



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 January 1, 2025.

Amendments pending approval or approved since January 1, 2025, may be found at:

www.michigan.gov/mdhhs >> Inside MDHHS >> Budget and Finance >> State Plan Amendments

[State Plan Amendments \(michigan.gov\)](http://www.michigan.gov/mdhhs)

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.

1	Single State Agency Organization	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.
2	Coverage & Eligibility	outlines Michigan Medicaid's eligibility conditions such as income, resources, assets and the various groups (i.e. aged, blind, disabled and family independence program)
3	Amount, Duration and Scope of Services Provided	Attachment 3.1-A lists the services covered under the Michigan Medicaid program and the Supplements to Attachment 3.1-A provide a more detailed description of those services, including any limitations or requirements to/for that coverage
4	General Program Administration	Medicaid reimbursement methodologies takes up the bulk of Section 4; specifically Attachment 4.19. Attachment 4.19-A provides a full description of inpatient hospital reimbursement, Attachment 4.19-B explains reimbursement to all providers except inpatient hospital and long term care facilities. Attachment 4.19-D covers Medicaid payment for long term care facilities.
5	Personnel Administration	provides assurances the State is in compliance with Federal Regulations regarding personnel administration standards and training.



Michigan Department of Health and Human Services

Medicaid State Plan



6	Financial Administration	provides assurances the State is in compliance with Federal Regulations regarding fiscal policies and accountability, cost allocation and financial participation.
7	General Provisions	covers additional federal requirements such as State Plan amendments, nondiscrimination and the Governor's review.

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

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

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No. 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: MICHIGAN

TABLE OF CONTENTS

<u>SECTION</u>	<u>PAGE NUMBERS</u>
State Plan Submittal Statement	1
SECTION 1 - SINGLE STATE AGENCY ORGANIZATION	2
1.1 Designation and Authority	2
1.2 Organization for Administration	7
1.3 Statewide Operation	8
1.4 State Medical Care Advisory Committee	9

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<u>SECTION</u>	<u>PAGE NUMBERS</u>
SECTION 2 - COVERAGE AND ELIGIBILITY	10
2.1 Application, Determination of Eligibility and Furnishing Medicaid	10
2.2 Coverage and Conditions of Eligibility	12
2.3 Residence	13
2.4 Blindness	14
2.5 Disability	15
2.6 Financial Eligibility	16
2.7 Medicaid Furnished Out of State	18

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<u>SECTION</u>	<u>PAGE NUMBERS</u>
SECTION 3 - SERVICES: GENERAL PROVISIONS	19
3.1 Amount, Duration, and Scope of Services	19
3.2 Coordination of Medicaid with Medicare Part B	29
3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases	30
3.4 Special Requirements Applicable to Sterilization Procedures	31
3.5 Medicaid for Medicare Cost Sharing for Qualified Medicare Beneficiaries	31a
3.6 Ambulatory Prenatal Care for Pregnant Women during Presumptive Eligibility Period	31b

<u>SECTION</u>	<u>PAGE NUMBERS</u>
SECTION 4 - GENERAL PROGRAM ADMINISTRATION	32
4.1 Methods of Administration	32
4.2 Hearings for Applicants and Recipients	33
4.3 Safeguarding Information on Applicants and Recipients	34
4.4 Medicaid Quality Control	35
4.5 Medicaid Agency Fraud Detection and Investigation Program	36
4.6 Reports	37
4.7 Maintenance of Records	38
4.8 Availability of Agency Program Manuals	39
4.9 Reporting Provider Payments to the Internal Revenue Service	40
4.10 Free Choice of Providers	41
4.11 Relations with Standard-Setting and Survey Agencies	42
4.12 Consultation to Medical Facilities	44
4.13 Required Provider Agreement	45
4.14 Utilization Control	46
4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases	51
4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees	52
4.17 Liens and Recoveries	53
4.18 Cost Sharing and Similar Charges	54
4.19 Payment for Services	57

<u>SECTION</u>	<u>PAGE NUMBERS</u>
4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services	67
4.21 Prohibition Against Reassignment of Provider Claims	68
4.22 Third Party Liability	69
4.23 Use of Contracts	71
4.24 Standards for Payments for Skilled Nursing and Intermediate Care Facility Services	72
4.25 Program for Licensing Administrators of Nursing Homes	73
4.26 RESERVED	74
4.27 Disclosure of Survey Information and Provider or Contractor Evaluation	75
4.28 Appeals Process for Skilled Nursing and Intermediate Care Facilities	76
4.29 Conflict of Interest Provisions	77
4.30 Exclusion of Providers and Suspension of Practitioners Convicted and Other Individuals	78
4.31 Disclosure of Information by Providers and Fiscal Agents	79
4.32 Income and Eligibility Verification System	79
4.33 Medicaid Eligibility Cards for Homeless Individuals	79a
4.34 Systematic Alien Verification for Entitlements	79b
4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation	79c

v

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<u>SECTION</u>	<u>PAGE NUMBERS</u>
SECTION 5 - PERSONNEL ADMINISTRATION	80
5.1 Standards of Personnel Administration	80
5.2 RESERVED	81
5.3 Training Programs; Subprofessional and Volunteer Programs	82

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<u>SECTION</u>	<u>PAGE NUMBERS</u>
SECTION 6 - FINANCIAL ADMINISTRATION	83
6.1 Fiscal Policies and Accountability	83
6.2 Cost Allocation	84
6.3 State Financial Participation	85

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<u>SECTION</u>	<u>PAGE NUMBERS</u>
SECTION 7 - GENERAL PROVISIONS	86
7.1 Plan Amendments	86
7.2 Nondiscrimination	87
7.3 Maintenance of AFDC Effort	88
7.4 State Governor's Review	89

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LIST OF ATTACHMENTS

No. Title of Attachments

- *1.1-A Attorney General's Certification
- *1.1-B Waivers under the Intergovernmental Cooperation Act
- 1.2-A Organization and Function of State Agency
- 1.2-B Organization and Function of Medical Assistance Unit
- 1.2-C Professional Medical and Supporting Staff
- 1.2-D Description of Staff Making Eligibility Determination
- *2.2-A Groups Covered and Agencies Responsible for Eligibility Determinations
 - * Supplement 1 - Reasonable Classifications of Individuals under the Age of 21, 20, 19 and 18
 - * Supplement 2 - Definitions of Blindness and Disability (Territories only)
 - * Supplement 3 - Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
- *2.6-A Eligibility Conditions and Requirements (States only)
 - * Supplement 1 - Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
 - * Supplement 2 - Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and other Optional Groups
 - * Supplement 3 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
 - * Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program
- *Forms Provided

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<u>No.</u>	<u>Title of Attachment</u>
* Supplement 5 -	Section 1902(f) Methodologies for Treatment of Resources that Differ from those of the SSI Program
* Supplement 5a-	Methodologies for Treatment of Resources for Individuals With Incomes Up to a Percentage of the Federal Poverty Level
* Supplement 6 -	Standards for Optional State Supplementary Payments
* Supplement 7 -	Income Levels for 1902(f) States - Categorically Needy Who Are Covered under Requirements More Restrictive than SSI
* Supplement 8 -	Resource Standards for 1902(f) States - Categorically Needy
* Supplement 8a-	More Liberal Methods of Treating Income Under Section 1902(r)(2) of the Act
* Supplement 8b-	More Liberal Methods of Treating Resources Under Section 1902(r)(2) of the Act
* Supplement 9 -	Transfer of Resources
* Supplement 10-	Consideration of Medicaid Qualifying Trusts--Undue Hardship
* Supplement 11-	Cost-Effective Methods for COBRA Groups (States and Territories).
*2.6-A	Eligibility Conditions and Requirements (Territories only)
* Supplement 1 -	Income Eligibility Levels - Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries
* Supplement 2 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
* Supplement 3 -	Resource Levels for Optional Groups with Incomes Up to a Percentage of the Federal Poverty Level and Medically Needy
* Supplement 4 -	Consideration of Medicaid Qualifying Trusts--Undue Hardship
* Supplement 5 -	More Liberal Methods of Treating Income under Section 1902(r)(2) of the Act
* Supplement 6 -	More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

*Forms Provided

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*4.18-A	Charges Imposed on Categorically Needy
*4.18-B	Medically Needy - Premium
*4.18-C	Charges Imposed on Medically Needy
4.19-A	Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care
4.19-B	Methods and Standards for Establishing Payment Rates - Other Types of Care
4.19-C	Payments for Reserved Beds
4.19-D	Methods and Standards for Establishing Payment Rates - Skilled Nursing and Intermediate Care Facility Services
4.19-E	Timely-Claims Payment - Definition of Claim
4.20-A	Conditions for Direct Payment for Physicians' and Dentists' Services
*4.22-A	Requirements for Third Party Liability--Identifying Liable Resources
*4.22-B	Requirements for Third Party Liability--Payment of Claims
*4.32-A	Income and Eligibility Verification System Procedures: Requests to Other State Agencies
*4.33-A	Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals
*4.35-A	Criteria for the Application of Specified Remedies for Skilled Nursing and Intermediate Care Facilities
*4.35-B	Alternative Remedies to Specified Remedies for Skilled Nursing and Intermediate Care Facilities
7.2-A	Methods of Administration - Civil Rights (Title VI)

***Forms Provided**

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August 1991

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

State/Territory: MICHIGAN

Citation

As a condition for receipt of Federal funds under
title XIX of the Social Security Act, the

42 CFR
430.10

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. 96-0702 Approval Date 9-23-96 Effective Date 04/01/96

Supersedes

TN No. 92-01

HCFA ID: 7982E

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

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 9-23-96 Effective Date 04/01/96

Supersedes

TN No. 74-48

Revision: HCFA-AT-30-38 (BPP)
May 22, 1980

State MICHIGAN

Citation
Sec. 1902(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.

☒ 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
TN #

Approval Date 4/26/76 Effective Date 1/01/74

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

State MICHIGAN

Citation
Intergovernmental
Cooperation Act
of 1968

1.1(c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

☒ Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

☐ Not applicable. Waivers are no longer in effect.

Not applicable. No waivers have ever been granted.

TN # 74-48

Supersedes _____

TN # _____

Approval Date 4/26/76

Effective Date 1/01/74

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

State MICHIGAN

Citation

42 CFR 431.10
AT-79-29

1.1(d) ☒ 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.

TN # 74-48

Supersedes _____

TN # _____

Approval Date 4/26/76

Effective Date 1/01/74

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

State MICHIGAN

Citation
42 CFR 431.10
AT-79-29

1.1(e) 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.

(f) All other requirements of 42 CFR 431.10 are met.

TN # 76-58
Supersedes _____
TN # _____

Approval Date 12/30/76 Effective Date 12/03/76

State of Michigan

Citation
42 CFR 431.11

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.

TN NO. 02-08

Approval Date 6/19/02

Effective Date 02/01/2002

Supersedes
TN No. 96-10

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

State MICHIGAN

Citation
42 CFR
431.50 (b)
AT-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

☒ The plan is State administered.

☐ The plan is administered by the political subdivisions of the State and is mandatory on them.

TN # 74-44

Supersedes

TN #

Approval Date 3/27/75

Effective Date 10/01/74

MICHIGAN MEDICAID STATE PLAN

9

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

State: Michigan

Citation

42 CFR 431.12(b) 1.4.a. 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.

42 CFR 438.104

☒ 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.

b. 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.

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Supersedes
TN No.: 03-13

Approval Date MAR 30 2011

Effective Date: 07/01/2010

MICHIGAN MEDICAID STATE PLAN

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

State: Michigan

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.

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Supersedes
TN No.: New

Approval Date MAR 30 2011

Effective Date: 07/01/2010

Revision: HCFA-PM-94-3 (MB)
 APRIL 1994
 State/Territory: MICHIGAN

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.

TN No. 94-20
 Supersedes
 TN No. N/A

Approval Date 10-14-94 Effective Date 10-01-94

Revision: HCFA-PM-94-3 (MB)

APRIL 1994

State/Territory: MICHIGANCitation

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 AgencyTN No. 74-30

Supersedes

N/A

TN No. Approval Date 10-14-94Effective Date 10/01/94

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

OMB No.: 0938-

State: MICHIGAN

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation
42 CFR
435.10 and
Subpart J

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.

TN No. 92-01
Supersedes
TN No. 75-46

Approval Date 9-11-92

Effective Date 10/01/91

HCFA ID: 7982E

MICHIGAN MEDICAID STATE PLAN

11

Revision: HCFA-PM- (MB)

State: Michigan

Citation

42 CFR
435.914
1902(a)(34)
of the Act

2.1(b) (1) 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.

1902(e)(8) and
1905(a) of the
Act

(2) 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.

1902(a)(47) and

(3) 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.

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Approval Date 12/9/2015

Effective Date: 08/13/2003

Supersedes
TN No.: 93-07

Revision: HCFA-PM-91-8 (MB)
October 1991

OMB No.

State/Territory: MICHIGAN

Citation

1902(a)(55) 2.1(d) 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.

TN No. 91-30

Supersedes

TN No. 91-22

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Effective Date 10-01-91

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

OMB No.: 0938-

State: MICHIGAN

Citation
42 CFR
435.10

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)(i)(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.

TN No. 42-21

Supersedes

TN No. 87-11

Approval Date 9-11-92

Effective Date 10/01/91

HCFA ID: 7982E

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State: MICHIGAN

Citation
435.10 and
435.403, and
1902(b) of the
Act, P.L. 99-272
(Section 9529)
and P.L. 99-509
(Section 9405)

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.

TN No. 87-11
Supersedes
TN No. 86-12

Approval Date 08/26/87

Effective Date 10/21/86

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State: MICHIGAN

Citation

42 CFR 435.530(b)

42 CFR 435.531

AT-78-90

AT-79-29

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.

TN No. 87-11

Supersedes
TN No. 75-50

Approval Date 08/26/87

Effective Date 04/01/87

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

OMB No. 0938-

State: MICHIGAN

Citation
42 CFR
435.121,
435.540(b)
435.541

2.5 Disability

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.

TN No. 93-61
Supersedes
TN No. 91-18

Approval Date 9-11-92

Effective Date 10/01/91

HCFA ID: 7982E

Revision: HCFA-PM-92-1
FEBRUARY 1992

(MB)

16-17

State: MICHIGAN

Citation(s)

2.6 Financial Eligibility

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

- (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.

TN No. 92-74
Supersedes Approval Date 04-16-92 Effective Date 01-01-92
TN No. 92-01

Revision: HCFA-PM-86-20 (BERC)
SEPTEMBER 1986

OMB-No. 0938-0193

State/Territory: MICHIGAN

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.

TN NO. 86-12
Supersedes
TN NO. 82-23

Approval Date 02/02/87

Effective Date 11/01/86

HCFA ID:0053C/0061E

Revision: HCFA-PM-94-5 (MB)
APRIL 1994

State/Territory: MICHIGAN

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR
Part 440,
Subpart B
1902(a), 1902(e),
1905(a), 1905(p),
1915, 1920, and
1925 of the Act

- (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:

1902(a)(10)(A) and
1905(a) of the Act

- (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.

