

Schedule E is designed to identify those costs for which reimbursement is claimed that contain expenditures for services, facilities, and/or supplies furnished to the provider by organizations related to the provider by common ownership or control.

Part I of Schedule E must be completed by all providers.

Parts II and III of Schedule E must be completed whenever the answer to Part I is "yes".

Schedule F - Statement of Administrator's and/or Owner's Compensation

Schedule F is designed to show the compensation paid to administrators as well as compensation paid to sole proprietors, partners and corporation officers. The amount shown in the schedule is also in the total expenses (line 27, Schedule D, Section 2).

Compensation is defined as the total benefit received or receivable by the administrator or owner for the services he renders the institution. It includes salary amounts paid for managerial, administrative, professional and other services; amounts paid by the institution for the personal benefit of the owner; and the cost of the assets and services which the owner receives from the institution.
Certification by Officer

Each cost report submitted must contain a certification to the accuracy of the report and be signed by an officer or administrator of the nursing home or supervised residential care facility.

Opinion of Certified Public Accountant (Optional)

The certification of the cost report by a certified public accountant is optional and may be made either in the abbreviated statement printed on the lower half of page 8, or in a separately prepared statement. However, the signed opinion must certify to the reliability of data contained in the "Statistical and Operating Cost Report", Schedule C and D, Sections 1, 2 and 3.

MAILING ADDRESS FOR THE COMPLETED REPORT

Mr. Richard E. Maharan
Institutional Review Division
Bureau of Medical Assistance
Michigan Department of Social Services
300 S. Capitol Avenue
Lansing, Michigan 48926

All questions and inquiries should be addressed to:

Mr. Richard E. Maharan at the above address or by telephone: area code (517) 374-9530.
## MICHIGAN NURSING CARE FACILITY
MICHIGAN SUPERVISED RESIDENTIAL CARE FACILITY
STATISTICAL AND OPERATING COST REPORT

### SCHEDULE A

<table>
<thead>
<tr>
<th>Name of Facility</th>
<th>Provider Number</th>
<th>For Year Ended</th>
<th>Report of (Check One)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### City

<table>
<thead>
<tr>
<th>Licensed As</th>
<th>Certified As</th>
<th>Type Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Extended Care (Title XVIII)</td>
<td>Voluntary Non-Profit</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>Skilled Nursing Home</td>
<td>Governmental</td>
</tr>
<tr>
<td>Home for Aged</td>
<td>Basic Nursing Home</td>
<td>Proprietary</td>
</tr>
</tbody>
</table>

### 1. TOTAL EXPENSES (Line 27 Schedule D, Sec. 2)

#### ADJUSTMENTS TO EXPENSES:

2. Income from telephone service (pay stations excluded)
3. Employee and guest meals
4. 
5. Sale of medical abstracts, etc.
6. Sale of scrap, waste, etc.
7. Rental Income
8. Cash, trade, quantity and other discounts on purchases
9. Rebates, refunds, recovery on insured loss of expenses
10. Allowance for administrative services rendered specialists
11. Interest income on commingled Unrestricted Funds
12. Grants, gifts, and income designated by donor for specific expenses
13. Fund Raising Expenses
14. Ancillary service expense (Schedule B)
15. Other
16. 
17. 
18. 
19. 
20. 
21. 
22. 
23. 
24. 
25. 

26. TOTAL ADJUSTMENTS (Lines 2 through 25)

27. Net Cost Routine Nursing Care Service (Line 1 less Line 26)

28. Number of resident or patient days of care

29. Average daily cost for Routine Nursing Services

### NOTE: This report is subject to audit.
### SCHEDULE B

**SCHEDULE OF OTHER THAN RESIDENTIAL OR ROUTINE NURSING SERVICE EXPENSES**

<table>
<thead>
<tr>
<th>Ancillary Services (Professionally manned)</th>
<th>Cost Per Books</th>
<th>Amount Non-Routine Nursing Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pharmacy - direct costs overhead allocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Radiology - direct costs overhead allocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Laboratory - direct costs overhead allocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Therapies - direct costs overhead allocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Purchased Services that are included in expenses (line 1, Schedule A):**

| 6. Prescription drugs                                                            |                |
| 7. X-Ray Services                                                                |                |
| 8. Laboratory Services                                                           |                |
| 9. Physical Therapy Treatments                                                    |                |
| 10. Occupational Therapy Treatments                                               |                |
| 11. Speech Therapy Treatments                                                     |                |
| 12. Braces and/or Prosthetic Devices                                              |                |
| 13. Physician and Dental: Services of physicians                                 |                |
| 14. Other                                                                        |                |

15. **Total Ancillary Service Expenses (Schedule A Line 14)**                       | $               |

### STATISTICAL DATA

<table>
<thead>
<tr>
<th>Complete Cols. 1, 2, and 3 for facility checked above</th>
<th>Basic Care</th>
<th>Skilled Care</th>
<th>Total of Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Beds available at beginning of period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Beds available at end of period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Total bed days available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Total inpatient days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Percent of occupancy (less fractional by line 3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Discharges, including deaths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Number of admissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Medical Care &amp; Intermediate Care Programs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Total inpatient days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Number of discharges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Number of admissions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DSS-1878 (11-77) 2.

5/1/80
SCHEDULE D, Section 4

SALARIES AND WAGES

<table>
<thead>
<tr>
<th>Officers' Salaries and Fees</th>
<th>Gross Wages Paid Last Calendar Year per W-2's</th>
<th>Average Hourly Rate of Pay</th>
<th>Total Hours Worked</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director of Nursing and Assistants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Service Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Charge Nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses Aides</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orderlies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records Clerks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office and Clerical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Housekeeping</td>
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<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kitchen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapist</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Salaries and Wages Paid as Reported to IRS (W-2's)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5/1/80

Provider No. __________________________

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.


**SCHEDULE D**

ANALYSES OF INCOME AND EXPENSES

FOR THE ENDED .

**SCHEDULE D, SECTION 1**

SELECTED PATIENT REVENUE (except routine nursing services)
AND OTHER INCOME ACCOUNTS

Inpatient Revenue:

<table>
<thead>
<tr>
<th>Item</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>$</td>
</tr>
<tr>
<td>3</td>
<td>$</td>
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<tr>
<td>4</td>
<td>$</td>
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<td>7</td>
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<td>11</td>
<td>$</td>
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<tr>
<td>12</td>
<td>$</td>
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<tr>
<td>13</td>
<td>$</td>
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</tbody>
</table>

Outpatient Revenue

<table>
<thead>
<tr>
<th>Item</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>$</td>
</tr>
<tr>
<td>15</td>
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<td>16</td>
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<td>17</td>
<td>$</td>
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<tr>
<td>18</td>
<td>$</td>
</tr>
<tr>
<td>19</td>
<td>$</td>
</tr>
</tbody>
</table>

Other income:

<table>
<thead>
<tr>
<th>Item</th>
<th>Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>$</td>
</tr>
<tr>
<td>21</td>
<td>$</td>
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<tr>
<td>22</td>
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<td>26</td>
<td>$</td>
</tr>
<tr>
<td>27</td>
<td>$</td>
</tr>
</tbody>
</table>

Total

**SCHEDULE D, SECTION 2**

OPERATING EXPENSES

<table>
<thead>
<tr>
<th>Item</th>
<th>Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>$</td>
</tr>
<tr>
<td>3</td>
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<td>26</td>
<td>$</td>
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<tr>
<td>27</td>
<td>$</td>
</tr>
</tbody>
</table>

**SCHEDULE D, SECTION 3**

DEPRECIATION

(Lines 17 and 18, above)