TN No. 94-14
Supersedes
TN No. 92-01 Approval Date 07-11-94 Effective Date 04/01/94

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

OMB No.: 0938-

State/Territory: MICHIGAN

Citation 3.1(a)(1) 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.

/X/ (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.

TN No. 92-01

Supersedes

TN No. 90-11

Approval Date 9-11-92

Effective Date 10/01/91

HCFA ID: 7982E

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: MICHIGAN

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

- | | | |
|---------------------------------|-------------------|---|
| | (vi) | Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan. |
| 1902(e)(7) of the Act | (vii) | Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(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. |
| 1902(e)(9) of the Act | <u>X</u> (viii) | Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan. |
| 1902(a)(52) and 1925 of the Act | (ix) | Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan. |
| 1905(a)(23) and 1929 | <u> </u> (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. |

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.

TN No. 93-06
Supersedes
TN No. 92-01

Approval Date

4-29-93

Effective Date

01-01-93

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)
1934 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.)

RECEIVED

TN No. 00-11

Approval Date 1-3-2001

Effective Date 01/01/2001

Supersedes
TN No. N/A – new page

DMCH - MI/MN/WI

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

OMB No.: 0938-

State/Territory: MICHIGAN

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440, (a)(2) Medically needy.
Subpart B

☒ 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:

42 CFR 440.220
1902(a)(10)(C)(iv)
of the Act

- (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.

☐ Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of
the Act

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

TN No. 92-01

Supersedes

TN No. 87-11

Approval Date 9-11-92

Effective Date 10-01-91

HCFA ID: 7982E

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

OMB No.: 0938-

State/Territory: MICHIGAN

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,

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

442.441,
Subpart C
1902(a)(20)

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

and (21) of the Act

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

TN No. 92-01

Supersedes

TN No. 90-01

Approval Date 9-11-92

Effective Date 10-01-91

HCFA ID: 7982E

Revision: HCFA-PM-93- 5 (MB)
MAY 1993

State: MICHIGAN

Citation

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

1902(e)(9) of
Act

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

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

- (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.

TN No. 93-29
Supersedes 93-06 Approval Date 12-7-93 Effective Date 10-1-93

State of Michigan
PACE State Plan Amendment Pre-Print

<u>Citation</u>	3.1(a)(2)	<u>Amount, Duration and Scope of Services: Medically Needy</u> (continued)
1905(a)(26) and 1934	(xii) <u>X</u>	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.)

TN No. 00-11

Approval Date 8-3-2001

Effective Date 10/01/00

Supersedes

TN No. N/A – new page

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

State: _____

Citation

3.1 Amount, Duration, and Scope of Services (continued)

- | | |
|---|---|
| <p>1902(a)(10)(E)(i)
and clause (VIII)
of the matter
following (F),
and 1905(p)(3)
of the Act</p> | <p>(a)(3) <u>Other Required Special Groups: Qualified Medicare Beneficiaries</u></p> <p>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.</p> |
| <p>1902(a)(10)
(E)(ii) and
1905(s) of the
Act</p> | <p>(a)(4)(i) <u>Other Required Special Groups: Qualified Disabled and Working Individuals</u></p> <p>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.</p> |
| <p>1902(a)(10)
(E)(iii) and
1905(p)(3)(A)(ii)
of the Act</p> | <p>(ii) <u>Other Required Special Groups: Specified Low-Income Medicare Beneficiaries</u></p> <p>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.</p> |
| <p>1902(a)(10)
(E)(iv)(I) 1905(p)(3)
(A)(ii), and 1933 of
the Act</p> | <p>(iii) <u>Other Required Special Groups: Qualifying Individuals - 1</u></p> <p>Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.</p> |

TN No. 92-01

Supersedes

TN No. 92-20

92-1

Approval Date 5/22/98 Effective Date 2/1/98

Enclosure 3 Continued

21-continued

Revision: HCFA-PM-97-3 (CMSO)
December 1997State: MICHIGAN1902(a)(10)
(E)(iv)(II), 1905(p)(2)
(A)(iv)(II), 1905(p)(3)
the Act(iv) Other Required Special Groups: Qualifying
Individuals - 2

The portion of the amount of increase to the Medicare Part 3 premium attributable to the Extra Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

1925 of the
Act

(1)(5)

Other Required Special Groups: Families
Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.3 of this plan.

TN No. 98-01

Supersedes

TN No. 92-01

Approval Date

5/22/98

Effective Date

02/01/98

21a

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

State: Michigan

Citation

Sec 245A(h)
of the
Immigration and
Nationality Act

(a)(6) 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 501(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.

TN No. 98-01
Supersedes
TN No. 96-22

Approval Date 5/22/98 Effective Date 2/1/98

MICHIGAN MEDICAID STATE PLAN

21b

Revision: HCFA-PM-91-4
August 1991

OMB No.: 0938-

State: Michigan

Citation

Amount, Duration, and Scope of Services:

1902(a) and
1903(v) of the Act

3.1(a)(6) 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.

1905(a)(9) of the
Act

(a)(7) 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.

1902(a)(47) and
1920 of the Act

(a)(8) 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.

42 CFR 441.55,
50 FR 43654,
1902(a)(43),
1905 (a)(4)(B),
and 1905 (r) of
the Act

(a)(9) 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.

TN No.: 05-05

Approval Date 4/25/05

Effective Date: 01/01/2005

Supersedes
TN No.: 92-01

- MICHIGAN MEDICAID STATE PLAN

22

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

OMB No.: 0938-

State: Michigan

Citation	3.1(a)(9)	Amount, Duration, and Scope of Services: EPSDT Services (continued)
42 CFR 441.60	[x]	<p>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.</p> <p>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.</p> <p>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.</p> <p>The Medicaid agency can compare the number of children due or overdue for EPSDT visits with the number of such visits provided.</p>
42 CFR 440.240 and 440.250	(a)(10)	<p>Comparability of Services</p> <p>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:</p> <p>(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.</p> <p>(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.</p> <p>(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.</p> <p>[x] (iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.</p> <p>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.</p>

TN No.: 03-13

Approval Date 12/9/2003

Effective Date: 08/13/2003

Supersedes
TN No.: 95-05

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

State MICHIGAN

Citation
42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

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
TN #

Approval Date 3/03/77 Effective Date 3/31/77

Revision: HCFA-PM-93-8 (BPD)
December 1993

State/Territory: MICHIGAN

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).

TN No. 94-07
Supersedes
TN No. 93-36

Approval Date 4-12-94 Effective Date 01/01/94

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

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
Supersedes
TN # _____

Approval Date 3/27/75

Effective Date 10/01/74

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

State MICHIGAN

Citation
42 CFR 441.20
AT-78-90

3.1(e) Family Planning Services

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACTState/Territory: MICHIGAN**Citation** 3.1 (f)(1)42 CFR
441.30
AT-78-90Optometric 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.

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

(2)

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.

TN NO.: 12-08Approval Date: JUL 31 2012Effective Date: 04/01/2012Supersedes
TN No.: 87-11

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: MICHIGAN.

Citation
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of
the Act,
P.L. 99-509
(Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

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--
 X 30 consecutive days;
 1 ___ 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.

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

 1 Not applicable. These services are not included in the plan.

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

Approval Date 01-14-83

Effective Date 12-23-77

HCFA ID: 1008P/0011P

28(a)

Revision: HCFA-PM-91-
1991

(MB)

State/Territory: Michigan

Citation

1905(a)(24) and
1930 of the Act
P.L. 101-508
(Section 4712
OBRA 90)

3.1(i)

Community supported living
arrangements services

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.

TN No. 96-006

Supercedes

No. 91-37

Approval Date: 07-07-96

Effective Date 04/01/96

Revision: HCFA-PM-93-5 (MB)
MAY 1993

State: MICHIGAN

Citation 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.

TN No. 93-24
Supersedes TN No. 90-23 Approval Date 12-7-93 Effective Date 10-01-93

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.

TN No. 99-01

Supersedes

Approval Date

5-17-99

Effective Date

1-1-99 4-1-99

TN No. 92-01, 98-01

RTH

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)(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.

TN No. 98-C1

Approval Date 5/22/98

Effective Date 02/01/98

Supersedes
TN No. 92-01

Enclosure 3 continued

29b

Revision: HCFA-PM-97-3 (CMCO)
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, IIV, 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

 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: 21-0017

Approval Date: JAN 14, 2022

Effective Date: 01/01/2022

Supersedes

TN NO: 98-01

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: MICHIGAN

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n),
1905(a), and 1916 of the Act

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)(E)(i) and
1905(p)(3) 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.

1902(a)(10), 1902(a)(30),
and 1905(a) 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:

42 CFR 431.625

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.

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).

TN No. 93-07

Supersedes

TN No. 92-01

Approval Date

5-17-99

Effective Date

1-1-93

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

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.

TN # 74-2
Supersedes
TN # _____

Approval Date 7/05/74 Effective Date 1/15/74

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

State MICHIGAN

Citation
42 CFR 441.252
AT-78-99

3.4 Special Requirements Applicable to
Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F
are met.

TN # 79-4
Supersedes
TN # _____

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

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

OMB No.: 0938-

State: MICHIGAN

Citation

1902(a)(52)
and 1925 of
the Act

3.5 Families Receiving Extended Medicaid Benefits

- (a) 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.

TN No. 93-01

Supersedes

Approval Date

9-11-92

Effective Date

10-01-91

TN No. 89-18

HCFA ID: 7982E

31b

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

OMB No.: 0938-

State: MICHIGAN

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.

TN No. 92-01
Supersedes TN No. 87-11 Approval Date 9-11-92 Effective Date 10-01-91

HCFA ID: 7982E

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

OMB No.: 0938-

State: MICHIGAN

Citation 3.5 Families Receiving Extended Medicaid Benefits
(Continued)

- (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

- ☐ 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).

TN No. 98-01
Supersedes
TN No. 90-11

Approval Date 9-11-92

Effective Date 10-01-91

HCFA ID: 7982E

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

OMB No.: 0938-

State: MICHIGAN

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).

TN No. 92-01
Supersedes Approval Date 9-11-92 Effective Date 10-01-91
TN No. 90-11

HCFA ID: 7982E

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: MICHIGAN

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

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.

TN No. 87-11
Supersedes
TN No. 74-2

Approval Date 08/26/87

Effective Date 04/01/87

HCFA ID: 1010P/0012P

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

State MICHIGAN

Citation
42 CFR 431.202
AT-79-29
AT-80-34

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.

TN # 74-2

Supersedes

TN #

Approval Date 7/05/74

Effective Date 1/15/74

Revision: HCFA-AT-87-9 (BERC)
AUGUST 1987

OMB No.: 0938-0193

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.

52 FR 5967

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

TN No. 87-19
Supersedes
TN No. 74-2

Approval Date 01-14-88

Effective Date 01-15-74

HCFA ID: 1010P/0012P

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: MICHIGAN

Citation
42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of
the Act,
P.L. 99-509
(Section 9407)

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).

☐ Yes.

☒ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

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

Approval Date 08/26/87

Effective Date 04/01/87

HCFA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: MICHIGAN

Citation
42 CFR 455.12
AT-78-90
48 FR 3742
52 FR 48817

4.5 Medicaid Agency Fraud Detection and Investigation
Program

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.

TN No. 88-19
Supersedes
TN No. 83-11

Approval Date 11-29-88

Effective Date 10-01-88

HCFA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERC)

SEPTEMBER 1988

State: MICHIGANCitation

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.

Revision: HCFA-PM-88-10 (BERC)

SEPTEMBER 1988

State: MICHIGANCitation

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.

TN NO.: 10-23Approval Date: MAR 09 2011Effective Date: 04/01/2011

Supersedes
TN No.: NEW

Revision: 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.

TN # 74-2
Supersedes
TN # _____

Approval Date 7/05/74 Effective Date 1/15/74

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

State MICHIGAN

Citation
42 CFR 431.17
AT-79-29

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.

TN # 74-2

Supersedes

TN #

Approval Date 7/05/74

Effective Date 1/15/74

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

State MICHIGAN

Citation
42 CFR 431.18 (b)
AT-79-29

4.8 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.

74-2
Supersedes
TN #

Approval Date 7/05/74 Effective Date 1/15/74

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

State MICHIGAN

Citation
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

TN #

Approval Date 7/05/74

Effective Date 1/15/74

New: HCFA-PM-99-3
JUNE 1999

State: Michigan

Citation

4.10 Free Choice of Provider

42 CFR 431.51
AT 78-90
46 FR 48524
46 FR 23212
1902(a)(23) of the Act
P.L. 100-93
(section 8(f))
P.L 100-203
(section 4113)

- (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,
- (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).

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

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

- (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).

TN No.:04-06
Supersedes
TN No.: 03-13

Approval Date SEP 03 2004

Effective Date: 07/01/2004

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

State MICHIGAN

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

- (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.

TN No. 96-042 Approval Date 9-23-96 Effective Date 4-1-96

Supersedes

TN No. 74-35

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

State MICHIGAN

<u>Citation</u> 42 CFR 431.610 AT-78-90 AT-89-34	4.11(d) The <u>Michigan Department of Consumer and Industry Services</u> (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.
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TN No. 96-010 Approval Date 9-23-96 Effective Date 4-1-96

Supersedes

TN No. 74-35

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

State MICHIGAN

Citation
42 CFR 431.105 (b)
AT-78-90

4.12 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).

☒ Yes, as listed below:

Institutions for Mental Diseases

☐ Not applicable. Similar services are not provided to other types of medical facilities.

TN # 75-14

Supersedes

TN #

Approval Date 8/08/75

Effective Date 4/01/75

MICHIGAN MEDICAID STATE PLAN

45

Revision: HCFA-PM-91-9 (MB)
October 1991

State: Michigan

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

- | | |
|-------------------------------------|---|
| 42 CFR 431.107 | (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met. |
| 42 CFR Part 483,
1919 of the Act | (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are met. |
| 42 CFR Part 483,
Subpart D | (c) For providers of ICF/MR services, the requirements of participation in 42 CFR 483, Subpart D are also met. |
| 1920 of the Act | (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.

TN No.: 05-05

Approval Date 4/25/05

Effective Date: 01/01/2005

Supersedes
TN No.: 92-01

MICHIGAN MEDICAID STATE PLAN

45(a)

Revision: HCFA-PM-91-9 (MB)
October 1991

State: Michigan

Citation

1902 (a)(58)

1902(w)

4.13

(e)

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

TN No.: 03-13

Approval Date 12/9/2003

Effective Date: 08/13/20023

Supersedes

TN No.: 91-29

MICHIGAN MEDICAID STATE PLAN

45(b)

Revision: HCFA-PM-91-9
October 1991

State: Michigan

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.

TN No.: 03-13

Approval Date 12/7/2003

Effective Date: 08/13/2003

Supersedes
TN No.: 91-29

Revision: HCFA-PM-91-10 (MB)
December, 1991

State: Michigan

<u>Citation</u>	<u>4.14</u>	<u>Utilization/Quality Control</u>
42 CFR 431.60 42 CFR 456.2 50 FR 15312 1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)	(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: <u>X</u> Directly <u>X</u> 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 — (1) Meets the requirements of §434.6(a): (2) Includes a monitoring and evaluation plan to ensure satisfactory performance; (3) Identifies the services and providers subject to PRO review; (4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and (5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.
1932(c)(2) and 1902(d) of the Act, P.L. 99-509 (section 9431)	<u>X</u>	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.

TN No.: 03-13

Approval Date 12/7/2003

Effective Date: 08/13/2003

Supersedes
TN No.: 92-10

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: MICHIGAN

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

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.

TN No. 88-7
Supersedes
TN No. 85-21

Approval Date 04/06/88

Effective Date 02/01/88

HCFA ID: 0048P/0002P

Revision: HCFA-PM-85-7 (BERC)
JULY 1985

OMB NO.: 0938-0193

State/Territory: MICHIGAN

Citation
42 CFR 456.2
50 FR 15312

4.14 (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.

TN No. 38-7
Supersedes
TN No. 85-21

Approval Date 04/06/88

Effective Date 02/01/88

HCFA ID: 0048P/0002P

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: MICHIGAN

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

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.

TN No. 85-21
Supersedes
TN No. 75-44

Approval Date 08/27/85

Effective Date 06/01/85

HCFA ID: 0048P/0002P

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: MICHIGAN

OMB NO. 0938-0193

Citation

42 CFR 456.2
50 FR 15312

4.14 ☒ (e) 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.

TN No. 85-21
Supersedes
TN No. 75-44

Approval Date 08/27/85

Effective Date 06/01/85

HCFA ID: 0048P/0002P

MICHIGAN MEDICAID STATE PLAN

50a

Revision: HCFA-PM-91-10
December 1991

State: Michigan

Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e) 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.

42 CFR 438.354
42 CFR 438.356(b) and (d) 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

TN No.: 03-13

Approval Date 12/9/2003

Effective Date: 08/13/2003

Supersedes
TN No.: 94-02

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: MICHIGAN

Citation 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

42 CFR Part
456 Subpart
I, and
1902(a)(31)
and 1903(g)
of the Act

— The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

— ICFs/MR;

— Inpatient psychiatric facilities for recipients under age 21; and

— Mental Hospitals.

42 CFR Part
456 Subpart
A and
1902(a)(30)
of the Act

X All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

— Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

— 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.

— Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

TN No. 92-25
Supersedes
TN No. 76-17

Approval Date 10-28-92

Effective Date 07-01-92

HCFA ID: _____

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

State MICHIGAN

Citation
42 CFR 431.615 (c)
AT-78-90

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.

TN # 74-2
Supersedes
TN # _____

Approval Date 7/05/74 Effective Date 1/15/74

Revision: HCFA-PM-95-3 (MB)

May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGANCitation(s)42 CFR 433.36
(c) 1902(a) (18)
and 1917(a) and
(b) of The Act

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.

TN NO.: 10-018Approval Date: MAY 23 2011Effective Date: 07/01/2010

Supersedes

TN No.: 83-3

Revision: HCFA-PM-95-3 (MB)

May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN(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.

☒ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

- (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).

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Supersedes

TN No.: 83-3

Revision: HCFA-PM-95-3 (MB)

May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN4.17 (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.

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Supersedes

TN No.: NEW PAGE

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

Citation(s)

- (4) ☐ 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

Revision: HCFA-PM-95-3 (MB)

May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

(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.

TN NO.: 10-018Approval Date: MAY 23 2011Effective Date: 07/01/2010

Supersedes

TN No.: NEW PAGE

Revision: HCFA-PM-95-3 (MB)

May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN(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

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TN No.: NEW PAGE

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

- (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.

TN NO.: 10-018

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TN No.: NEW PAGE

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

RESERVED

TN NO.: 13-16

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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

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TN No.: 92-01

HCFA ID: 7982E

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

OMB No.: 0938-

State/Territory: MICHIGAN

Citation

1916(c) of
the Act

4.18(b)(4) ☐ 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.

1902(a)(52)
and 1925(b)
of the Act

4.18(b)(5) ☒ 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.

1916(d) of
the Act

4.18(b)(6) ☐ 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.

TN No. 93-01

Supersedes

TN No. 86-12

Approval Date

9-11-92

Effective Date

10-01-91

HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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TN NO.: 13-16

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TN No.: 92-01

HCFA ID: 7982E

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

OMB No.: 0938-

State/Territory: MICHIGAN

Citation 4.19 Payment for Services

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

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

☒ 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.

☐ Inappropriate level of care days are not covered.

TN No. 92-01
Supersedes Approval Date 9-11-92 Effective Date 10-01-91
TN No. 87-11

HCFA ID: 7982E

Revision: HCFA-PM-93- 6
August 1993

(MB)

OMB No.: 0938-

State/Territory: MICHIGAN

Citation

42 CFR 447.201
42 CFR 447.302
52 FR 28648
1902(a)(13)(E)
1903(a)(1) and
(n), 1920, and
1926 of the Act

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.

No. 94-12
Supersedes
TN No. 92-01

Approval Date 06-30-94 Effective Date 04/01/94

TN

HCFA-PM-93-6-219:80149

Revision: 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
TN # _____

Approval Date 1/20/78 Effective Date 10/01/77

State/Territory: MICHIGAN

Citation

4.19 (d)

42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

- ☒ (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 SNFs 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 SNF 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.

TM No. 91-32

Supersedes

TM No. 87-19

Approval Date 3-29-93

Effective Date 10-02-91

HCFA ID: 1010P/0012P

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

State MICHIGAN

Citation
42 CFR 447.45 (c)
AT-79-50

4.19 (e) 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.

TN # 79-17
Supersedes
TN #

Approval Date 11/28/79 Effective Date 8/23/79

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: MICHIGAN

Citation
42 CFR 447.15
AT-78-90
AT-80-34
48 FR 5730

4.19 (f) 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 charge.

TN No. 87-11
Supersedes
TN No. 83-14

Approval Date 08/26/87

Effective Date 04/01/87

HCFA ID: 1010P/0012P

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

State MICHIGAN

<u>Citation</u>	4.19 (g)	The Medicaid agency assures appropriate
42 CFR 447.201		audit of records when payment is based on
42 CFR 447.202		costs of services or on a fee plus
AT-78-90		cost of materials.

TN # <u>79-14</u>	Approval Date <u>11/28/79</u>	Effective Date <u>8/06/79</u>
Supersedes		
TN # <u></u>		

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State MICHIGAN

Citation	4.19(h)	The Medicaid agency meets the requirements
42 CFR 447.201		of 42 CFR 447.203 for documentation and
42 CFR 447.203		availability of payment rates.
AT-78-90		

TN # 79-14

Supersedes _____

TN # _____

Approval Date 11/28/79

Effective Date 8/06/79

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

State MICHIGAN

Citation
42 CFR 447.201
42 CFR 447.204
AT-78-90

4.19 (i) 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.

TN # 79-14

Supersedes

TN #

Approval Date 11/28/79

Effective Date 8/06/79

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

OMB No.: 0938-

State: MICHIGAN

Citation

42 CFR 4.19(j) The Medicaid agency meets the requirements
447.201 of 42 CFR 447.205 for public notice of any changes in
and 447.205 Statewide method or standards for setting payment
rates.

1903(v) of the (k) The Medicaid agency meets the requirements
Act 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.

TN No. 92-01
Supersedes Approval Date 9-11-92 Effective Date 10-01-91
TN No. 87-19

HCFA ID: 7982E

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: Michigan

Citation

1903(i)(14)
of the Act

4.19(1)

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.

TN No. 93-06
Supersedes 81-17 Approval Date 4-19-93 Effective Date 01-01-93
TN No. _____

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1994

State/Territory: MICHIGAN

Citation

4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

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

(ii) 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.

X 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

1926 of (iii) Medicaid beneficiary access to immunizations is
the Act assured through the following methodology:

Other

TN No. 94-035
Supersedes Approval Date 2-2-95 Effective Date 10-1-94
TN No. N/A

MICHIGAN MEDICAID STATE PLAN

66c

Revision: HCFA-PM

(MB)

OMB No.: 0938-1136

State Territory: Michigan

Citation

42 CFR 447, 434, 4.19(n) Payment Adjustment for Provider Preventable Conditions
438 and

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

TN No.: 11-08

Approval Date MAY 25 2012

Effective Date: 07/01/11

Supersedes

TN No.: N/A - New

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

State MICHIGAN

Citation
42 CFR 447.25 (b)
AT-78-90

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.

TN # 74-40
Supersedes
TN # _____

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

Revision: HCFA-AT-81-34 (BPP)

10-81

State MichiganCitation 4.21 Prohibition Against Reassignment of
Provider Claims42 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.

TN # 81-17

Supersedes

TN # 78-12Approval Date 11/30/81Effective Date 7/1/81

State of Michigan

Citation

42 CFR 433.137

4.22 Third Party Liability

(a) The Medicaid agency meets all requirements of:

- 1902(a)(25) of the Act
- 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) of the Social Security Act

(b) Attachment 4.22-A Specifies the Following:

- 42 CFR 433.138(f)
- 42 CFR 433.138(g)(1)(ii) and (2)(ii)
- 42 CFR 433.138(g)(3)(i) and (iii)
- 42 CFR 433.138(g)(4)(i) through (iii)
- 1) 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) The methods the agency uses for meeting the follow up requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
 - 3) 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) The methods the agency uses for following up on paid claims identified under §433.138(e) and specifies the time frames for incorporation into the eligibility case file and into its third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
February 1994

State/Territory: MICHIGAN

Citation

- 42 CFR 433.139(b)(3)(ii)(A) X (c) 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.
- 42 CFR 433.139(b)(3)(ii)(C) (d) 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.
 - 4) The Medicaid agency assures that the state has in effect the 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, under section 1902(a)(25) of the social security act, and specifies the compliance with 1902(a)(25)(e) and 1902(a)(25)(f).
- 1902(a)(25) of the Act
- 42 CFR 447.20 (e) 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.

Revision: HCFA-PM-94-1 (MB)
February 1994

State/Territory: MICHIGAN

Citation: 4.22 (Continued)

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.)

☒ 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.

TN NO.: 21-0017

Approval Date: JAN 14, 2022

Effective Date: 01/01/2022

Supersedes

TN No.: 97-01

MICHIGAN MEDICAID STATE PLAN

71

Revision: HCFA-AT-84-2 (BERC)
01-84

State: Michigan

Citation

4.23 Use of Contracts

42 CFR 434.4
48 FR 54013

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.

 Not applicable. The State has no such contracts.

42 CFR Part 438

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:

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

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

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

 Not applicable.

TN No.: 03-13

Approval Date 12/7/2003

Effective Date: 08/13/2003

Supersedes
TN No.: 84-9

Revision: HCFA-PM-94-2 (BPD)
July 1994 State/

Territory:

MICHIGAN

Citation 4.24
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

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.

TN

No. 94-10
Supersedes
TN No. 89-15 Approval Date 06-30-94 Effective Date 04/01/94

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

State MICHIGAN

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing
Homes

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.

TN # 74-2
Supersedes
TN #

Approval Date 7/05/74

Effective Date 1/15/74

Revision: HCFA-PM- (MB)

State/Territory: Michigan

Citation

1927(g)
42 CFR 456.700

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.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results

1927(g)(1)(a)
42 CFR 456.705(b) and
456.709(b)

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

1927(g)(1)(B)
42 CFR 456.703
(d)and(f)

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

TN No. 93-28
Supersedes
TN No. 92-25

Approval Date 12-3-93 Effective Date 10-01-93

State/Territory: MichiganCitation

Section 4.26 Drug Utilization Review Program (Continued)

1927 (g) (1) (D) 42 CFR 456.703(b)	D.	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 never-the-less chosen to include nursing home drugs in: _ Prospective DUR. <u>X</u> Retrospective DUR.
1927 (g) (2) (A) 42 CFR 456.705(b)	E.1.	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.
1927 (g) (2) (A) (i) 42 CFR 456.705(b), (1) – (7)	2.	Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to: <ul style="list-style-type: none"> • Therapeutic duplication • Drug-disease contraindications • Drug-drug interactions • Drug-interactions with non-prescription or over-the-counter drugs • Incorrect drug dosages or duration of drug treatment • Drug allergy interactions • Clinical abuse/misuse
1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)	2.1	Prospective DUR also includes the implementation of Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271). Michigan is in compliance with these requirements by screening each opioid prescription filled or delivered to an individual receiving benefits as follows: <ul style="list-style-type: none"> • Days' supply • Early refills • Duplicate fills • Quantity limitations • Maximum daily morphine milligram equivalents (MME) • Age edits for children younger than the state specified age receiving antipsychotics

TN NO.: 19-0012Approval Date: MAR 11, 2020Effective Date: 10-01-19

Supersedes

TN No.: 93-28

State/Territory: MichiganCitation

Section 4.26 Drug Utilization Review Program (Continued)

1927 (g) (2) (A) (ii) 42 CFR 456.705 (c) and (d)	3.	Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance patient profiles.
1927 (g) (2) (B) 42 CFR 456.709 (a) 1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT ACT)	F.1.	The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify: <ul style="list-style-type: none"> • Patterns of fraud and abuse • Gross overuse • Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.
1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)	F.1.1	Retrospective DUR also includes the implementation of Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271). Michigan is in compliance with these requirements by periodic examination of claims data and other records to identify: <ul style="list-style-type: none"> • Days' supply • Early refills • Duplicate fills • Quantity limitations • Opioid prescriptions exceeding limitations • Maximum daily morphine milligram equivalents (MME) • Concurrent utilization of opioids and benzodiazepines • Concurrent utilization of opioids and antipsychotics • Appropriateness for children including foster children of all ages receiving antipsychotics

TN NO.: 19-0012Approval Date: MAR 11, 2020Effective Date: 10-01-19

Supersedes

TN No.: 93-28

State/Territory: MichiganCitation927(g)(2)(C)
42 CFR 456.709(b)

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

1927(g)(2)(D)
42 CFR 456.711

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.

1927(g)(3)(A)
42 CFR 456.716(a)

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

- X Directly, or
— Under contract with a private organization

1927(g)(3)(B)
42 CFR 456.716
(A) AND (B)

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.

927(g)(3)(C)
42 CFR 456.716(d)

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.

TN No. 93-28
Supersedes
TN No. 92-25Approval Date 12-5-93 Effective Date 10-01-93

Revision: HCFA-PM-

(MB)

OMB No.

State/Territory: MichiganCitation

1927(g)(3)(C)
42 CFR 456.711
(a)-(d)

G.4 The interventions include in appropriate instances:

- Information dissemination
- Written, oral, and electronic reminders
- Face-to-Face discussions
- Intensified monitoring/review of prescribers/dispensers

1927(g)(3)(D)
42 CFR 456.712
(A) and (B)

H. 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.

1927(h)(1)
42 CFR 456.722

I.1. 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.