<table>
<thead>
<tr>
<th>Description of Property</th>
<th>Date Acquired</th>
<th>Cost or other basis</th>
<th>Depreciation allowed or allowable in prior year</th>
<th>Method computing Depreciation</th>
<th>Life or rate</th>
<th>Depreciation claimed for this year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings</td>
<td></td>
<td>$</td>
<td>$</td>
<td>Straight Line</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furniture and Fixtures</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation Equipment</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Machinery &amp; other Equipment</td>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td>$</td>
<td>$</td>
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<td></td>
<td></td>
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<tr>
<td>Fully Depreciated Assets</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total to lines 17 &amp; 18, Schedule D, Section 2, above</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Assessed Valuation - Real Property exclusive of land $  

Personal Property $  

OSS-1876 (11-77) $  

5/1/80
### SCHEDULE C

Provider Number

**BALANCE SHEET ACCOUNTS ON**

(date) **19**

**ASSETS**

1. Cash on hand and in banks $ _________
2. Accounts and notes receivable (less allowance $ _________)
3. Inventories priced at
4. Investments
5. Prepaid Expenses

**6. Fixed Assets:**

<table>
<thead>
<tr>
<th></th>
<th>Cost</th>
<th>Reserve</th>
<th>Book Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Land</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Buildings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Leasehold Improvements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. **TOTAL ASSETS**

**LIABILITIES:**

8. Accounts Payable
9. Notes Payable
10. Accrued salaries, wages, fees payable
11. Deferred Income

Long Term Liabilities:

12. Mortgage Payable
13. Notes Payable
14. Other

15. **TOTAL LIABILITIES**

**CAPITAL**

16. Owners Equity (Proprietary or Partnership)
17. Capital Stock (Corporation) outstanding

18. Surplus - beginning of year
19. current year's operating profit (loss)
20. other surplus account transactions (net)
21. balance, end of year

22. **TOTAL LIABILITIES AND CAPITAL** $ _________
The Michigan Department of Social Services defines a "claim" as a "bill for services" in accordance with 42 CFR 447.45(b).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Requirements for Third Party Liability – Identifying Liable Resources

(1) Data Exchange Frequency (42 CFR 433.138(f))

The Michigan Department of Human Services accesses the Michigan Employment Security Commission files weekly and makes the files available to IV-D and Friends of the Court.

The Michigan Department of Human Services IV-A program determines Title XIX eligibility and secures information on Medicaid recipients that are employed and their employer on a continuous basis.

The Michigan Department of Community Health has an agreement with the Worker's Disability Compensation Bureau to provide the Third Party Liability Division with information at least monthly, to pursue third party resources. The Department also reviews information on a monthly basis from the Departments of Transportation and State Police for all injury related and fatal accidents.

Monthly the Michigan Department of Community Health identifies paid claims with diagnosis and trauma codes as designated by the Code of Federal Regulations and published updates.

(2) Follow-up Requirements (42 CFR 433.138(g))

When appropriate, the Michigan Department of Community Health follows up on acquired information within 30 days to determine the legal liability of other resources. County caseworkers, as a matter of routine, pursue potential employer leads for both outside income and other insurance. Other third party resources discovered by the caseworkers as a result of the follow up are reported to third party and incorporated into the third party and eligibility case files. This information is accessed to assure appropriate claims payment.

Within 60 days information is obtained to determine the legal liability of other resources. Health insurance information received from the caseworkers is entered on the TPL Master File for use in both the cost-avoidance and recovery processes. Valid Worker’s Compensation information is maintained in a recovery case file.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Requirements for Third Party Liability – Identifying Liable Resources

(3) State Motor Vehicle Accident Report (42 CFR 433.138(g)(3))

Monthly all reported accidents are matched to the Medicaid Management Information System to determine Medicaid eligibility status. If the individual is Medicaid eligible, the case is reviewed for potential recovery action.

(4) Trauma Code Editing Follow-up (42 CFR 433.138(g)(4))

Monthly all claims with diagnosis and trauma edit codes as designated by the Code of Federal Regulations, are matched to the Medicaid Management Information system to determine Medicaid eligibility status. If the individual is Medicaid eligible, the case is reviewed for potential recovery action.

TN NO.: 07-05 Approval Date: SEP 11 2007 Effective Date: 01/03/2007

Supersedes
TN No.: 90-13

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Requirements for Third Party Liability – Payment of Claims

1) Method Used to Determine Provider Compliance

The State requires the provider to utilize all other resources to their fullest extent before presenting the claim to Medicaid for payment.

2) Guidelines Used to Determine Cost Effectiveness and Time/Dollar Thresholds for Billing

Paternity Confinement Expenses - The State of Michigan IV-D program refers paternity cases to the local prosecuting attorney who petitions the court to order the absent parent to provide support for the minor child and repay Medicaid confinement expenses. The prosecutor and/or court requests from the Third Party Liability Division a statement of confinement expenses for inclusion in the court order. Confinement expense statements are provided by the Third Party Liability Division for every paternity case whether or not repayment is ordered and the terms of repayment is at the discretion of the court. Enforcement and collection is vested with an extension of each judicial circuit court in Michigan.

Health Insurance - Recoveries from Health Insurers are initiated within 30 days of adding Health Insurance information to the TPL Master File. Billing for reimbursement is retrospective.

Medicare- All current Medicare eligible recipients are monitored by the Invoice Processing system to assure payment of the lesser of the coinsurance and deductible amounts or the Medicaid screen amount minus any Medicare payment. Retroactive Medicare eligibility is pursued for covered provider types regardless of dollar amount since the process is automated. The part A and part B claims are claim adjusted to the Medicaid providers.

Casualty - The Michigan Department of Health and Human Services pursues recovery of Casualty claims when claims exceed $300 for automobile cases or $1000 for general liability or medical malpractice cases. Requests from insurance companies and attorneys are processed regardless of the value of the paid claims. Claims for no-fault auto are accumulated for as much as 12 months. If the claims do not exceed the threshold as noted in the first sentence of this subsection, the case is closed. General Liability claims are accumulated to extend 6 months from the date of event or date of notification, whichever is longer. If the claims do not exceed the threshold, the case is closed. Once the case has been identified as exceeding the cost effective threshold, recovery is pursued.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **MICHIGAN**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1906 of the Act</td>
<td>State Method on Cost Effectiveness of Employer-Based Group Health Plans</td>
</tr>
</tbody>
</table>

**TN No.** 91-30

Supersedes Approval Date 07-06-92 Effective Date 10-01-91

**TN No.** N/A

HCFA ID: 7985E
Citation | Sanctions for Psychiatric Hospitals
---|---
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2)) | (a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital’s deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.

1902(y)(1)(A) of the Act | (b) The State terminates the hospital’s participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital’s deficiencies immediately jeopardize the health and safety of its patients.

1902(y)(1)(B) of the Act | (c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital’s deficiencies do not immediately jeopardize the health and safety of its patients, the State may:

1. terminate the hospital's participation under the State plan; or

2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or

3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.

1902(y)(2)(A) of the Act | (d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Program Administration

<table>
<thead>
<tr>
<th>Citation</th>
<th>Sanctions for MCOs and PCCMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1932(e)</td>
<td>(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:</td>
</tr>
<tr>
<td>42 CFR 428.726</td>
<td>(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management.</td>
</tr>
<tr>
<td></td>
<td>(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).</td>
</tr>
<tr>
<td></td>
<td>__ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.</td>
</tr>
</tbody>
</table>

TN NO.: 03/13       Approval Date: 08/13/2003       Effective Date: 08/13/2003

Supersedes
TN No.: N/A – new page
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES

REQUESTS TO OTHER STATE AGENCIES

1. We request quarterly wage information from the Michigan Employment Security Commission, which is not yet the designated SWICA.

2. We request, from the Secretary of State, using an on-line inquiry system, descriptions of any licensed vehicles owned or being purchased by recipients.