1927(g)(2)(A)(i)
42 CFR 456.705(b)

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

1927(j)(2)
42 CFR 456.703(c)

J. 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.

• U.S. G.P.O.:1993-342-239:80043

TN No. 93-28 Approval Date 12-3-93 Effective Date 10-01-93
Supersedes
TN No. N/A

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
TN #

Approval Date 5/14/80

Effective Date 10/15/79

Revision: HCFA-PM-93-1
January 1993

(BPD)

State/Territory: MICHIGAN

Citation

42 CFR 431.152;
AT-79-18
52 FR 22444;
Secs.
1902(a)(2)(D)(i)
and 1919(e)(7) of
the Act; P.L.
100-203 (Sec. 4211(c)).

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 431 Subpart E, 42 CFR 483.12, 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.

TN No. 93-16
Supersedes 88-19
Approval Date 6-28-93 Effective Date 07/01/93

Revision: HCFA-PM-99-3
June 1999

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).

TN No.: 03-13
Supersedes

Approval Date 12/9/2003

Effective Date: 08/13/2003

TN No.: un-numbered/Dempsey 1979 letter referenced

••

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: MICHIGAN

Citation
42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

4.30 Exclusion of Providers and Suspension of
Practitioners and Other Individuals

(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

MICHIGAN MEDICAID STATE PLAN

78a

Revision: HCFA-AT-87-14 (BERC)
October 1987

State: Michigan

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).

TN No.: 03-13

Approval Date 12/7/2003

Effective Date: 08/13/2003

Supersedes

TN No.: 87-22

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: MICHIGAN

Citation

1902(a)(39) of the Act
P.L. 100-93
(sec. 8(f))

(2) Section 1902(a)(39) of the Act by--

(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--

1902(a)(41)
of the Act
P.L. 96-272,
(sec. 308(c))

(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

1902(a)(49) of the Act
P.L. 100-93
(sec. 5(a)(4))

(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.

TN No. 87-22
Supersedes
TN No. N/A

Approval Date 01-14-88

Effective Date 11-01-87

HCFA ID: 1010P/0012P

MICHIGAN MEDICAID STATE PLAN

79

Revision: HCFA-PM-87-14 (BERC)
October 1987

OMB No.: 0938-0193

State: Michigan

Citation

455.103 44 4.31
FH 41644
1902(a)(38)
P.L. 100-
93(sec.
8(f))

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.

435.940
through
435.960
52 FR 5967

4.32 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.

TN NO.: 13-02

Approval Date: MAR 18 2013

Effective Date: 01/01/2013

Supersedes

TN No.: 87-22

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: MICHIGAN

Citation
1902(a)(48)
of the Act,
P.L. 99-570
(Section 11005)
P.L. 100-93
(sec. 5(a)(3))

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.

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

Approval Date 01-14-88

Effective Date 11-01-87

HCFA ID: 1010P/0012P

Revision: HCFA-PH-90- 2 (BPD)
JANUARY 1990

OMB No.: 0938-0193

State/Territory: MICHIGAN

Citation

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation

1919(h)(1)
and (2)
of the Act,
P.L. 100-203
(Sec. 4213(a))

- (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.

☐ Not applicable to intermediate care facilities; these services are not furnished under this plan.

☒ (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.

1919(h)(2)(B)(ii)
of the Act

- ☒ (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.

1919(h)(2)(F)
of the Act

- ☐ (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.

TN No. 94-21
Supersedes
TN No. N/A

Approval Date 5-18-95

Effective Date 07/01/94

HCFA ID: 1010P/0012P

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: _____

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR
§488.402(f)

(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.

42 CFR
§488.434

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

42 CFR
§488.402(f)(2)

(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.

42 CFR
§488.456(c)(d)

(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

42 CFR
§488.488.404(b)(1)

(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.

TN No. 95-15
Supersedes
TN No. 94-21

Approval Date: 11-2-95

Effective Date: 9-30-95

Revision: HCFA-FM-95-4 (HSQB)
JUNE 1995

State/Territory: Michigan

Citation

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.

42 CFR
\$488.414
\$1919(h)(2)(D)
of the Act.

- (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.

42 CFR
\$488.408
1919(h)(2)(A)
of the Act.

- (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).

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

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

TN No. 99-07

Supersedes

TN No. 95-15

Approval Date: 6-6-01

Effective Date: 3/24/99

79c.3

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: Michigan

Citation

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

(11) ☒ 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.

42 CFR
§488.303(b)
1910(h)(2)(F)
of the Act.

(e) ☒ State Incentive Programs

- ☒ (1) Public Recognition
- ☒ (2) Incentive Payments

TN No. 99-07
Supersedes
TN No. 95-15

Approval Date: 6-6-01

Effective Date: 3/24/99

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

OMB No.: 0938-

State/Territory: MICHIGAN

Citation 4.36 Required Coordination Between the Medicaid and WIC Programs

1902(a)(11)(C)
and 1902(a)(53)
of the Act

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.

TN No. 22-01
Supersedes
TN No. N/A

Approval Date 9-11-92

Effective Date 10-01-91

HCFA ID: 7982E

Revision: HCFA-PM-91- 10
DECEMBER 1991

(BPD)

State/Territory: MICHIGAN

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

4.38 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.
- X (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
Supersedes
TN No. N/A

Approval Date 04-08-92

Effective Date 01-01-92

Revision: HCFA-PM-91- 10
DECEMBER 1991

79o
(BPD)

State/Territory: MICHIGAN

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (g) 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.
- (h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
- (i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
- (j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
- (k) For program reviews other than the initial review, the State visits the entity providing the program.
- (l) 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).

TN No. 42-1
Supersedes
TN No. N/A

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Revision: HCFA-PM-91-10
DECEMBER 1991

79p
(BPD)

State/Territory: MICHIGAN

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (m) 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.
- (n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
- (o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
- (p) 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).
- X (q) 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.
- (r) 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.

TN No. 9270
Supersedes
TN No. N/A

Approval Date 04-08-92

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Revision: HCFA-PM-91-10
DECEMBER 1991

79g
(BPD)

State/Territory: MICHIGAN

Citation

42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (s) 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.
- (t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
- (u) 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.
- (v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
- (w) 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.
- X (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
- (y) The State has a standard for successful completion of competency evaluation programs.

TN No. 92-10
Supersedes
TN No. N/A

Approval Date 04-08-92

Effective Date 01-01-92

Revision: HCFA-PM-91-10
DECEMBER 1991

79r
(BPD)

State/Territory: MICHIGAN

Citation
42 CFR 483.75; 42
CFR 483 Subpart D;
Secs. 1902(a)(28),
1919(e)(1) and (2),
and 1919(f)(2),
P.L. 100-203 (Sec.
4211(a)(3)); P.L.
101-239 (Secs.
6901(b)(3) and
(4)); P.L. 101-508
(Sec. 4801(a)).

- (z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
- X (aa) 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).
- (bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
- (cc) The State includes home health aides on the registry.
- X (dd) The State contracts the operation of the registry to a non State entity.
- X (ee) 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)(1)(iii) and (iv).
- X (ff) 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).

TN No. 92-10
Supersedes
TN No. N/A

Approval Date 04-08-92 Effective Date 01-01-92

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: MICHIGAN

Citation
Secs.

1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act;
P.L. 100-203
(Sec. 4211(c));
P.L. 101-508
(Sec. 4801(b)).

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.

TN No. 93-16
Supersedes _____ Approval Date 6-28-93 Effective Date 07/01/93
TN No. N/A

Revision: HCFA-PM-92-3 (HSQB)

OMB No.:

July 1992

State/Territory: MICHIGANCitation4.40 Survey & Certification ProcessSections

1919(g)(1)
thru (2) and
1919(g)(4)
thru (5) of
the Act P.L.
100-203
(Sec.
4212(a))

(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.

1919(g)(1)
(B) of the
Act

(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.

1919(g)(1)
(C) of the
Act

(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.

1919(g)(1)
(C) of the
Act

(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?

1919(g)(1)
(C) of the
Act

(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.

1919(g)(1)
(C) of the
Act

(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.

TN No. 93-10
Supersedes
TN No. N/A

Approval Date 4-1-93Effective Date 1-1-93HCFA ID: PM 92-03

Revision: HCFA-PM-92-3
APRIL 1992

(HSQB)

OMB No:

State/Territory: Michigan

- 1919(g)(2)
(A)(i) of
the Act
- (g) 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.
- 1919(g)(2)
(A)(ii) of
the Act
- (h) 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.
- 1919(g)(2)
(A)(iii)(I)
of the Act
- (i) The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
- 1919(g)(2)
(A)(iii)(II)
of the Act
- (j) 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.
- 1919(g)(2)
(B) of the
Act
- (k) The State conducts extended surveys immediately or, if not practicable, not later than 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.
- 1919(g)(2)
(C) of the
Act
- (l) 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.

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Supersedes
TN No. N/A

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APRIL 1992

(HSQB)

OMB No:

State/Territory: MICHIGAN

- 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.

TN No. 93-10
Supersedes
TN No. N/A

Approval Date 4-1-93

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Revision: HCFA-PM-92- 2
MARCH 1992

(HSQB)

State/Territory: MICHIGAN

Citation

4.41 Resident Assessment for Nursing Facilities

Sections
1919(b)(3)
and 1919
(e)(5) of
the Act

- (a) 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.

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

- (b) 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

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

— 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)].

TN No. 92-25
Supersedes
TN No. N/A

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HCFA ID: _____

State of MICHIGAN

Citation 4.42 Employee Education About False Claims Recoveries

1902(a)(68)
of the Act
P.L. 109-
171 (§6032)

(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

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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.

AUG 17 2007

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

State MICHIGAN

SECTION 5 PERSONNEL ADMINISTRATION

Citation
42 CFR 432.10 (a)
AT-78-90
AT-79-23
AT-80-34

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.

TN # 77-20
Supersedes
TN #

Approval Date 10/12/77

Effective Date 9/28/77

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

State MICHIGAN

5.2 [Reserved]

TN # _____
Supersedes _____
TN # _____

Approval Date _____

Effective Date _____

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

State MICHIGAN

Citation
42 CFR Part 432,
Subpart B
AT-78-90

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.

TN # 78-2
Supersedes
TN # _____

Approval Date 5/24/78

Effective Date 2/27/78

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

State MICHIGAN

SECTION 6 FINANCIAL ADMINISTRATION

Citation
42 CFR 433.32
AT-79-29

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.

TN # 74-2
Supersedes
TN # _____

Approval Date 7/05/74

Effective Date 1/15/74

Revision: HCFA-AT-81- (BPP)

State MICHIGAN

Citation

42 CFR 433.34

47 FR 17490

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.

TN # 82-21

Supersedes

TN # 76-33

Approval Date 8/20/82

Effective Date 7/16/82

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

State Michigan

Citation
42 CFR 433.33
AT-79-29
AT-80-34

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.

TN # 84-3
Supersedes
TN # 74-2

Approval Date 3/23/84 Effective Date 1/1/84

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

OMB No. 0938-

State/Territory: MICHIGAN

SECTION 7 - GENERAL PROVISIONS

Citation

7.1 Plan Amendments

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.

TN No. 93-07

Supersedes

TN No. 74-02

Approval Date 9-11-92

Effective Date 10-01-91

HCFA ID: 7982E

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

OMB No. 0938-

State/Territory: MICHIGAN

Citation 7.2 Nondiscrimination

45 CFR Parts
80 and 84

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.

TN No. 92-01
Supersedes 79-07 Approval Date 9-11-92 Effective Date 10-01-91
TN No. _____

HCFA ID: 7982E

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

OMB No. 0938-

State/Territory: MICHIGAN

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.

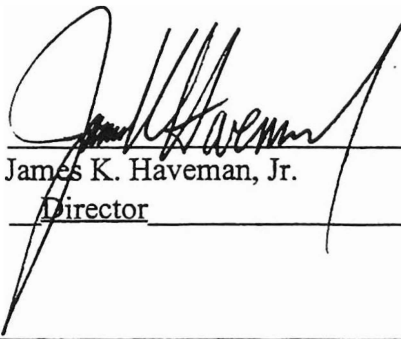
☐ Wishes to review only the plan materials specified in the enclosed document.

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. 96-010 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

Section 105 of the Michigan Social Welfare Act (Act 280, Public Acts of 1939), as most recently amended by Act 289, Public Acts of 1967.
(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

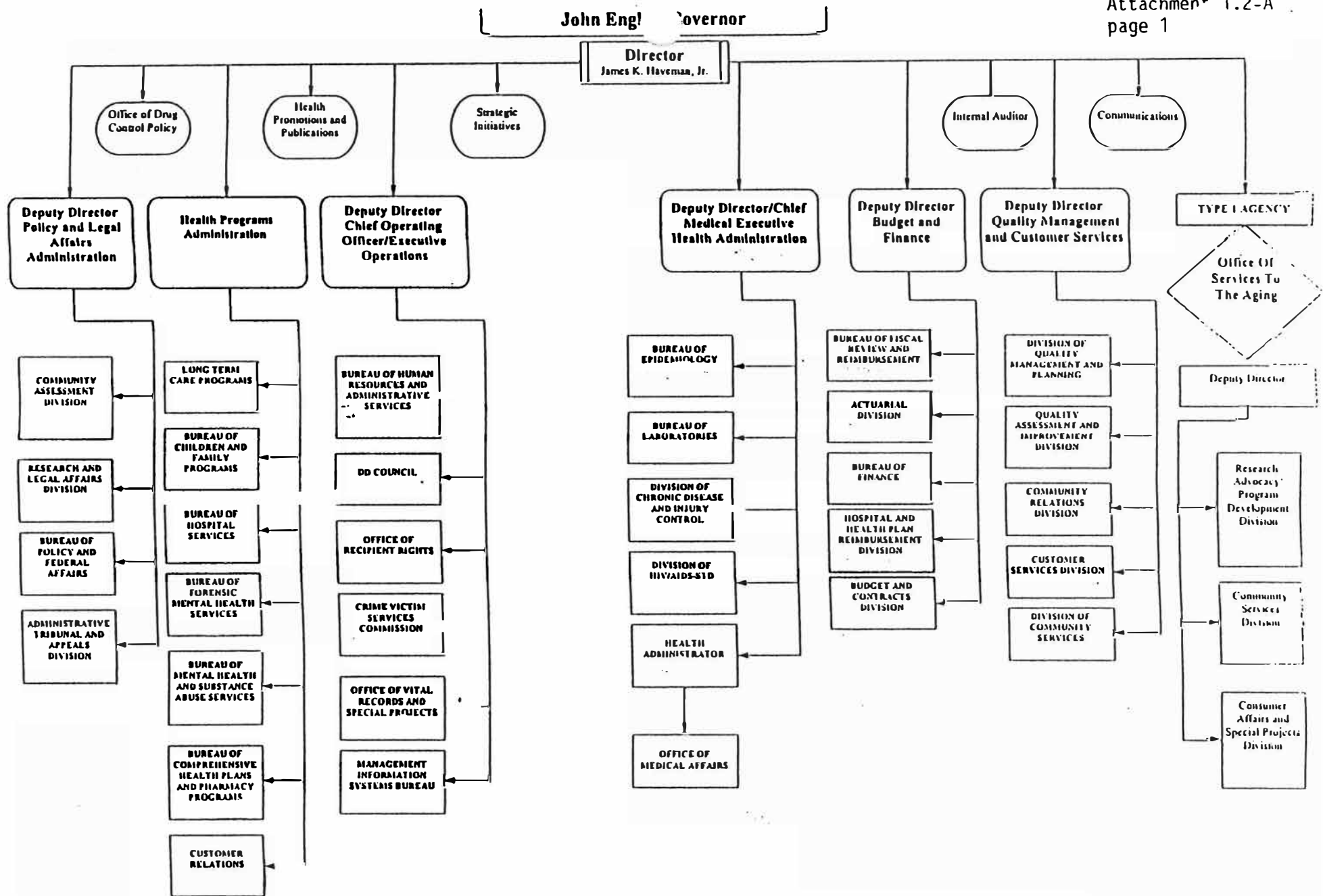
(statutory citation)

June 13, 1996

DATE


Frank J. Kelley
Attorney General

FA No. 96-010 Approval Date 2-23-24 Effective Date 4/1/96
Steno Series



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.