3. Since the Michigan Department of Social Services is a single State agency with a single data base, information from all other state administered programs is routinely available while making determinations of Medicaid eligibility.

IN No. 87-4
Supersedes
TN No. N/A

Approval Date 04/16/87
Effective Date 06/01/86

HCFA ID: 0123P/0002P

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MICHIGAN

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

The homeless individual may designate where he/she wants the Medicaid eligibility card sent, including the local Department of Social Services office.
TO: Administrators/Managers of Hospitals, Nursing Homes, Hospice Programs, Home Health Agencies and Health Maintenance Organizations

FROM: Walter S. Wheeler III, Chief, Bureau of Health Systems

SUBJECT: New Federal Requirements

The Federal Omnibus Budget Reconciliation Act of 1990 (OBRA) contains a section we now refer to as the "Patient Self-Determination Act" (PSDA) which imposes new responsibilities on certain providers of Medicare and/or Medicaid services. Effective December 1, 1991, hospitals, nursing homes, certain HMO agencies, home health agencies and hospice programs are required to develop policies and programs on advance directives and those programs must:

- Provide written information to patients/residents at admission regarding their rights under State law to make decisions regarding medical care and on the programs' policies governing implementation of those rights.

- Document in the patient/resident medical record whether or not he/she has executed an advance directive.

- Ensure compliance with the requirements of Michigan law respecting advance directives at the institution.

- Provide, individually or with others, education for staff and the community on issues concerning advance directives.

(Continued)
Page Two
November 25, 1991

- Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

In addition to this memorandum, this mailing contains a reprinting of the federal statutory change along with a short article on practical considerations regarding implementation that should be shared with your legal advisor and those responsible for implementation of this new requirement.

To assist you in explaining patients' rights under Michigan law, the Michigan Department of Public Health convened a panel of experts who were responsible for drafting and finalizing the enclosed guide entitled "MICHIGAN NOTICE TO PATIENTS." While you are required to provide the information contained in this guide to your patients at the time of admission, you are not required to use the document provided by the State. You may photocopy the material (with or without your own logo) or you may elect to include the contents of the guide in other material you are preparing to fulfill this new regulatory requirement.

Long-term care providers (nursing homes) will notice that the "MICHIGAN NOTICE TO PATIENTS" differs from the memorandum we issued in February 1991, which implied that a guardian was needed if a resident was no longer "able" to make his/her treatment decisions and that resident had not previously appointed a surrogate decision maker consistent with Michigan law. Our panel of experts considered this matter carefully and concluded that it is not always necessary to seek guardianship appointments when residents are "unable" to exercise their treatment decision options.

We believe this material will be of considerable assistance as your program changes to meet new federal requirements. We understand that several provider organizations are working with their members to assist in implementation. Questions specific to a type of provider should be referred to that organization. In addition, the legal community has expressed significant interest in this subject and is available for consultation. Many State Senators and Representatives have available in their office material describing the process for the appointment of a surrogate decision maker consistent with Michigan law.

Enclosure
MICHIGAN NOTICE TO PATIENTS

REQUIRED BY THE PATIENT SELF DETERMINATION ACT ("PSDA")

Distributed by the Michigan Department of Public Health
Bureau of Health Systems
Nov. 1991
YOUR RIGHTS TO MAKE MEDICAL TREATMENT DECISIONS

We are giving you this material to tell you about your right to make your own decisions about your medical treatment. As a competent adult, you have the right to accept or refuse any medical treatment. "Competent" means you have the ability to understand your medical condition and the medical treatments for it, to weigh the possible benefits and risks of each such treatment and then to decide whether you want to accept treatment or not.

WHO DECIDES WHAT TREATMENT I WILL GET?

As long as you are competent, you are the only person who can decide what medical treatment you want to accept or reject. You will be given information and advice about the pros and cons of different kinds of treatment and you can ask questions about your options. But only you can say "yes" or "no" to any treatment offered. You can say "no" even if the treatment you refuse might keep you alive longer and even if others want you to have it.

WHAT IF I'M IN NO CONDITION TO DECIDE?

If you become unable to make your own decisions about medical care, decisions will have to be made for you. If you haven't given prior instructions, no one will know what you would want. There may be difficult questions: for instance, would you refuse treatment if you were unconscious and not likely to wake up? Would you refuse treatment if you were going to die soon no matter what? Would you want to receive any treatment your care givers recommend? When your wishes are not known, your family or the courts may have to decide what to do.

WHAT CAN I DO NOW TO SEE THAT MY WISHES ARE HONORED IN THE FUTURE?

While you are competent, you can name someone to make medical treatment decisions for you should you ever be unable to make them for yourself. To be certain that the person you name has the legal right to make those decisions, you must fill out a form called either a durable power of attorney for health care or a Patient Advocate Designation. The person named in the form to make or carry out your decisions about treatment is called a Patient Advocate. You have the right to give your Patient Advocate, your care givers and your family and friends written or spoken instructions about what medical treatment you want and don't want to receive.
WHO CAN BE MY PATIENT ADVOCATE?

You can choose anyone to be your Patient Advocate as long as the person is at least 18 years old. You can pick a family member or a friend or any other person you trust, but you should make sure that person is willing to serve by signing an acceptance form. It's a good idea to name a backup choice, too, just in case the first person is unwilling or unable to act when the time comes.

WHERE CAN I GET A PATIENT ADVOCATE DESIGNATION FORM?

Many Michigan hospitals, health maintenance organizations, nursing homes, homes for the aged, hospices and home health care agencies make forms available to people free of charge. Many senior citizens' groups and church and civic groups do, too. You can also get a free form from various members of the Michigan legislature. Many lawyers also prepare Patient Advocate Designations for their clients. The forms aren't all alike. You should pick the one which suits your situation the best.

HOW DO I SIGN A PATIENT ADVOCATE DESIGNATION FORM SO THAT IT'S VALID?

All you have to do is fill in the name of the advocate and sign the form in front of two witnesses. But that's not as simple as it sounds, because under this law some people cannot be your witnesses. Your spouse, parents, grandchildren, children, and brothers or sisters, for example, cannot witness your signature. Neither can anyone else who could be your heir or who is named to receive something in your will, or who is an employee of a company that insures your life or health. Finally, the law disqualifies the person you name as your Patient Advocate, your doctors and all employees of the facility or agency providing health care to you from being a witness to your signature.

It is easier to make a Patient Advocate Designation before you become a patient or resident of a health care facility or agency. Friends or co-workers are often good people to ask to be witnesses, since they see you often and can, if necessary, swear that you acted voluntarily and were of sound mind when you made out the form.
DO I HAVE TO GIVE MY PATIENT ADVOCATE INSTRUCTIONS?

No. A Patient Advocate Designation can be used just to name your Patient Advocate, the person you want to make decisions for you. But written instructions are generally helpful to everybody involved. And, if you want your Patient Advocate to be able to refuse treatment and let you die, you have to say so specifically in the Patient Advocate Designation document itself. Any other instructions you have you can either write down or just tell your Patient Advocate. Either way, the Patient Advocate's job is to follow your instructions.

CAN I JUST GIVE INSTRUCTIONS AND NOT NAME A PATIENT ADVOCATE?

Yes, you can simply tell somebody, for example, your care giver or your family and close friends, what your wishes are. Better yet, you can write what is called a "Living Will," which is a written statement of your choices about medical treatment. Even though there is not yet a state Living Will law, courts and health care providers still find Living Wills valuable. Those taking care of you will pay more attention to what you have written about your treatment choices, whether in a Patient Advocate Designation or a Living Will, because they can be more confident they know what you would have wanted. Most doctors, hospitals and other health care providers will also pay attention to what you've said to others, especially your family, about medical treatment. But again, it's better for everyone involved if you write your wishes down.