TN NO. 02-08

Approval Date 6/19/02

Effective Date 02/01/2002

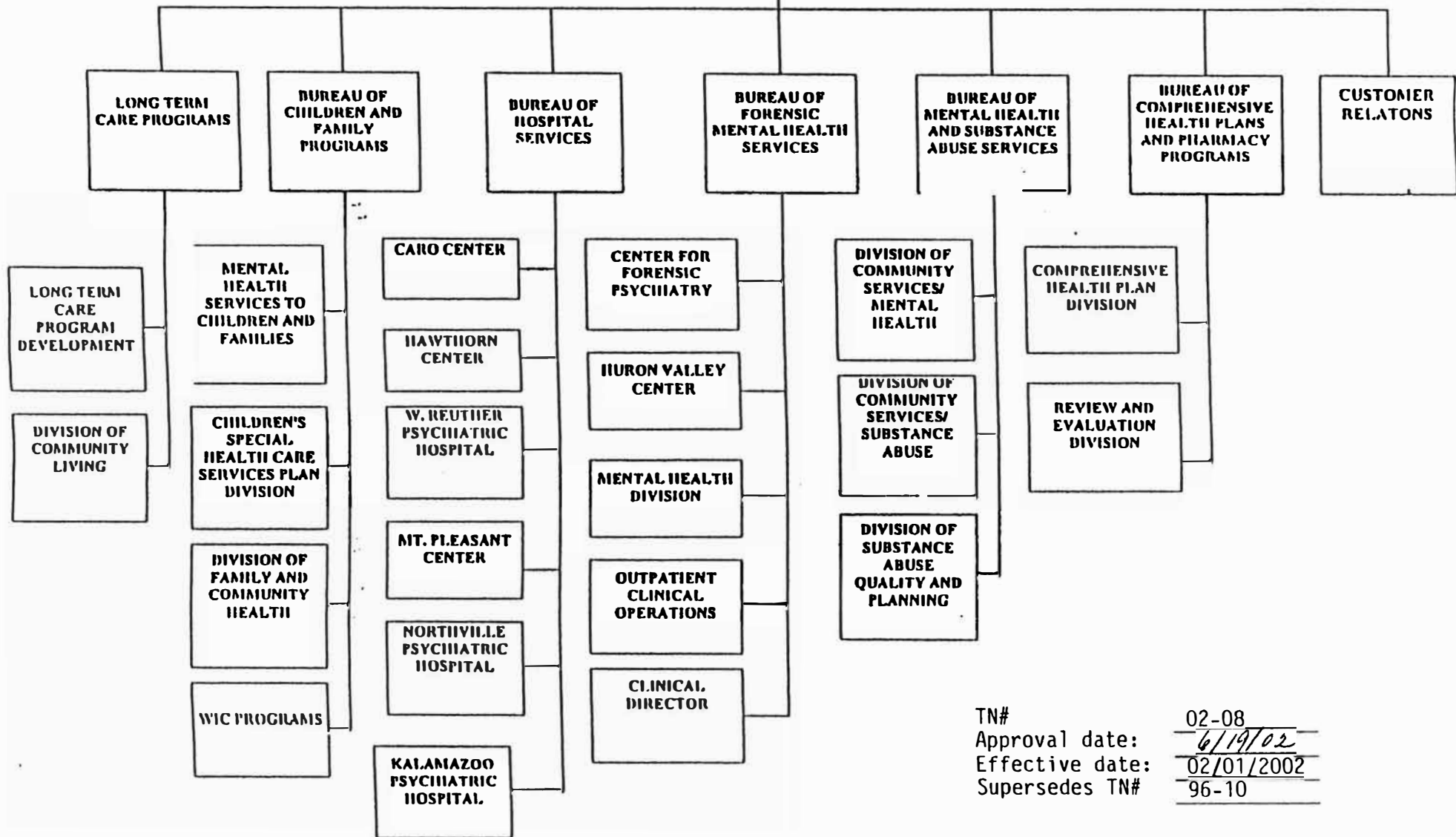
Supersedes

TN No. 96-10

Director
James K. Haveman, Jr.

Attachment 1.7

**HEALTH PROGRAMS
ADMINISTRATION**
P. Barrie-Senior Deputy Director



TN#
Approval date: 02-08
Effective date: 6/19/02
Supersedes TN# 02/01/2002
96-10

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

9-20-96

ATTACHMENT 1.2-D
Page 1

FAMILY INDEPENDENCE AGENCY

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.

TN No. 96-010 Approval Date 09-23-96 Effective Date 04-01-96
Supersedes
TN No. N/A

SECTION 2: Coverage & Eligibility

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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The following groups are covered under this plan.

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

MDSS 42 CFR 435.110 1. Recipients of AFDC

The approved State AFDC plan includes:

☒ Families with an unemployed parent for the
mandatory 6-month period and an optional
extension of 6 months.

☒ 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.

The standards for AFDC payments are listed in
Supplement 1 of ATTACHMENT 2.6-A.

MDSS 42 CFR 435.115 2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment
solely because the amount would be less than \$10.

*Agency that determines eligibility for coverage.

TN No. <u>92-02</u>	Approval Date <u>03-13-92</u>	Effective Date <u>10-01-91</u>
Supersedes		
TN No. <u>86-12</u>		HCFA ID: 7983E

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

ATTACHMENT 2.2-A
Page 2
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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**A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)**

2. Deemed Recipients of AFDC.

- | | |
|---|--|
| 1902(a)(10)(A)(i)(I)
of the Act | 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. |
| 402(a)(22)(A)
of the Act | c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds. |
| 406(h) and
1902(a)(10)(A)
(i)(I) of the Act | 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. |
| 1902(a) of
the Act | 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. |

***Agency that determines eligibility for coverage.**

TN No. <u>92-02</u>	Approval Date <u>03-19-92</u>	Effective Date <u>10-01-91</u>
Supersedes		
TN No. <u>90-11</u>	HCFA ID: 7983E	

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)

ATTACHMENT 2.2-A
Page 2a
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

MDSS 407(b), 1902
(a)(10)(A)(i)
and 1905(m)(1)
of the Act

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.

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

MDSS 1902(a)(52)
and 1925 of
the Act

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.)

*Agency that determines eligibility for coverage.

TN No. <u>92-02</u>	Approval Date <u>13-19-92</u>	Effective Date <u>10-01-91</u>
Supersedes		
TN No. <u>87-19</u>		HCFA ID: 7983E

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

ATTACHMENT 2.2-A
Page 3
OMB NO.: 0938-

State: MICHIGAN

Agency* Citation(s) Groups Covered

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

MDSS 42 CFR 435.113

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) Stepparents 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.

TN No. 92-02
Supersedes
TN No. 86-12

Approval Date 03-23-92

Effective Date 10-01-91

HCFA ID: 7983E

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

MDSS	42 CFR 435.114	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.
------	----------------	--

X 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).

— 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).

— Not applicable with respect to intermediate care facilities; State did or does not cover this service.

MDSS 1902(a)(10)
(A)(1)(III)
and 1905(n) of
the Act

7. Qualified Pregnant Women and Children.

a. A pregnant woman whose pregnancy has been medically verified who--

- (1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

*Agency that determines eligibility for coverage.

TN No. <u>92-03</u>	Approval Date <u>03-13-92</u>	Effective Date <u>10-01-91</u>
Supersedes		
TN No. <u>N/A</u>		HCFA ID: 7983E

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)

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.

1902(a)(10)(A)
(i)(III) and 1905(n)
of the Act

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

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(I)(IV) and 1902(l)(1)(A) and (B) of the Act	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(l)(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:
1902(a)(10)(A)(I)(VI) and 1902(l)(1)(C) of the Act	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.
1902(a)(10)(A)(I)(VII) and 1902 (l)(1)(D) if the Act	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 7-17-98

Effective Date 05/01/98

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

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.

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

Approval Date 4-17-98

Effective Date 05/01/98

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
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.

TN No. 92-14
Supersedes
TN No. 92-02

Approval Date 01-16-92 Effective Date 01-01-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Coverage and Conditions of Eligibility
Groups Covered***

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (continued)

- | | | |
|--------------------------|-----|---|
| 1902(e)(4)
of the Act | 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 |
| 42 CFR
435.120 | 13. | Aged, Blind and Disabled Individuals Receiving Cash Assistance

<u>X</u> 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.
<u>X</u> Aged
<u>X</u> Blind
<u>X</u> Disabled |

TN NO.: 10-11

Approval Date: OCT 15 2010

Effective Date: 10/01/2010

Supersedes
TN No.: 92-14

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

435.121

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.)

1619(b)(1)
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.

TN No. <u>42-02</u>	Approval Date <u>03-13-92</u>	Effective Date <u>10-01-91</u>
Supersedes		
TN No. <u>87-11</u>		HCFA ID: 7983E

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)

- | | | |
|-----|--|---|
| SSA | 1902(a)
(10)(A)
(i)(II)
and 1905
(q) of
the Act | <p>14. Qualified severely impaired blind and disabled individuals under age 65, who--</p> <p>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</p> <p>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--</p> <p>(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;</p> <p>(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;</p> <p>(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;</p> |
|-----|--|---|

*Agency that determines eligibility for coverage.

TN No. <u>92-02</u>	Approval Date <u>03-13-92</u>	Effective Date <u>10-01-91</u>
Supersedes		
TN No. <u>87-11</u>	HCFA ID: 7983E	

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

ATTACHMENT 2.2-A
Page 6c
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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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.

*Agency that determines eligibility for coverage.

TN No. <u>92-02</u>	Approval Date <u>03-13-92</u>	Effective Date <u>10-01-</u>
Supersedes		
TN No. <u>87-11</u>		HCFA ID: 7983E

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

ATTACHMENT 2.2-A
Page 6d
OMB NO.: 0938-

State: MICHIGAN

Agency* Citation(s)

Groups Covered

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

1619(b)(3)
of the Act

/ /

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.

*Agency that determines eligibility for coverage.

TN No. 92-02
Supersedes
TN No. N/A

Approval Date 63-13-92

Effective Date 10-01-91

HCFA ID: 7983E

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)		
MDSS	1634(c) of the Act	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. <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> 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.
MDSS	42 CFR 435.122	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.
SSA	42 CFR 435.130	17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

TN No. 92-02 Approval Date 03-13-92 Effective Date 10-01-91
Supersedes
TN No. N/A HCFA ID: 7983E

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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**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. <u>02-02</u>	Approval Date <u>03-13-92</u>	Effective Date <u>10-01-91</u>
Supersedes		
TN No. <u>N/A</u>		HCFA ID: 7983E

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

ATTACHMENT 2.2-A
Page 6g
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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**A. Mandatory Coverage - Categorically Needy and Other
Required Special Groups (Continued)**

- | | | |
|----------------|-----|--|
| 42 CFR 435.132 | 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. |
|----------------|-----|--|

- | | | |
|---------------------|-----|--|
| MDSS 42 CFR 435.133 | 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. |
|---------------------|-----|--|

*Agency that determines eligibility for coverage.

TN No. <u>92-02</u>	Approval Date <u>03-13-92</u>	Effective Date <u>10-01-91</u>
Supersedes		
TN No. <u>N/A</u>		HCFA ID: 7983E

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

ATTACHMENT 2.2-A
Page 7
OMB NO.: 0938-

State: MICHIGAN

Agency* Citation(s) Groups Covered

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

MDSS	42 CFR 435.134	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.
		<u>/X/</u>	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).
		<u>/</u>	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).
		<u>/</u>	Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

TN No. 92-02
Supersedes
TN No. 87-11

Approval Date 03-13-92

Effective Date 10-01-91

HCFA ID: 7983E

State: MICHIGAN

Agency* Citation(s) Groups Covered

**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 July 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.

TN No. 02-02 Approval Date 03-19-92 Effective Date 10-01-91
Supersedes
TN No. 87-11 HCFA ID: 7983E

State: MICHIGAN

Agency* Citation(s) Groups Covered

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

- MDSS 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 equalling 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. 92-12 Approval Date 03-13-92 Effective Date 10-01-91
Supersedes
TN No. 86-12 HCFA ID: 7983E

State/Territory: MICHIGAN

Agency*	Citation(s)	Groups Covered
1634(d) of the Act	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)	
	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.	
	<u> </u> The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.	
	<u> X </u> 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.	
	<u> </u> 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.	
	<u> </u> 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.

TN No. 92-10
Supersedes
TN No. 92-02

Approval Date 04-08-92

Effective Date 01-01-92

State: Michigan

Agency*	Citation(s)	Groups Covered
	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (continued)	
1902(a)(10)(E)(i) and 1905(p) and 1860D-14 (a)(3)(D) of the Act	25.	Qualified 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 does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resources limit, adjusted annually by the increase in the Consumer Price Index. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan).
1902(a)(10)(E)(ii), 1905(s), and 1905(p)(3)(A)(i) and 1860D – 14(a)(3)(D) of the Act	26.	Qualified Disabled and Working Individuals a. Who are entitled to hospital insurance benefits under Medicare Part A, under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed two times the SSI resource limit. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act).

*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

State: Michigan

Agency*	Citation(s)	Groups Covered
	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (continued)	
1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii) and 1860D – 14(a)(3)(D) of the Act	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.)	
1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D – 14(a)(3)(D) 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.