DO I HAVE TO MAKE A DECISION NOW ABOUT MY FUTURE MEDICAL TREATMENT?

No. You don't have to fill out a Patient Advocate Designation or a Living Will and you don't have to tell anybody your wishes about medical treatment. You will still get the medical treatment you choose now, while you are competent. If you become unable to make decisions, but you've made sure that your family and friends know what you would want, they will be able to follow your wishes. Without instructions from you, your family or friends and care givers may still be able to agree how to proceed. If they don't, however, a court may have to name a guardian to make decisions for you.

IF I MAKE DECISIONS NOW, CAN I CHANGE MY MIND LATER?

Yes. You can give new instructions in writing or orally. You can also change your mind about naming a Patient Advocate at all and cancel a Patient Advocate Designation at any time.
You should review your Patient Advocate Designation or Living Will at least once a year to make sure it still accurately states how you want to be treated and/or names the person you want to make decisions for you.

WHAT ELSE SHOULD I THINK ABOUT?

Treatment decisions are difficult. We encourage you to think about them in advance and discuss them with your family, friends, advisors and care givers. You can and should ask your facility or agency about their treatment policies and procedures to be sure you understand them and how they work.

If you want more information about a Patient Advocate Designation or Living Wills, or sample forms, please ask your care givers for assistance. Many facilities and agencies have staff available who can answer your questions. Additional materials may be available from your state representative or senator.
OMNIBUS BUDGET RECONCILIATION ACT OF 1990
P.L. 101-508

TEXT OF THE PATIENT SELF-DETERMINATION ACT

SEC. 4206. MEDICARE PROVIDER AGREEMENTS ASSURING THE IMPLEMENTATION OF A PATIENT'S RIGHT TO PARTICIPATE IN AND DIRECT HEALTH CARE DECISIONS AFFECTING THE PATIENT.

(a) In General — Section 1866(a)(1)(42 U.S.C. 1395cc(a)(1)) is amended —

(1) in subsection (a)(1) —

(A) by striking "and" at the end of subparagraph (O).

(B) by striking the period at the end of subparagraph (P) and inserting "; and"

(C) by inserting after subparagraph (P) the following new subparagraph:

"(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives)."; and

(2) by inserting after subsection (e) the following new subsection:

"(O)(1) For purposes of subsection (a)(1)(Q) and sections 1819 (c)(2)(E), 1833(f), 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization —

"(A) to provide written information to each such individual concerning —

"(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

"(ii) the written policies of the provider or organization respecting the implementation of such rights;

"(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

"(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

"(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

"(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

"(2) The written information described in paragraph (1)(A) shall be provided to an adult individual —

"(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

"(B) in the case of a skilled nursing facility, at the time of the individual's admission as a resident,

"(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

"(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

"(E) in the case of an eligible organization (as defined in section 1876(B)) or an organization provided payments under section 1833(a)(1)(A), at the time of enrollment of the individual with the organization..

"(3) In this subsection, the term ‘advance directive’ means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.".

(b) Application to Prepaid Organizations. — (1) Eligible Organizations. — Section 1876(c) of such Act (42 U.S.C. 1395 mm(c)) is amended by adding at the end the following new paragraph:
"(B) A contract under this section shall provide that the eligible organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).".

(2) Other Prepaid Organizations. — Section 1833 of such Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

"(r) The Secretary may not provide for payment under subsection (a) (1) (A) with respect to an organization unless the organization provides assurances satisfactory to the Secretary that the organization meets the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).".

(c) Effect on State Law. — Nothing in subsections (a) and (b) shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which, as a matter of conscience, cannot implement an advance directive.

(d) Conforming Amendments. —

(1) Section 1819 (c)(1) of such Act (42 U.S.C. 1395l-3(c)(1)) is amended by adding at the end the following new subparagraph:

"(E) Information Respecting Advance Directives. — A skilled nursing facility must comply with the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).".

(2) Section 1891(a) of such Act (42 U.S.C. 1395bbb(a)) is amended by adding at the end the following:

"(6) The agency complies with the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).".

(c) Effective Dates. —

(1) The amendments made by subsections (a) and (d) shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act.

(2) The amendments made by subsection (b) shall apply to contracts under section 1876 of the Social Security Act and payments under section 1833 (a)(1)(A) of such Act as a first day of the first month beginning more than 1 year after the date of the enactment of this Act.

SEC. 4751. REQUIREMENTS FOR ADVANCED DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE.

(a) In General. — Section 1902 (42 U.S.C. 1396a(a)), as amended by sections 4401(a)(2), 4601(d), 4701(a), 4711, and 4722 of this title, is amended —

(1) in subsection (a) —

(A) by striking "and" at the end of paragraph (55),

(B) by striking the period at the end of paragraph (56) and inserting "; and", and

(C) by inserting after paragraph (56) the following new paragraphs:

"(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or health maintenance organization (as defined in section 1903(m)(1)(A)) receiving funds under the plan shall comply with the requirements of subsection (w);

"(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w); and

(2) by adding at the end the following new subsection:

"(w)(1) For purposes of subsection (a)(57) and sections 1903(m)(1)(a) and 1919(c)(2)(E), the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization —

"(A) to provide written information to each such individual concerning —

"(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

"(ii) the provider's or organization's written policies respecting the implementation of such rights;

"(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

"(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;"
(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

"(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

"(2) The written information described in paragraph (1)(A) shall be provided to an adult individual —

"(A) in the case of a hospital, at the time of the individual’s admission as an inpatient,

"(B) in the case of a nursing facility, at the time of the individual’s admission as a resident,

"(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

"(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

"(E) in the case of a health maintenance organization, at the time of enrollment of the individual with the organization.

"(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive."

"(4) In this subsection, the term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(b) Conforming Amendments. —

(1) section 1903(m)(1)(A)(42 U.S.C. 1396(b)(m)(1)(A)) is amended —

(A) by inserting "meets the requirement of section 1902 (w)" after "which" the first place it appears, and

(B) by inserting "meets the requirement of section 1902(a) and after "which" the second place it appears.

(2) Section 1919(c)(2) of such Act (42 U.S.C. 1396r(c)(2)) is amended by adding at the end the following new subparagraph:

"(E) Information respecting advance directives. — A nursing facility must comply with the requirement of section 1902(w) (relating to maintaining written policies and procedures respecting advance directives)."

(c) Effective Date. — The amendments made by this section shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act.

(d) Public Education Campaign. —

(1) In General. — The Secretary, no later than 6 months after the date of enactment of this section, shall develop and implement a national campaign to inform the public of the option to execute advance directives and of a patient’s rights to participate and direct health care decisions.

(2) Development and Distribution of Information. — The Secretary shall develop or approve nationwide informational materials that would be distributed by providers under the requirements of this section, to inform the public and the medical and legal profession of each person’s right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

(3) Providing Assistance to States. — The Secretary shall assist appropriate State agencies, associations, or other private entities in developing the State-specific documents that would be distributed by providers under the requirements of this section. The Secretary shall further assist appropriate State agencies, associations, or other private entities in ensuring that providers are provided a copy of the documents that are to be distributed under the requirements of the section.

(4) Duties of Secretary. — The Secretary shall mail information to Social Security recipients, add a page to the medicare handbook with respect to the provisions of this section.

PROVIDED COURTESY OF THE NATIONAL HEALTH
LAYWERS ASSOCIATION
PRACTICAL CONSIDERATIONS FOR HEALTHCARE PROVIDERS REGARDING THE IMPLEMENTATION OF THE PATIENT SELF-DETERMINATION ACT OF 1990

By Thomas M. Fahey, Esquire, and Anne M. Murphy, Esquire, of Coffield Ungaretti Harris & Slavin, Chicago, Illinois.