TN NO.: 10-20

Approval Date: FEB 01 2011

Effective Date: 10-1-2010

Supersedes
TN No.: 99-01

HCFA ID: 7983E

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

ATTACHMENT 2.2-A
Page 9c
OMB No.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy

42 CFR ☒ 1. Individuals described below who meet the
435.210 income and resource requirements of AFDC, SSI, or an
1902(a) optional State supplement as specified in 42
(10)(A)(ii) and CFR 435.230, but who do not receive cash
1905(a) of assistance.
the Act

☒ 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 ☐ 2. Individuals who would be eligible for AFDC, SSI
435.211 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
Supersedes
TN No. 92-02

Approval Date 10/15/97

Effective Date 10-01-96

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)

42 CFR 435.212 &
1902(e)(2) of the Act,
P.L. 99-272 (section
9517) P.L. 101-508
(section 4732)

- [] 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: 12/9/2003

Effective Date: 08/13/2003

Supersedes

TN No.: 92-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Groups Covered and Agencies Responsible for Eligibility Determination

Agency: FLA

Citation(s)

Groups Covered

1932 (a)(4) of the
ActB. Optional Groups Other Than Medically Needy (continued)

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.

1903(m)(2)(H),
1902(a)(52) of the Act
P.L. 101-508
42 CFR 438.56(g)

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

Supersedes
TN No.: 99-13

State/Territory: MICHIGAN

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.217

- 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.

*Agency that determines eligibility for coverage.

TN No. 94-70 Approval Date 04-28-92 Effective Date 01-01-92
Supersedes
TN No. 92-02 HCFA ID: 7983E

State: MICHIGAN

Agency* Citation(s) Groups Covered

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

1902(a)(10)
(A)(ii)(VII)
of the Act

☒ 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. 9203 Approval Date 03-13-92 Effective Date 10-01-91
Supersedes
TN No. N/A HCFA ID: 7983E

State: MICHIGAN

Agency* Citation(s) Groups Covered

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

42 CFR 435.220 ☒ 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.

1902(a)(10)(A)(ii) and 1905(a) of the Act ☒ The State covers only the following group or groups of individuals:

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

42 CFR 435.222
1902(a)(10)(A)(i) and
1905(a)(i) of the Act

7. ☒ a. 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

TN No. 92-02
Supersedes
TN No. 86-12

Approval Date 07-13-92

Effective Date 10-01-91

HCFA ID: 7983E

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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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). 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).

TN No. 9202
Supersedes
TN No. 86-12

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AUGUST 1991

ATTACHMENT 2.2-A
Page 13a
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

- (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.

TN No. <u>92-02</u>	Approval Date <u>03-13-92</u>	Effective Date <u>10-01-91</u>
Supersedes <u>N/A</u>		
TN No. <u> </u>		HCFA ID: 7983E

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 - -

☒ 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

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

ATTACHMENT 2.2-A
Page 14a
OMB No.: 0938-

State: MICHIGAN

Agency* Citation (s) Groups Covered

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

42 CFR 435.223 L7

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)
(A)(ii) and
1905(a) of
the Act

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

TN No. 92-02
Supersedes
TN No. N/A

Approval Date 03-13-92

Effective Date 10/01/91

HCFA ID: 7983E

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

ATTACHMENT 2.2-A
Page 15
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

SSA 42 CFR 435.230 /X 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

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.

- X (1) All aged individuals.
- X (2) All blind individuals.
- X (3) All disabled individuals.

TN No. 82-22
Supersedes
TN No. 86-12

Approval Date 03-13-92

Effective Date 10/01/91

HCFA ID: 7983E

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
		B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)
42 CFR 435.230		<input checked="" type="checkbox"/> (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		<input checked="" type="checkbox"/> (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		<input checked="" type="checkbox"/> (6) Disabled individuals in domiciliary Facilities or other group living arrangements as defined under SSI.
		<input checked="" type="checkbox"/> (7) Individuals receiving a Federally Administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		<input checked="" type="checkbox"/> (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:

TN No. 98-06
Supersedes
TN No. ~~97-09~~

Approval Date

8/20/98

Effective Date 01/01/98

92-02

Revision: HCFA-PM-91-4 (BPD)
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ATTACHMENT 2.2-A
Page 16a
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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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.

TN No. 92-02
Supersedes
TN No. N/A

Approval Date 03-13-92

Effective Date 10/01/91

HCFA ID: 7983E

Agency*	Citation(s)	Groups Covered
MDSS	435.231 1902(a)(10) (A)(ii)(V) of the Act, P.L. 97-248 (Section 137) and P. L. 99-272 (Section 9510)	<input checked="" type="checkbox"/> 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. * <input type="checkbox"/> The State covers all individuals as described above. <input checked="" type="checkbox"/> The State covers only the following group or groups of individuals: <input checked="" type="checkbox"/> Aged <input checked="" type="checkbox"/> Blind <input checked="" type="checkbox"/> Disabled <input type="checkbox"/> Individuals under the age of-- <input type="checkbox"/> 21 <input type="checkbox"/> 20 <input type="checkbox"/> 19 <input type="checkbox"/> 18 <input type="checkbox"/> Caretaker relatives <input type="checkbox"/> Pregnant women
MDSS	1902(e)(3) of the Act, P.L. 97-248 (Section 134)	<input checked="" type="checkbox"/> 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.

*Agency that determines eligibility for coverage.

TN No. 91-28
Supersedes
TN No. 87-21

Approval Date 01-16-92 Effective Date 01-01-92

HCFA ID: 1036P/0015P

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AUGUST 1991

ATTACHMENT 2.2-A
Page 18
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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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:

TN No. 92-02
Supersedes
TN No. 86-12

Approval Date 03-13-92

Effective Date 10/01/91

HCFA ID: 7983E

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

ATTACHMENT 2.2-A
Page 18a
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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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.

TN No. 92-02
Supersedes
TN No. N/A

Approval Date 03-13-92

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HCFA ID: 7983E

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AUGUST 1991

ATTACHMENT 2.2-A
Page 19
OMB No.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.231 <u>X</u> 1902(a)(10) (A)(ii)(V) of the Act	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 <u>ATTACHMENT 2.6-A</u> . *
--	--

 The State covers all individuals as described above.

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

1902(a)(10)(A)
(ii) and 1905(a)
of the Act

<u> X </u>	Aged
<u> X </u>	Blind
<u> Y </u>	Disabled
<u> </u>	Individuals under the age of--
<u> </u>	21
<u> </u>	20
<u> </u>	19
<u> </u>	18
<u> </u>	Caretaker relatives
<u> </u>	Pregnant women

* The income standard is \$ 1,452.

TN No. 97-09

Supersedes 96-01

TN No. 96-01

Approval Date 6/5/97

Effective Date 04/01/97

HCFA ID: 7983E

State: MICHIGAN

Agency* Citation(s) Groups Covered

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

- MDSS 1902(e)(3) of the Act ☒ 13. 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.
- 1902(a)(10) (A)(ii)(IX) and 1902(1) of the Act ☐ 14. 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:
- a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and
 - b. Infants under one year of age.

TN No. 92-02
Supersedes
TN No. 89-18

Approval Date 03-13-92

Effective Date 10/01/91

HCFA ID: 7983E

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

- | | | |
|---|-----|--|
| 1902(a) <input checked="" type="checkbox"/> | 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 <u>Supplement 1 of ATTACHMENT 2.6-A</u> for a family of the same size. |
| (10)(A) | | |
| (11)(IX) | | |
| and 1902(1)(1) | | |
| (D) of the Act | | |

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.

TN No. 92-02
Supersedes
TN No. N/A

Approval Date 03-13-92

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(BPD)

ATTACHMENT 2.2-A
Page 22
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a). /X/
(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.

TN No. 95-01
Supersedes
TN No. 92-02

Approval Date 6-16-95

Effective Date 01/01/95

HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Groups Covered and Agencies Responsible for Eligibility Determination

Citation(s)	Groups Covered
	B. <u>Optional Groups Other than the Medically Needy</u> (continued)
1902(a)(47) and 1920 of the Act	<u>X</u> 17. Pregnant women who are determined by a "qualified provider" (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 <u>Attachment 2.6-A</u> and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with section 1920 of the Act.

TN NO.: 05-05

Approval Date: 4/25/05

Effective Date: 01/01/2005

Supersedes

TN No.: 92-14

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 2.2-A
Page 23a
OMB NO.:

State/Territory: MICHIGAN

Citation	Groups Covered
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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 <u>1</u> 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 expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A. |

TN No. 91-30

Supercedes

TN No. N/A

Approval Date 07-06-92

Effective Date 10-01-91

HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: MICHIGAN

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATIONS

AGENCY*	CITATION(S)	GROUPS COVERED
	1902(a)(10)(A)(ii)(XIV) of the Act	<input type="checkbox"/> 20. Optional Targeted Low Income Children who: <ul style="list-style-type: none"> 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 July 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: <ul style="list-style-type: none"> <input type="checkbox"/> All children described above who are under age ____ (18, 19) with family income at or below ____ percent of the poverty level. <input type="checkbox"/> 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.)

TN No. 02-17Approval Date 10/8/2002Effective Date 10-1-2002

Supersedes

TN No. n/a - new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Groups Covered and Agencies Responsible for Eligibility Determinations

Agency*	Citation(s)	Groups Covered
	1902(e)(12) of the Act	<u>X</u> 21. A child under age <u>19</u> (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of <u>12</u> (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.
	1920A of the Act	<u>X</u> 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. 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.

TN NO.: 05-05

Approval Date: 4/25/05

Effective Date: 01/01/2005

Supersedes

TN No.: 02-17

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Michigan

Citation(s)

Group Covered

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~~ 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

TN No. 01-13

Approval Date

Effective Date July 1, 2001
10/01/01

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.

TN NO.: 04-03

Approval Date: JUN 22 2004

Effective Date: 01/01/04

Supersedes

TN No.: N/A new page

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) ☒ 26. All "Independent foster care adolescents" (as defined in (ii)(XVII) and §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 1905(w) of the Act the jurisdiction of the State, without consideration of income, assets or resources.

a) Reasonable classifications of individuals described in 26 above as follows:

☒ 1) Individuals under the age of

— 19

— 20

☒ 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

☒ There is no income test for this group

— The income test for this group is:

— 2) ☒ There is no resource test for this group

— The resource test for this group is:

TN NO.: 07-13

Approval Date: FEB 21 2008

Effective Date: 10/01/2007

Supersedes

TN No.: N/A new page

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

ATTACHMENT 2.2-A
Page 24
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy

42 CFR 435.301 This plan includes the medically needy.

☐ No.

☒ Yes. This plan covers:

- | | | |
|------|----------------------------------|---|
| MDSS | | 1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act. |
| MDSS | 1902(e) of the Act | 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. |
| DSS | 1902(a)(10)(C)(ii)(I) of the Act | 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. |

TN No. 92-02
Supersedes
TN No. N/A

Approval Date 03-13-92

Effective Date 10/01/91

HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Coverage and Conditions of Eligibility
Groups Covered***

C. Optional Coverage of Medically Needy (continued)

4. Reserved

42 CFR 435.308 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 ____).

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Approval Date: OCT 15 2010

Effective Date: 10/01/2010

Supersedes
TN No.: 92-02

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

ATTACHMENT 2.2-A
Page 25a
OMB NO.: 0938-

State: MICHIGAN

Agency*	Citation(s)	Groups Covered
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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.

TN No. 92-02
Supersedes
TN No. N/A

Approval Date 03-13-92

Effective Date 10/01/91

HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

Groups Covered

C. Optional Coverage for the Medically Needy (Continued)

- | | | | | |
|------|-------------------------------------|----------|-----|--|
| MDCH | 42CFR 435.310 | <u>X</u> | 6. | Caretaker Relatives |
| MDCH | 42CFR 435.320 and
42 CFR 435.330 | <u>X</u> | 7. | Aged Individuals |
| MDCH | 42CFR 435.322 and
42CFR 435.330 | <u>X</u> | 8. | Blind Individuals |
| MDCH | 42CFR 435.324 and
42CFR 435.330 | <u>X</u> | 9. | Disabled Individuals |
| | 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. |

TN NO 03-09 Approval Date Effective Date 04-01-03

Supersedes
TN No. 02-22

Revision: HCFA-PM-91-8 (BPD)

October 1991

ATTACHMENT 2.2-A

Page 26a

OMB NO.: 0938-

State: MICHIGAN

Citation(s)

Groups Covered

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 1 months.

TN No. 91-30 Approval Date 07-06-92 Effective Date 10-01-91

Supersedes

TN No. N/A

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☒ No. Does not apply. State does not cover optional categorically needy groups.

Yes. State covers the following optional categorically needy groups.

(*Select all that apply*):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: (*Select one*):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.

Income limit: (*Select one*):

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify*): %

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s))*:

- (c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s))*:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219.

(Select one):

☒ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.

(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: (Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (Describe, if any):

☐ OTHER (describe):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.

Income limit: (Select one):

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (Specify): %

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: (Specify waiver name(s) and number(s)):

- (c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. (*Specify demonstration name(s) and number(s)*):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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.

TN NO.: 05-17

Approval Date: Agv 10/1/05 Effective Date: 07/01/2005

Supersedes

TN No.: n/a new page

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

SUPPLEMENT 1 TO ATTACHMENT 2.2-A
Page 1
OMB NO.: 0938-

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

TN No. <u>92-02</u>	Approval Date <u>03-13-92</u>	Effective Date <u>10/01/91</u>
Supersedes		
TN No. <u>85-24</u>		HCFA ID: 7983E

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AUGUST 1991

SUPPLEMENT 3 TO ATTACHMENT 2.2-A
Page 1
OMB NO.: 0938-

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 6year, 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.

TN No. 92-02
Supersedes
TN No. N/A

Approval Date 03-13-92

Effective Date 10/01/91

HCFA ID: 7983E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
A. <u>General Conditions of Eligibility</u>	
Each individual covered under the plan:	
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(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.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.
1902(m) of the Act	(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.

TN No. 92-14
Supersedes
TN No. 92-03 Approval Date 04-16-92 Effective Date 01-01-92

State Michigan

Citation	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c. 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.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
1905(p)(3)(A)(ii)	e. For financially eligible specified low income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) and (p)(3)(A)(ii).
42 CFR 435.402	3. Is residing in the United States and--
	a. Is a citizen;
	b. 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.
	/x/ 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.
	c. 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.)

TN No. 96-20
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 TN No. 92-01

Approval Date 10/15/97 Effective Date 11/1/97

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

ATTACHMENT 2.6-A
Page 3
OMB No.: 0938-

State: MICHIGAN

Citation	Condition or Requirement
	d. 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
	e. 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).
42 CFR 435.403 1902(b) of the Act	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. <input type="checkbox"/> State has interstate residency agreement with the following States: <input type="checkbox"/> State has open agreement(s). <input type="checkbox"/> Not applicable; no residency requirement.

TN No. 92-03
Supersedes
TN No. 87-11

Approval Date 03-19-92

Effective Date 10/01/91

HCFA ID: 7985E

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 2.6-A
Page 3a
OMB No.: 0938-

State/Territory: MICHIGAN

Citation	Condition or Requirement
42 CFR 435.1008	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.
42 CFR 435.1008 1905(a) of the Act	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. <input type="checkbox"/> Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 CFR 433.145 1912 of the Act	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.)

TN No. 91-30

Supersedes

Approval Date 07-06-92

Effective Date 10-01-91

TN No. N/A 92-03

*per Lymanne
HCFA 6-24-99*

HCFA ID: 7985E

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October 1991

ATTACHMENT 2.6-A
Page 3a.1
OMB No.: 0938-

State/Territory: MICHIGAN

Citation	Condition or Requirement
	<p>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(1)(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.</p> <p>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.</p> <p><u>X</u> Assignment of rights is automatic because of State law.</p>
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).

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AUGUST 1991

ATTACHMENT 2.6-A
Page 3b
OMB No.: 0938-

State: MICHIGAN

Citation	Condition or Requirement
1902(c)(2)	8. 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.
1902(e)(10)(A) and (B) of the Act	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.)

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Supersedes
TN No. N/A

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

- | | |
|--|---|
| 1906 of the Act | 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). |
| <i>New York State
Department of
Social Services
v. Dublino,
413 U.S.(1973)</i> | 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

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

Citation	Condition or Requirement
435.725	B. <u>Post-Eligibility Treatment of Institutionalized Individuals</u>
435.733	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:
435.832	
	1. Personal Needs Allowance
	a. Aged, blind, disabled— Individuals <u>\$ 30 plus *</u> Couples <u>\$ 60 plus *</u>
	For the following individuals with greater need—
	b. AFDC related— Children <u>\$ 30 plus *</u> Adults <u>\$ 30 plus *</u>
	c. Individuals under age 21 covered in this plan as specified in Item B.7. of Attachment 2.2-A \$ _____
435.725	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—
435.733	
435.832	
	SSI level \$ _____
	SSP level \$ _____
	Medically need level \$ <u>**</u> _____
	Other as follow \$ _____

*Any income over \$30 (\$60 for couples) for guardianship fees paid for court-appointed guardians up to a maximum amount of \$83 per month for actual guardianship fees.

**Applicable protected income level for one person (see Supplement 1).

TN NO.: 18-0012

Approval Date: DEC 20, 2018

Effective Date: 11-01-2018

Supersedes

TN No.: 17-0010

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation

Condition or Requirement

B. Post-Eligibility Treatment of Institutionalized Individuals (continued)

3. For children, each family member:

AFDC level	\$ _____
Medically needy level	\$ <u>see Supplement 1</u>
Other as follows	\$ _____

4. Amounts for incurred medical expenses not subject to payment by a third party:

- a. Health insurance premiums, deductibles and co-insurance charges;
- 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).

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.

☒ Yes. Amount for maintenance of home to equal the federal SSI benefit rate per month

☐ No

1902(1) of the Act

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.

TN NO.: 13-05

Approval Date: APRIL 17 2013

Effective Date: 01/01/2013

Supersedes
TN No.: 12-07

Revision: HCFA Region V
November 1989
STATE MICHIGAN

Attachment 2.6-A
Page 5a

CITATION

CONDITION OR REQUIREMENT

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

X 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

X 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 use is \$_____.

___ c. 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.

TN No. 90-02 Approval Date 3-21-91 Effective Date 01-01-90
Supersedes TN No. 89-33

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	<p>C. <u>Financial Eligibility</u></p> <p>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.</p> <p>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.</p> <p><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.</p>

TN No. 92-14
Supersedes
TN No. 92-03

Approval Date 04-16-92 Effective Date 01-01-92

State: _____

Citation	Condition or Requirement
<u>X</u>	<u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
—	<u>Supplement 7 to ATTACHMENT 2.6-A</u> specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI
—	<u>Supplement 4 to ATTACHMENT 2.6-A</u> 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.
—	<u>Supplement 5 to ATTACHMENT 2.6-A</u> 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.
<u>X</u>	<u>Supplement 8a to ATTACHMENT 2.6-A</u> 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.
<u>X</u>	<u>Supplement 8b to ATTACHMENT 2.6-A</u> 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.
—	<u>Supplement 14 to ATTACHMENT 2.6-A</u> 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

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	<p>1. <u>Methods of Determining Income</u></p> <p>a. <u>AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</u></p> <p>(1) In determining countable income for AFDC-related individuals, the following methods are used:</p> <p>— (a) The methods under the State's approved AFDC plan only; or</p> <p><u>X</u> (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p>(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.</p>
1902(e)(6) the Act	<p>(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.</p>

TN No. 94-8
Supersedes
TN No. 92-14

Approval Date 2-27-95

Effective Date 07-01-94

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. <u>Aged individuals.</u> 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: <u> </u> The methods of the SSI program only. <u>X</u> The methods of the SSI program and/or any more liberal methods described in <u>Supplement</u> <u>8a to ATTACHMENT 2.6-A.</u>

TN No. 92-14
Supersedes
TN No. N/A Approval Date 04-16-92 Effective Date 01-01-92

State: MICHIGAN

Citation	Condition or Requirement
<input type="checkbox"/>	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 <u>Supplement 4 to ATTACHMENT 2.6-A</u> ; and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
<input type="checkbox"/>	For institutional couples, the methods specified under section 1611(e)(5) of the Act.
<input type="checkbox"/>	For optional State supplement recipients under \$435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> .
<input type="checkbox"/>	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 <u>Supplement 8a to ATTACHMENT 2.6-A</u> . — Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
	In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

TN No. 92-03
Supersedes
TN No. 88-01

Approval Date 03-19-92

Effective Date 10-01-91

HCFA ID: 7985E

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

ATTACHMENT 2.6-A
Page 9
OMB No.: 0938-

State: MICHIGAN

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. <u>Blind individuals</u> . In determining countable income for blind individuals, the following methods are used: — The methods of the SSI program only. <u>X</u> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> . — 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 <u>Supplement 4 to ATTACHMENT 2.6-A</u> , and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> . — 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 <u>Supplement 4 to ATTACHMENT 2.6-A</u> . — 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 <u>Supplement 8a to ATTACHMENT 2.6-A</u> . — Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .

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AUGUST 1991

ATTACHMENT 2.6-A
Page 10
OMB No.: 0938-

State: MICHIGAN

Citation	Condition or Requirement
	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. <u>Disabled individuals.</u> 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. <u>X</u> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u> — 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 <u>Supplement 4 to ATTACHMENT 2.6-A.</u> — 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 <u>Supplement 4 to ATTACHMENT 2.6-A</u> ; and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>

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AUGUST 1991

ATTACHMENT 2.6-A
Page 11
OMB No.: 0938-

State: MICHIGAN

Citation	Condition or Requirement
—	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 <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
—	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 <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .

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.

TN No. <u>9203</u>	Approval Date <u>03-19-92</u>	Effective Date <u>10-01-91</u>
Supersedes		
TN No. <u>90-02</u>		

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902 (l)(3)(E) and 1902 (r)(2) of the Act	<p>e. <u>Poverty level pregnant women, infants, and children.</u> 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—</p> <p>(1) The following methods are used in determining countable income:</p> <p><input checked="" type="checkbox"/> The methods of the State's approved AFDC plan.</p> <p><input type="checkbox"/> The methods of the approved title IV-E plan.</p> <p><input checked="" type="checkbox"/> The methods of the approved AFDC State plan and/or any more liberal methods described in <u>Supplement 8a to Attachment 2.6-A.</u></p> <p><input type="checkbox"/> The methods of the approved title IV-E plan and/or any more liberal methods described in <u>Supplement 8a to Attachment 2.6-A.</u></p>

95-01
92-14²

TN No. 98-05
Supersedes
TN No. 95-01

Approval Date

9-17-98

Effective Date 05/01/98

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	(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.
1902(e)(6) of the Act	(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.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f. <u>Qualified Medicare beneficiaries.</u> In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used: — The methods of the SSI program only. <u>X</u> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u> — For institutional couples, the methods specified under section 1611(e)(5) of the Act.

TN No. 92-14
Supersedes
TN No. 92-03

Approval Date 04-16-92 Effective Date 01-01-92

Revision: HCFA-PM-93-2 (MB)
MARCH 1993
State: MICHIGAN

ATTACHMENT 2.6-A
Page 12a

Citation

Condition or Requirement

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.

TN No. 93-07

Supersedes

TN No. 92-14

Approval Date

5-17-99

Effective Date

1-1-93

* U.S. G.P.O.:1993-342-239:80032

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October 1991

ATTACHMENT 2.6-A
Page 12b
OMB No.:

State/Territory: MICHIGAN

Citation	Condition or Requirement
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1902(u)
of the Act

(h) COBRA Continuation Beneficiaries

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).

TN No. 91-30
Supersedes

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Effective Date 10-01-91

TN No. N/A

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XIII) of the Act	<p>(i) <u>Working Individuals with Disabilities – BBA</u></p> <p>In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied:</p> <p>___ The methodologies of the SSI program.</p> <p>___ 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.</p> <p>___ 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.</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Eligibility Conditions and Requirements

CitationCondition or Requirement

1902(a)(1O)(A)
(ii)(XV) of the Act

(ii) Working Individuals with Disabilities - Basic Coverage Group
TWWIIA

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)

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TN No.: 04-03

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation	Condition or Requirement
1902 (a)(10)(A) (ii)(XV) of the Act (cont.)	<p><u>Income Methodologies</u></p> <p>In determining whether an individual meets the income standard described above, the agency uses the following methodologies:</p> <p>_____ The income methodologies of the SSI program.</p> <p>_____ 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</p> <p><u>X</u> 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</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont)	<p><u>Resource Methodologies</u></p> <p>In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.</p> <p>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.</p> <p>— The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.</p> <p>— 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.</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont)	<input type="checkbox"/> The agency does not disregard funds in retirement accounts.
	<input checked="" type="checkbox"/> 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.
	<input type="checkbox"/> The agency uses the resource methodologies of the SSI program.
	<input type="checkbox"/> 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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act	<p>(iii) <u>Working Individuals with Disabilities – Employed Medically Improved Individuals – TWWIIA</u></p> <p>In determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied:</p> <p>— The agency does not apply any income or resource standard.</p> <p>— The agency applies the following income and/or resource standard(s):</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont)	<p><u>Income Methodologies</u></p> <p>In determining whether an individual meets the income standard described above, the agency uses the following methodologies:</p> <ul style="list-style-type: none">— The income methodologies of the SSI program.— 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— The agency uses more liberal income methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont)	<p><u>Resource Methodologies</u></p> <p>In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.</p> <p>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.</p> <p>_____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.</p> <p>_____ 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.</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont)	— The agency does not disregard funds in retirement accounts.
	— 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.
	— The agency uses the resource methodologies of the SSI program.
	— 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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) and 1905 (v)(2) of the Act	<u>Definition of Employed – Employed Medically Improved Individuals – TWWIIA</u>
7	<p>— The agency uses the statutory definition of “employed” i.e., earning at least the minimum wage and working at least 40 hours per month.</p> <p>— 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:</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act	<p><u>Payment of Premiums or Other Cost Sharing Charges</u></p> <p>For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of Attachment 2.2-A:</p> <p>— 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:</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act (cont)	<p>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:</p> <p><u>X</u> 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.</p> <p>The premiums or other cost-sharing charges, <u>and</u> how they are applied, are described on page 12o.</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Eligibility Conditions and Requirements

Citation

Sections 1902(a)(10)(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.

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TN No.: 04-03

State: MICHIGAN

Citation	Condition or Requirement
1902(k) of the Act	<p>2. Medicaid Qualifying Trusts</p> <p>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.</p> <p><input type="checkbox"/> 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. <u>Supplement 10 of ATTACHMENT 2.6-A</u> specifies what constitutes an undue hardship.</p>
1902(a)(10) of the Act	<p>3. Medically needy income levels (MNILs) are based on family size.</p> <p><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, <u>Supplement 1</u> so indicates.</p>

TN No. 92-03
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TN No. 88-01

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HCFA ID: 7985E

State: MICHIGAN

Citation	Condition or Requirement
42 CFR 435.732, 435.831	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 ____ or 1 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.

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Supersedes
TN No. 89-18

Approval Date 03-19-92 Effective Date 10-01-91

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Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 2.6-A
Page 14a
OMB No.

State/Territory: MICHIGAN

Citation	Condition or Requirement
1903(f)(2) of the Act	a. <u>Medically Needy (Continued)</u> (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

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Approval Date 07-06-92

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HCFA ID: 7985E/

State: MICHIGAN

Citation	Condition or Requirement
	b. <u>Categorically Needy - Section 1902 (f) States</u>
42 CFR 435.732	<p>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:</p> <ol style="list-style-type: none">(1) Any SSI benefit received.(2) 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)(XI) of the Act.(3) 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.(4) Other deductions from income described in this plan at <u>Attachment 2.6-A, Supplement 4</u>.(5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	<p>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.</p>

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October 1991

ATTACHMENT 2.6-A
Page 15a
OMB No.

State/Territory: MICHIGAN

Citation	Condition or Requirement
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4.b. Categorically Needy - Section 1902(f) States
Continued

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.

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Approval Date 07-06-92

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HCFA ID: 7985E/

State: MICHIGAN

Citation	Condition or Requirement
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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.

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TN No. 91-04

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

ATTACHMENT 2.6-A
Page 16a
OMB No.: 0938-

State: MICHIGAN

Citation	Condition or Requirement
5. <u>Methods for Determining Resources</u>	
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act	<p>b. <u>Aged individuals</u>. 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:</p> <p>— The methods of the SSI program.</p> <p><u>X</u> SSI methods and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A</u>.</p> <p>— 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. <u>Supplement 5 to ATTACHMENT 2.6-A</u> describes the more restrictive methods and <u>Supplement 8b to ATTACHMENT 2.6-A</u> specifies the more liberal methods.</p>

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HCFA ID: 7985E

State: MICHIGAN

Citation	Condition or Requirement
	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), 1902(m)(1)(B), and 1902(r) of the Act	<p>c. <u>Blind individuals</u>. For blind individuals the agency uses the following methods for treatment of resources:</p> <p>— The methods of the SSI program.</p> <p><u>X</u> SSI methods and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A</u>.</p> <p>— Methods that are more restrictive and/or more liberal than those of the SSI program. <u>Supplement 5 to ATTACHMENT 2.6-A</u> describe the more restrictive methods and <u>Supplement 8b to ATTACHMENT 2.6-A</u> specify the more liberal methods.</p> <p>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.</p>

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TN No. 89-18

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HCFA ID: 7985E

State: MICHIGAN

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	<p>d. <u>Disabled individuals, including individuals covered under section 1902(a)(10)(A)(i)(X) of the Act.</u> The agency uses the following methods for the treatment of resources:</p> <p>— The methods of the SSI program.</p> <p><u>X</u> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p>— 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 <u>Supplement 5 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p>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.</p>
1902(1)(3) and 1902(r)(2) of the Act	<p>e. <u>Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(i)(IX)(A) of the Act.</u></p> <p>The agency uses the following methods in the treatment of resources.</p> <p>— The methods of the SSI program only.</p> <p>— The methods of the SSI program and/or any more liberal methods described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p>

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TN No. 47-11

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HCFA ID: 7985E

State: MICHIGAN

Citation	Condition or Requirement
	<p>Methods that are more liberal than those of SSI. The more liberal methods are specified in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p><u>X</u> Not applicable. The agency does not consider resources in determining eligibility.</p> <p>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.</p>
1902(l)(3) and 1902(r)(2) of the Act	<p>f. <u>Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.</u></p> <p>The agency uses the following methods for the treatment of resources:</p> <p>Methods more liberal than those in the State's approved AFDC plan.</p> <p>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u></p>
1902(l)(3)(C) of the Act	<p>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p>
1902(r)(2) of the Act	<p><u>X</u> Not applicable. The agency does not consider resources in determining eligibility.</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act	g. 1. <u>Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act.</u> 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 <u>Supplement 5a of ATTACHMENT 2.6-A.</u> — Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u> — <u>X</u> 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.
1902(1)(3)(C) of the Act	
1902(r)(2) of the Act	

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act	g. 2. <u>Poverty level children under section 1902(a)(10)(A)(i)(VII)</u> The agency uses the following methods for the treatment of resources: <input type="checkbox"/> The methods of the State's approved AFDC plan.
1902(1)(3)(C) the Act	<input type="checkbox"/> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u>
1902(r)(2) of the Act	<input type="checkbox"/> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u> <input checked="" type="checkbox"/> 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.	