Healthcare institutions subject to the patient self-determination provisions of OBRA 1990 (the "Act") will need to address a number of issues regarding implementation of the Act. Some of these questions involve interpreting the language of the Act itself and, when issued, regulations to be promulgated by the Health Care Financing Administration (HCFA), (the "Regulations"). Others involve deciding whether it is advisable to take measures technically not mandated under the Act, but which may logically flow from these requirements.

Set forth below are a number of issues commonly raised by healthcare institutions making preliminary plans for compliance with the Act. Institutions may derive some comfort from the recognition that they are not alone in having these questions; however, there are not pat answers to most concerns. Lack of definitive guidance is caused by a number of factors, including the relatively broad nature of the Act, the current lack of regulatory guidance and anticipated brevity of the interpretive Regulations, the continuing evolution of State law in many jurisdictions regarding advance directives and the right to terminate life support, and the need to evaluate the Act's requirements in the context of each institution's unique characteristics.

(i) The Act requires distribution of written information to certain patients. Many institutions are unclear as to the scope of their responsibilities in implementing this provision.

(a) Written information must have two components: (i) a summary of individual rights under State law to make decisions regarding medical care (including the right to refuse or accept medical treatment and execute an advance directive); and (ii) the written policies of the entity regarding implementation of those rights.

(i) The summary of State law ultimately should be furnished to providers by a State agency or association, thereby presumably maximizing consistency among institutions. In some jurisdictions, rapid evolution in the law will make it very difficult to compile an accurate, understandable summary.

(ii) Each institution will be required to maintain a written policy regarding application by it of State law covering the right to accept or terminate medical treatment and execute advance directives. Healthcare institutions without such a policy in place will have to draft one. In drafting such a document, some institutions may avail themselves of State-specific form policies distributed by agencies or associations. Thought must be given to which persons or committees are best suited to the task of drafting or approving this policy. This may be especially difficult for nonhospital entities such as nursing facilities and home health agencies, which may not have expertise to address fully these concerns. If State law in this area is confused, formulation of a written policy reflecting the law will be made more difficult.

(b) Written information is to be distributed to all adults. The Act makes no provision for distributing written information to an adult patient that is admitted or initially comes under care while incompetent. Unless addressed in the Regulations, institutions will have to decide whether or how to distribute written information in these situations.

(c) Written information, generally stated, must be distributed to the patient at the time of admission to a hospital or nursing facility, or initially upon coming under the care of a home health agency, hospice or HMO. "Admission" is not defined in the Act, although it might be clarified in the Regulations. If consistent with the Regulation, institutions might consider mailing written information with preadmission materials.

(d) The Act is silent as to exactly how, or by whom, the written information is to be distributed to patients. Institutions may wish to consult with other providers already voluntarily making this type of information available to get a sense of the range of options available (i.e., use of social workers, chaplains, designated professional or nonprofessional staff members).

(e) The Act does not instruct an institution how to handle instances in which distribution of written information prompts a patient request to execute an advance directive. In other words, institutions are neither required to, nor prohibited from, providing assistance to patients wishing to prepare such a document. Again, preliminary indications are that the Regulations also will not provide a mandate on this issue. As a result, institutions probably will have to decide for themselves whether to decline any involvement in this process, make forms available or
provide more extensive counseling regarding advance directives. If an institution decides to provide some
guidance to patients, care must be taken to avoid the
appearance of undue influence by institution personnel
(this may be especially true in nursing facilities) — for
example, by prohibiting employees from witnessing
advance directives if this is not already prohibited under
State law.

(2) Institutions must document the patient's medical record
to indicate whether an advance directive exists. The Act
does not require that a copy of the advance directive be
obtained and made a part of the medical record, although
State law regarding advance directives may otherwise
impose this obligation upon the attending physician,
hospitals, or other providers. Institutions nevertheless might
decide that the advance directive should be made a part of
the medical record, with provisions for confirming its
continued validity upon any re-admission or renewal of
services.

(3) The Act mandates that institutions provide education to
the staff and the community regarding advance directives
issues. It is important to note that these programs can be
provided by a number of different institutions acting
collectively.

Provided Courtesy of the National Health Lawyers Association
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT.

State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

TN No. 95-15
Supersedes
TN No. 94-21

Approval Date: 11-2-95
Effective Date: 9-30-95
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-15  Approval Date: 11-2-95  Effective Date: 9-30-95

Supersedes TN No. 94-21

October 1, 2018 Version. This plan is provided for informational use only and does not replace the original version.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

TN No. 95-15  Approval Date: 11-2-95  Effective Date: 9-30-95
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Enforcement of Compliance for Nursing Facilities Civil Money Penalty:

Specified Remedy

Alternative Remedy

Civil Money Penalty – Alternate Remedy

A civil money penalty (CMP) may be assessed for any Level 2 or higher deficiency, but is primarily assessed for F-SQC or Harm deficiencies, and Level 2 deficiencies following removal of an Immediate Jeopardy.

The State Survey Agency (SSA) may consider using a Per Instance Civil Money Penalty of $1,000 to $10,000 when the beginning date of the deficiency cannot be determined, or when a Civil Money Penalty is combined with other enforcement actions, e.g. a discretionary denial of payment for new admissions, a directed plan of correction, or a directed in-service training.

The total civil money penalties assessed cannot exceed $3,000 per day or $10,000 per instance. For Immediate Jeopardy citations, a minimum of $3,000 per day or per instance up to a maximum of $10,000 per day or per instance is assessed.

No Opportunity to Correct

Providers will not be given an opportunity to correct deficiencies before remedies are imposed when they have deficiencies of actual harm (or higher) on the current survey event, as well as on the previous standard survey or any intervening survey. The previous harm (or higher) level deficiency must have been in a completed survey cycle with compliance verified. The MDCH will impose either a Civil Money Penalty or Denial of Payment for New Admissions, or both. The MDCH may impose other optional federal remedies, described by remedy category at the end of this section. Enforcement remedies imposed under state licensure authority are also specified.

Opportunity to Correct

An opportunity to correct deficiencies before remedies are imposed is not assured. The SSA has no obligation to give a provider an opportunity to correct deficiencies prior to imposing remedies and must only meet the minimum notice requirements that are applicable to the imposition of remedies. At the SSA’s discretion, it may provide facilities an opportunity to correct deficiencies before remedies are imposed when they do not meet the criteria for “No Opportunity to Correct.”

When an opportunity to correct deficiencies before remedies are imposed is offered, the SSA will request an acceptable plan of correction; provide initial notice of possible enforcement action; conduct a revisit (if applicable); and, provide formal notice of other remedies if noncompliance continues at revisit. While formal notice of denial of payment for new admissions is generally provided in the first revisit letter, the SSA may provide it to the facility in the initial deficiency notice.

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TN No.: 99-07

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of MICHIGAN

Chapter

The MDCH must impose a Denial of Payment for New Admissions (DPNA) no later than three months after the last day of the survey that identified the noncompliance if substantial compliance is not achieved.

The MDCH may impose either a per day or per instance Civil Money Penalty for past noncompliance for days of noncompliance after the finding is made, or a combination thereof. Amounts will be determined by the MDCH based on facility history, repeating deficiencies, high number of deficiencies, culpability of the provider, failure to achieve or maintain substantial compliance and for increasing noncompliance.

Prior notice is not required before the imposition of CMPs. A penalty equivalent to a one-day penalty will apply in all circumstances even if the violation(s) is immediately corrected. The daily penalty will end on the day prior to the determination of substantial compliance, or on the day prior to the determination that a civil money penalty is no longer warranted. The SSA determines compliance. CMP amounts may be increased to reflect changes in levels of noncompliance at revisit or for repeat deficiencies.

The SSA has developed a CMP schedule for Immediate Jeopardy and Harm or Potential Harm occurrences to promote a consistent application of penalties. The CMP schedule conforms to 42 CFR 488.408 and is intended to cover the majority of cases of CMP imposition. Situations may occur that justify exceptions.

Accrual of CMPs ceases when one of the following situations occurs:

- the facility is determined by the SSA to have achieved substantial compliance
- closure of a facility as evidenced by the filing of a notice of discontinuance of operation with the Michigan Department of Community Health under section 21785 of Act 368 of the Public Acts of 1978, as amended, being 333.21785 of the Michigan Compiled Laws.
- termination of a provider agreement

Installment schedules are not allowed for payment of CMPs. Civil money penalties are not allowable Medicaid costs.

Use of CMP Funds

Money collected by the State Medicaid Agency (SMA) as a result of civil money penalties is held in a special fund to be applied to the protection of the health or property of residents of any nursing facility that MDCH finds deficient. Money recovered by the SMA from funds due a facility (because of lack of payment of civil money penalties by the facility) is also deposited in this fund.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Failure to Re-admit a Qualified Medicaid Resident

A daily Civil Money Penalty (CMP) of $400 will be imposed when an enrolled Medicaid facility refuses to re-admit a qualified Medicaid resident (as defined by CMS) following hospitalization. An opportunity to correct will not be provided. This daily CMP will start on the date validated by MDCH that nursing home readmission should have occurred. The daily $400 CMP continues until the resident is offered the next qualifying available Medicaid bed at the refusing facility, or the resident is placed in another suitable facility. The refusing facility will be notified by the SSA when an allegation of failure to readmit a qualified Medicaid resident is being investigated.

Alternate Remedy is as Effective in Deterring Non-compliance.

Imposition of CMPs conforms to the regulation. The alternative component of MDCH’s application of the remedy is that repayment schedules are not allowed. If the entire penalty amount is not voluntarily submitted within 30 days of notice that the CMP is due and payable or within 15 days of issuance of appeal results, the CMP amount is recovered in full by gross adjustment against the facility’s next available Medicaid warrant or during final cost settlement in a change of ownership. Therefore, interest does not accrue. This alternative to the federal regulation of requiring collection of daily interest has been found to be administratively simple. Fine collection is not unduly delayed. Disallowing penalty payment schedules reduces paperwork for MDCH and providers and saves time in negotiating penalty payment schedules.

Federal Enforcement Remedies

Each federal remedy below is described in rules as stated in 42 CFR 488 et.seq., and further discussed in the CMS State Operations manual for Medicaid and/or Medicare certified facilities. Federal remedies available to MDCH or CMS include, but are not limited to:

Category One:

- State Monitoring
- Directed Plan of Correction
- Directed In-service Training

Category Two:

- Denial of Payment for new Admissions
- Denial of Payment for All Individuals, Imposed by CMS
- Civil Money Penalties $50 to $3,000
- Administrative/Clinical Advisor (Additional Remedy)

Category Three:

- Temporary Management

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Supersedes

TN No.: 99-07
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of MICHIGAN

Eligibility Conditions and Requirements

- Termination of Medical Assistance Provider Enrollment and Trading Partner Agreement
- Civil Money Penalties $3,050 to $10,000
- Transfer of residents
- Closure of Facility with Transfer of Residents
- Alternative or specified state remedies approved by CMS

The SSA has the option of imposing any state or federal remedy based on the facility’s failure to maintain compliance, deficiencies cited within the same regulatory grouping that repeat within the last 24 months (or two standard survey cycles), and the degree of culpability of the facility. In addition to federal remedies, the SMA may accept one or more of the following enforcement actions taken by the SSA under state licensure authority.

Michigan Enforcement Rules for Long Term Care Facilities at R 330.11001-330.11017:

- Emergency Order Limiting, Suspending or Revoking a License
- Notice of Intent to Revoke Licensure
- Correction Notice to Ban Admissions or Readmissions
- Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific Requirements
- Appointment of a Temporary Manager/Advisor
- State Patient Rights Penalties, if applicable

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents: Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Enforcement of Compliance for Nursing Facilities Additional Remedies:

Public Notice – Additional Remedy

This additional remedy will be used in conjunction with other federally specified remedies. When public notice is utilized, the state survey agency will issue it (under State licensure authority) using the process specified in part 333.21799b, section 21799b(1)(e) of the Michigan Public Health Code. When public notice is utilized the information will be published in a daily newspaper of general circulation in the area in which the nursing facility is located. The notice will include the action taken by the State and the conditions that caused the corrective action to be taken. The state survey agency will post notice of the corrective actions at the facility. Public Notice is a Category One remedy.

Temporary Administrative or Clinical Advisor or Both – Additional Remedy

This additional remedy will be used in conjunction with other federally specified remedies. It is the responsibility of the temporary clinical or administrative advisor to mentor facility personnel. This includes, but is not limited to:

- Counsel and teach clinical staff and administration regarding maintenance of compliance over time.
- Reinforce and support appropriate/optimal patterns of care.
- Specific duties of the advisor for each facility placement shall be outlined in a written plan.
- If specific deficient practices affecting health and safety, not addressed in the written plan should occur during the appointment of the advisor, it would be the responsibility of the advisor to work with the facility and licensing staff to address and correct those issues.

Temporary Administrative or Clinical Advisor as an Additional Remedy is a Category Two Remedy.

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Approval Date: Effective Date: 11/01/2004

Supersedes
TN No.: 99-07
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MICHIGAN

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

The Michigan registry discloses through initial telephone contact 1) that the aide is certified and 2) abuse information. Written follow-up verification is sent which contains:

- Name, Date of Birth, Gender
- Address
- City
- Where employed and addresses
- Date of training
- Location of training
- Date of written test
- Location of written test
- Date of clinical test
- Location of clinical test
- Clinical evaluator code
- Certification date
- Certification code
- Certification number

Approval Date 04-01-92  Effective Date 01-01-92

HCFA ID: N/A

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: MICHIGAN

COLLECTION OF ADDITIONAL Registry INFORMATION

In addition to data specified in 42 CFR 483.15b(c), the Michigan register stores clinical evaluator codes which identify the individual that performed the clinical evaluation.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Program

The State has in effect the following survey and certification periodic education program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

Through a cooperative effort between the Michigan Department of Public Health (as the State Survey Agency (SSA)) and health care associations and/or other professional or state agencies, regional and periodic education programs are conducted. These programs focus on disseminating knowledge pertinent to relevant state and federal regulatory requirements through the following mechanisms:

(1) Formal and informal presentations/instructions by Staff Development Unit personnel regarding regulatory changes, interpretations, agency policy/procedure, and how to access information/other resources furnished to clients and providers of care.

(2) Technical assistance and educational and training programs furnished by SSA Licensing/Certification staff.

(3) Notification to residents of their right to attend and/or participate in the survey/certification exit conference.

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HCFA ID: 
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility by another individual used by the facility in providing services to such a resident.

Michigan Public Health Code:

333.21771 Abusing, mistreating, or neglecting patient; reports; investigation; retaliation prohibited

(1) A licensee, nursing home administrator, or employee of a nursing home shall not physically, mentally, or emotionally, abuse, mistreat, or harmfully neglect a patient.

(2) A nursing home employee who becomes aware of an act prohibited by this section immediately shall report the matter to the nursing home administrator or nursing director. A nursing home administrator or nursing director who becomes aware of an act prohibited by this section immediately shall report the matter by telephone to the Department of Public Health, which in turn shall notify the Department of Social Services.

(3) Any person may report a violation of this section to the Department.

(4) A physician or other licensed health care personnel of a hospital or other health care facility to which a patient is transferred who becomes aware of an act prohibited by this section shall report the act to the Department.

(5) Upon receipt of a report made under this section, the Department shall make an investigation. The Department may require the person making the report to submit a written report or to supply additional information, or both.

(6) A licensee or nursing home administrator shall not evict, harass, dismiss, or retaliate against a patient, a patient's representative, or an employee who makes a report under this section.

333.21799(a) Violation; complaint; investigation; disclosure; determination; listing violation and provisions violated; copies of documents; public inspection; report of violation; penalty; request for hearing; notice of hearing.

(1) A person who believes that this part, a rule promulgated under this part, or a federal certification regulation applying to a nursing home may have been violated may request an investigation of a nursing home. The request shall be submitted to the Department State Survey Agency—Michigan Department of Public Health as a written complaint or the Department shall
ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

assist the person in reducing an oral request to a written complaint within seven (7) days after the oral request is made.

(2) The substance of the complaint shall be provided to the licensee no earlier than at the commencement of the on-site inspection of the nursing home which takes place pursuant to the complaint.

(3) The complaint; a copy of the complaint; or a record published, released, or otherwise disclosed to the nursing home shall not disclose the name of the complainant or a [resident] named in the complaint unless the complainant or [resident] consents in writing to the disclosure or the investigation results in an administrative hearing or a judicial proceeding, or unless disclosure is considered essential to the investigation by the Department. If the disclosure is considered essential to the investigation, the complainant shall be given the opportunity to withdraw the complaint before disclosure.

(4) Upon receipt of a complaint, the Department shall determine, based on the allegations presented, whether this part, a rule promulgated under the part, or a federal certification regulation for nursing homes has been, is, or is in danger of being violated. The Department shall investigate the complaint according to the urgency determined by the Department. The initiation of a complaint investigation shall commence within 15 days after receipt of the written complaint by the Department.

(5) If, at any time, the Department determines that this part, a rule promulgated under this part, or a federal certification regulation for nursing homes has been violated, the Department shall list the violation and provisions violated on the state and federal licensure and certification forms for nursing homes. The violations shall be considered, as evidenced by a written explanation, by the Department when it makes a licensure and certification decision or recommendation.

(6) In all cases, the Department shall inform the complainant of its findings unless, otherwise indicated by the complainant. Within 30 days after the receipt of complaint, the Department shall provide the complainant a copy, if any, of the written determination, the correction notice, the warning notice, and the state licensure or federal certification form, or both, on which the violation is listed, or a status report indicating when these documents may be expected. The final report shall include a copy of the original complaint. The complainant may request additional copies of the documents listed in this subsection and shall reimburse the Department for the copies in accord with established policies and procedures.
ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

(7) A written determination, correction notice, or warning notice concerning a complaint shall be available for public inspection, but the name of the complainant or patient shall not be disclosed without the complainant’s or patient’s consent.

(8) A violation discovered as a result of the complaint investigation procedure shall be reported to persons administering sections 21799c to 21799e. The violation shall be assessed a penalty as described in this act.

(9) A complainant who is dissatisfied with the determination or investigation by the Department may request a hearing. A request for a hearing shall be submitted in writing to the Director within 30 days after the mailing of the Department’s findings as described in subsection (6). Notice of the time and place of the hearing shall be sent to the complainant and the nursing home. And any other provisions within the Michigan Public Health Code, if applicable.
The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

Michigan Public Health Code:

333.20155 Visits to health facilities and agencies; investigations or inspections; prior notice; misdemeanor; consultation visits; record; periodic reports; access to documents; confidentiality; disclosure and copies of records; delegation of functions; voluntary inspections; forwarding evidence of violation to licensing agency.

(1) Except as provided for clinical laboratories in Section 20511, the Department [Michigan Department of Public Health as the State Survey Agency] shall make annual and other visits to health facilities and agencies covered by this article, other than a licensee under Part 215, for the purposes of survey, evaluation, and consultation. Except for facilities described in Section 20106(1)(f) and (h) [i.e., home for the aged and nursing home], the Department shall determine whether the visits shall be announced or unannounced, except that a complaint investigation shall not be announced and there shall be at least one (1) unannounced visit other than a complaint investigation annually to the facilities described in Section 20106(1)(c) and (d) [i.e., county medical care facility and freestanding surgical outpatient facility]. The Department shall make biennial visits to hospitals for survey and for evaluation for the purpose of licensure. However, this requirement shall not be construed to prohibit the Department from conducting investigations or inspections pursuant to Section 20156 or from conducting surveys of hospitals for the purpose of complaint investigation or federal certification, nor to preclude the State Fire Marshal from conducting annual surveys of hospitals.

(2) Investigations or inspections, other than inspections of financial records of facilities described in Section 20106(1)(f) and (h) [i.e., home for the aged and nursing home], shall be conducted without prior notice to the facility. An employee of a state agency charged with inspecting the facility or an employee of a local health department who directly or indirectly gives prior notice regarding an inspection, other than an inspection of the financial records, to the facility or to an employee thereof, is guilty of a misdemeanor. Consultation visits, not for the purpose of annual or follow-up inspection or survey, may be announced.

(3) The Department shall maintain a record indicating whether visits are announced or unannounced. Information gathered at all visits, announced or unannounced, shall be taken into account in licensure decisions.
The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

Activities typically conducted on a routine or special basis include:

1. Surveyor attendance at HCFA-sponsored training on various issues related to LTC survey process and interpretations of requirements.
2. Monthly in-service training on general or specific issues identified as actual/potential inconsistency areas.
3. Upper-level management and quality assurance reviews of all surveys involving specified deficiencies prior to issuance of survey reports.
4. Periodic reviews of deficiency data for trends which may indicate significant deviations from national, regional, and state citation rates.
5. Special studies of survey processes and deficiency decision-making (e.g., during FY92 the State Survey Agency participated, as one of 10 selected states, in a study of OBRA survey process conducted by ABT Associates under a HCFA contract).
6. Analyses, in conjunction with HCFA, of Federal Monitoring Surveys conducted by HCFA surveyors subsequent to State surveys of providers on a sampled basis.
7. Informal reconsideration of deficiencies in cases where providers have cause to question validity and encouragement for providers to participate in survey process and exit conference.
8. Routine communications/meetings with provider and consumer organizations to discuss possible areas of inconsistency and/or misinterpretations.
9. Rotation of team leaders and other surveyors assigned to participate in individual surveys by each licensing unit. Rotation of providers assigned to each licensing unit.
10. Participation of quality assurance staff (senior surveyors) in surveys, either in an active surveyor role or as observers.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

(11) Ongoing activities related to consistent interpretations of regulations, through receipt and distribution of HCFA material and by identification of issues needing interpretation and/or clarification by HCFA.

(12) Participation in HCFA Surveyor Minimum Qualifications Test (SMQT).

(13) Participation in periodic provider training programs addressing the LTC requirement and interpretations, with intent of addressing perceived inconsistencies which are due to provider misinterpretations of requirements.

(14) Increased emphasis on proper documentation of deficiencies in survey reports, including use of HCFA "Principles of Documentation" guidelines published in 1992.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility’s compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

Michigan Public Health Code:
333.21799(a) Violation; complaint; investigation; disclosure; determination; listing violation and provisions violated; copies of documents; public inspection; report of violation; penalty; request for hearing; notice of hearing.

(1) A person who believes that this part, a rule promulgated under this part, or a federal certification regulation applying to a nursing home may have been violated may request an investigation of a nursing home. The request shall be submitted to the Department State Survey Agency—Michigan Department of Public Health as a written complaint or the Department shall assist the person in reducing an oral request to a written complaint within seven (7) days after the oral request is made.

(2) The substance of the complaint shall be provided to the licensee no earlier than at the commencement of the on-site inspection of the nursing home which takes place pursuant to the complaint.

(3) The complaint; a copy of the complaint; or a record published, released, or otherwise disclosed to the nursing home shall not disclose the name of the complainant or a [resident] named in the complaint unless the complainant or [resident] consents in writing to the disclosure or the investigation results in an administrative hearing or a judicial proceeding, or unless disclosure is considered essential to the investigation by the Department. If the disclosure is considered essential to the investigation, the complainant shall be given the opportunity to withdraw the complaint before disclosure.

(4) Upon receipt of a complaint, the Department shall determine, based on the allegations presented, whether this part, a rule promulgated under the part, or a federal certification regulation for nursing homes has been, is, or is in danger of being violated. The Department shall investigate the complaint according to the urgency determined by the Department. The initiation
ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Complaints and Monitoring

of a complaint investigation shall commence within 15 days after receipt of the written complaint by the Department.

(5) If, at any time, the Department determines that this part, a rule promulgated under this part, or a federal certification regulation for nursing homes has been violated, the Department shall list the violation and provisions violated on the state and federal licensure and certification forms for nursing homes. The violations shall be considered, as evidenced by a written explanation, by the Department when it makes a licensure and certification decision or recommendation.

(6) In all cases, the Department shall inform the complainant of its findings unless, otherwise indicated by the complainant. Within 30 days after the receipt of complaint, the Department shall provide the complainant a copy, if any, of the written determination, the correction notice, the warning notice, and the state licensure or federal certification form, or both, on which the violation is listed, or a status report indicating when these documents may be expected. The final report shall include a copy of the original complaint. The complainant may request additional copies of the documents listed in this subsection and shall reimburse the Department for the copies in accord with established policies and procedures.

(7) A written determination, correction notice, or warning notice concerning a complaint shall be available for public inspection, but the name of the complainant or patient shall not be disclosed without the complainant's or patient's consent.

(8) A violation discovered as a result of the complaint investigation procedure shall be reported to persons administering sections 21799c to 21799e. The violation shall be assessed a penalty as described in this act.

(9) A complainant who is dissatisfied with the determination or investigation by the Department may request a hearing. A request for a hearing shall be submitted in writing to the Director within 30 days after the mailing of the Department's findings as described in subsection (6). Notice of the time and place of the hearing shall be sent to the complainant and the nursing home.

And any other provisions within the Michigan Public Health Code, if applicable.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Employee Education about False Claims Recoveries

The Michigan Department of Community Health (MDCH), Medical Services Administration (MSA) conducts an annual review of all enrolled Medicaid providers, Medical Care Organizations (MCOs), Pre-paid Inpatient Hospital Plans (PIHPs), Program of All-Inclusive Care for the Elderly (PACE) contractors and any other entity that provides Medicaid health care items or services under Michigan's State Plan and waivers to determine those entities meeting the criteria covered by section 1902(a)(68) of the Social Security Act (SSA). Each provider, MCOs, PIHPs, PACE contractors and any other entity that provides Medicaid health care items or services under Michigan's State Plan and waivers meeting the criteria is sent an informational packet outlining the requirements of Section 6032 of the Deficit Reduction Act (DRA) of 2005 and their obligations and responsibilities under that mandate. This is done each year for all identified providers, MCOs, PIHPs, PACE contractors and any other entity that provides Medicaid health care items or services under Michigan's State Plan and waivers whether or not they received instructions in previous years.

For calendar year 2007, initial letters outlining the entities' responsibilities and notices of the requirement to provide attestation and a 'Certification of Compliance' were sent to all identified entities during the second calendar year quarter. The initial letters were sent April 5, 2007, followed by the notice and 'Certification of Compliance' on June 27, 2007. Beginning with calendar year 08 and on an annual basis thereafter, each identified entity receives a letter outlining their obligations and a 'Certification of Compliance' to be signed by an individual within the entity with attestation authority. The certification stipulates that the entity is in full compliance with the requirements of section 6032 of the Deficit Reduction Act of 2005. The notices and 'Certification of Compliance' are sent prior to the end of the first calendar year quarter of each year. For calendar year 07 and 08 and beyond, the entities have 60 days to return their attestations. Follow up to the attestation is conducted as part of the routine, ongoing monitoring and oversight of any entity conducted by the MDCH.
**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State of MICHIGAN

**Cooperation with Medicaid Integrity Program Efforts**

<table>
<thead>
<tr>
<th>Citation</th>
<th>4.43 Cooperation with Medicaid Integrity Program Efforts</th>
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<td>1902(a)(69) of the Act, P.L. 109-171 (section 6034)</td>
<td>The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.</td>
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**TN NO.: 08-05**

Approval Date: **JUL 17 2008**

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Supersedes

TN No.: **N/A**

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

State of MICHIGAN

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**Cooperation with Medicaid Integrity Program Efforts**

<table>
<thead>
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<th>Citation</th>
<th>4.44</th>
<th>Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States</th>
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<tbody>
<tr>
<td>1902(a)(80) of the Social Security Act, P.L. 111-148 (section 6505)</td>
<td></td>
<td>The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.</td>
</tr>
</tbody>
</table>

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Supersedes TN No.: N/A new page

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperation with Medicaid Integrity Program Efforts

Citation

1902(a)(77) 4.45 Provider Screening and Enrollment
1902(a)(39)
1902(kk);
P.L. 111-148
and
P.L. 111-152

42 CFR 455 Subpart E
PROVIDER SCREENING
☒ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

42 CFR 455.410 ENROLLMENT AND SCREENING OF PROVIDERS
☒ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.
☒ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.

42 CFR 455.412 VERIFICATION OF PROVIDERS LICENSES
☒ Assures that the State Medicaid agency has a method for verifying providers licensed by the State and that such providers licenses have not expired or have no current limitations.

42 CFR 445.414 REVALIDATION OF ENROLLMENT
☒ Assures that providers will be revalidated regardless of provider type at least every 5 years.

42 CFR 455.416 TERMINATION OR DENIAL OR ENROLLMENT
☒ Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

42 CFR 455.420 REACTIVATION OF PROVIDER ENROLLMENT
☒ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422 APPEAL RIGHTS
☒ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

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42 CFR 455.432 SITE VISITS ☒ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434 CRIMINAL BACKGROUND CHECKS ☒ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse of that category of provider.

42 CFR 455.436 FEDERAL DATABASE CHECKS ☒ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER ☒ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS ☒ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460 APPLICATION FEE ☒ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470 TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS ☒ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries’ access to medical assistance.

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SECTION 7: General Provisions
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

NONDISCRIMINATION

This certifies that the Statement of Compliance (Form CB-FS 5022) and the State agency's implementing methods of administration submitted on March 2, 1965 and June 15, 1965 as a part of the State CWS and PA Plans are hereby extended to the State Title XIX, Medical Assistance Program.

The State Plan for Medical Assistance will be administered in such a way that no person in the United States will, on the ground of race, color, sex or national origin, be excluded from participation in, be denied any aid, care, services, or other benefits of, or be otherwise subjected to discrimination in the program under the State Plan.

In addition to the previously submitted implementing methods, the State agency will:

1. Provide an informational pamphlet to all persons requesting medical assistance which outlines the guarantees afforded them by the Civil Rights Act and the manner in which those subjected to discrimination may obtain redress.

2. Provide a separate pamphlet to all persons requesting or providing assistance outlining the requirements of the Civil Rights Act as it relates to departmental operations, and the rights of all persons receiving services from the department or from vendor agencies and organizations. This pamphlet will also outline grievance procedures which may be followed in the event of alleged discrimination.

3. Assure that all medical institutions, agencies, and organizations providing services under the program have signed a statement of compliance either as a condition of participation under Title XVIII, as a condition of receiving other Federal funds or specifically for this program.

4. Require a certification on all bills submitted by providers of services who have not signed a statement of compliance that the services were rendered in accordance with the provisions of the Civil Rights Act of 1964.