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October 1991

ATTACHMENT 2.6-A
Page 20
OMB No.:

State/Territory: MICHIGAN

Citation	Condition or Requirement
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act	5. h. <u>For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources:</u> — The methods of the SSI program only. <u>X</u> The methods of the SSI program and/or more liberal methods as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u>
1905(s) of the Act	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.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: <u>X</u> The methods of the SSI program only. — More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

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State: MICHIGAN

Citation	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	<p>k. <u>Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act--</u></p> <p>The agency uses the same method as in 5.h. of <u>Attachment 2.6-A.</u></p> <p>6. Resource Standard - Categorically Needy</p> <p>a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:</p> <p>___ Same as SSI resource standards.</p> <p>___ More restrictive.</p> <p>The resource standards for other individuals are the same as those in the related cash assistance program.</p> <p>b. Non-1902(f) States (except as specified under items 6.c. and d. below)</p> <p>The resource standards are the same as those in the related cash assistance program.</p> <p><u>Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.</u></p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3)(A), (B) and (C) of the Act	<p>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.</p> <p><u> </u> 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.</p> <p><u> X </u> No. The agency does not apply a resource standard to these individuals.</p>
1902(1)(3)(A) and (C) of the Act	<p>d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard.</p> <p><u> </u> 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.</p> <p><u> X </u> No. The agency does not apply a resource standard to these individuals.</p>

TN No. 92-14
Supersedes
TN No. 92-03

Approval Date 04-16-92 Effective Date 01-01-92

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

ATTACHMENT 2.6-A
Page 21a
OMB No.: 0938-

State: MICHIGAN

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	<p>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:</p> <p><u>X</u> Same as SSI resource standards.</p> <p>— Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).</p> <p><u>Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.</u></p>

TN No. 95-01
Supersedes
TN No. 92-03

Approval Date 6-16-95

Effective Date 01-01-95

HCFA ID: 7985E

State: Michigan

Citation	Condition or Requirement
	<p>7. Resource Standard -- Medically Needy</p> <p>a. Resource standards are based on family size.</p> <p>1902(a)(10C)(i) of the Act b. A single standard is employed in determining resource eligibility for all groups.</p> <p><input type="checkbox"/> c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for –</p> <p><input type="checkbox"/> Aged <input type="checkbox"/> Blind <input type="checkbox"/> Disabled</p> <p><u>Supplement 2 to Attachment 2.6-A</u> specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.C., <u>Supplement 2 to Attachment 2.6-A</u> so indicates.</p>
1902(a)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B), and 1860D-4(a)(3)(D) of the Act	<p>8. Resource Standard – Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals</p> <p>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.</p>
1902(a)(10)(E)(ii), 1905(s), and 1860D-4(a)(3)(D) of the Act	<p>9. Resource Standard – Qualified Disabled and Working Individuals</p> <p>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.</p>

TN NO.: 10-20
Supersedes
TN No.: 93-029

Approval Date: FEB 01 2011

Effective Date: 10-01-2010

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 2.6-A
Page 22a
OMB No.:

State/Territory: MICHIGAN

Citation	Condition or Requirement
1902(u) of the Act	9.1 For COBRA continuation beneficiaries, the resource standard is: <u>X</u> Twice the SSI resource standard for an individual. — More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

TN No. 91-30
Supersedes

Approval Date 07-06-92

Effective Date 10-01-91

TN No. N/A

HCFA ID: 7985E

Revision: HCFA-PM-93-5 (MB)
MAY 1993

ATTACHMENT 2.6-A
Page 23

State: MICHIGAN

Citation	Condition or Requirement
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
	<u>X</u> 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.

TN No. 93-29
Supersedes 92-03 Approval Date 12-7-93 Effective Date 10-01-93

State: MICHIGAN

Citation	Condition or Requirement
42 CFR 435.914	<p>11. Effective Date of Eligibility</p> <p>a. Groups Other Than Qualified Medicare Beneficiaries</p> <p>(1) For the prospective period.</p> <p>Coverage is available for the full month if the following individuals are eligible at any time during the month.</p> <p><u>X</u> Aged, blind, disabled. <u>X</u> AFDC-related.</p> <p>Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.</p> <p><u>X</u> Aged, blind, disabled. * <u>X</u> AFDC-related. *</p> <p>(2) For the retroactive period.**</p> <p>Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:</p> <p><u>X</u> Aged, blind, disabled. <u>X</u> AFDC-related.</p> <p>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..</p> <p><u>X</u> Aged, blind, disabled. <u>X</u> AFDC-related.</p>

TN No. 92-03
Supersedes
TN No. 87-11

Approval Date 03-19-92 Effective Date 10-01-91

HCFA ID: 7985E

* 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Eligibility Conditions and Requirements

Citation(s)	Condition or Requirement
	<p>11. Effective Date of Eligibility</p> <p>a. Groups Other Than Qualified Medicare Beneficiaries (continued)</p>
1920(b)(1) of the Act	<p><u>X</u> (3) For a presumptive eligibility for pregnant women only</p> <p>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 <u>Attachment 2.6-A</u> 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.</p>
1902(e)(8) and 1905(a) of the Act	<p><u>X</u> 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</p> <p><u>X</u> 12 months</p> <p><u> </u> 6 months</p> <p><u> </u> months (no less than 6 months and no more than 12 months)</p>

TN NO.: 05-05Approval Date: 4/25/15Effective Date: 01/01/2005

Supersedes

TN No.: 92-14

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of MICHIGAN

Citation	Condition or Requirement
1902 (a) (18) and 1902 (f) of the Act	<p>12. Pre-OBRA 93 Transfer of Resources- Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals</p> <p>The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.</p> <p>Disposal of resources at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9 to Attachment 2.6-A.</u></p>
1917 (c)	<p>13. Transfer of Assets-All eligibility groups</p> <p>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.</p> <p>Disposal of assets at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9(a) to ATTACHMENT 2.6-A.</u>, except in instances where the agency determines that the transfer rules would work an undue hardship.</p>
1917 (d)	<p>14. Treatment of Trusts – All eligibility groups</p> <p>The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.</p> <p><input type="checkbox"/> The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts:</p> <p><input type="checkbox"/> The agency meets the requirements in section 1917(d)(4)(B) of the Act for use of Miller trusts.</p> <p>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 <u>Supplement 10 to ATTACHMENT 2.6-A.</u></p>

TN NO.: 18-0004

Approval Date: June 18, 2018

Effective Date: 04/01/2018

Supersedes
TN No.: 96-11

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:

<u>Family Size</u>	<u>Need Standard</u>	<u>Payment Standard</u>	<u>Maximum Payment Amounts</u>
	Need Standard is 120% of the payment standard. See page 1a.	See page 1b.	Maximum payment is 100% of the payment standard.

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 1		Table 2	
Group Size	ALL ADC/GA-F GROUPS	Group Size	ALL ADC/GA-F GROUPS
Shelter Area		Shelter Area	
All Shelter Areas	Basic Shelter Allowance is \$0	All Shelter Areas	Basic Shelter Allowance is \$50

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.

ADC/GA-F Group Size						
Shelter Area	1	2	3	4	5	6 or more
I	115	115	120	145	155	200
II	115	120	130	155	165	210
III	120	130	140	165	175	220
IV	135	145	155	180	190	235
V	150	160	170	195	205	250
VI	165	175	185	210	220	265

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

Table 4 - Zone I Only						
Group Size	1	2	3	4	5	6+
Rental Situation						
Heat Included						
in Rent	\$47	\$53	\$54	\$56	\$62	\$71
Utilities Included						
in Rent	\$18	\$21	\$22	\$23	\$26	\$30
Heat & Utilities						
Included in Rent	\$65	\$74	\$76	\$79	\$88	\$101

Table 5 - Zone II ONLY						
Group Size	1	2	3	4	5	6+
Rental Situation						
Heat Included						
In Rent	\$51	\$57	\$58	\$60	\$66	\$75
Utilities Included						
In Rent	\$18	\$21	\$22	\$23	\$26	\$30
Heat & Utilities						
Included in Rent	\$69	\$78	\$80	\$83	\$92	\$105

TN No. 92-04 Approval Date 5-3-93 Effective Date 1-1-92

Supersedes

TN No. 87-1

ELIGIBLE GRANTEE LIVING ARRANGEMENT
ADC MONTHLY ASSISTANCE PAYMENT STANDARDS TABLE

PAYMENT STANDARDS						
Shelter Area Group Size	I	II	III	IV	V	VI
ONE	\$ 255	\$ 255	\$ 260	\$ 276	\$ 290	\$ 305
TWO	341	346	356	371	386	401
THREE	424	434	444	459	474	489
FOUR	528	538	548	563	578	593
FIVE	624	634	644	659	674	689
SIX	757	767	777	792	807	822
SEVEN	833	843	853	868	883	898
EIGHT or more	▶ Add \$76 for each additional person.					

TN No. 92-15 Approval Date 16-23-92 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.

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TN No. 92-04 Approval Date 04-16-92 Effective Date 01-01-92

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AUGUST 1991

SUPPLEMENT 1 TO ATTACHMENT 2.6-A
Page 3
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

INCOME ELIGIBILITY LEVELS (Continued)

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).

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	\$ <u> </u>
<u>2</u>	\$ <u> </u>
<u>3</u>	\$ <u> </u>
<u>4</u>	\$ <u> </u>
<u>5</u>	\$ <u> </u>

N/A

TN No. <u>92-04</u>	Approval Date <u>5-3-93</u>	Effective Date <u>1-1-92</u>
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SUPPLEMENT 1 TO ATTACHMENT 2.6-A
Page 4
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

INCOME ELIGIBILITY LEVELS (Continued)

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.

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	\$ _____
<u>2</u>	\$ _____
<u>3</u>	\$ _____
<u>4</u>	\$ _____
<u>5</u>	\$ _____
<u>6</u>	\$ _____
<u>7</u>	\$ _____
<u>8</u>	\$ _____
<u>9</u>	\$ _____
<u>10</u>	\$ _____

N/A

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TN No. 91-02

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Effective Date 1-1-92

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

INCOME ELIGIBILITY LEVELS (Continued)

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.

TN No. 95-01 Approval Date 6-16-95 Effective Date 02-01-95
Supersedes
TN No. 92-14

MA MONTHLY PROTECTED INCOME LEVELS

By County Shelter Area

ZONE I COUNTIES

Shelter Area	I	II	III	IV	V	VI
Number of Persons	Amount	Amount	Amount	Amount	Amount	Amount
1	333.	333.	341.	358.	375.	400.
2	450.	450.	466.	483.	500.	516.
3	481.	486.	499.	514.	529.	544.
4	512.	521.	531.	544.	558.	572.
5	604.	613.	622.	636.	649.	663.
6	730.	740.	749.	762.	776.	790.
7	804.	813.	823.	836.	850.	864.
8	878.	887.	896.	910.	924.	938.
9	952.	961.	970.	984.	998.	1,011.
10*	1,026.	1,035.	1,044.	1,058.	1,072.	1,085.

ZONE II COUNTIES

1	341.	341.	350.	366.
2	450.	458.	466.	491.
3	483.	492.	500.	520.
4	516.	525.	534.	548.
5	607.	616.	625.	639.
6	734.	743.	752.	766.
7	808.	817.	826.	840.
8	882.	891.	900.	914.
9	956.	965.	974.	988.
10*	1,030.	1,039.	1,048.	1,062.

*For each additional person, add \$67.

TN 91-0017
Supersedes
TN 91-5

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SUPPLEMENT 1 TO ATTACHMENT 2.6-A
Page 8
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

X Applicable to all groups.
See pages 9a and 9b of Supplement
1 to Attachment 2.6-A.

Applicable to all groups except
those specified below. Excepted
group income levels are also
listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____ months	Amount by which Column (2) exceeds limits specified in 42 CFR	Net income level for persons living in rural areas for _____ months	Amount by which Column (4) exceeds limits specified in 42 CFR
<input type="checkbox"/> urban only		435.1007 ^{1/}		435.1007 ^{1/}
<input type="checkbox"/> urban & rural				
1	\$	\$	\$	\$
2	\$	\$	\$	\$
3	\$	\$	\$	\$
4	\$	\$	\$	\$

For each
addi-
tional
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
TN No. N/A

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SUPPLEMENT 1 TO ATTACHMENT 2.6-A
Page 9
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

INCOME LEVELS (Continued)

See pages 9a and 9b
of Supplement 1 to
Attachment 2.6-A

D. MEDICALLY NEEDY

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____ months	Amount by which Column (2) exceeds limits specified in 42 CFR	Net income level for persons living in rural areas for _____ months	Amount by which Column (4) exceeds limits specified in 42 CFR
<input type="checkbox"/> urban only		435.1007 ^{1/}		435.1007 ^{1/}
<input type="checkbox"/> urban & rural				
5	\$	\$	\$	\$
6	\$	\$	\$	\$
7	\$	\$	\$	\$
8	\$	\$	\$	\$
9	\$	\$	\$	\$
10	\$	\$	\$	\$

For each
addi-
tional
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
TN No. N/A

Approval Date 5-3-93

Effective Date 1-1-92

HCFA ID: 7985E

ADC/MA SHELTER AREAS

SHELTER AREA I

02 Alger
07 Baraga
27 Gogebic
32 Huron
36 Iron
42 Keweenaw
48 Luce
54 Mecosta
55 Menominee
71 Presque Isle
77 Schoolcraft

SHELTER AREA II

06 Arenac
17 Chippewa
21 Delta
31 Houghton
35 Iosco
43 Lake
51 Manistee
64 Oceana
66 Ontonagon
67 Osceola
68 Oscoda

SHELTER AREA III

01 Alcona
10 Benzie
16 Cheboygan
20 Crawford
22 Dickinson
26 Gladwin
30 Hillsdale
38 Jackson
40 Kalkaska
49 Mackinac
53 Mason
57 Missaukee
59 Montcalm
61 Muskegon
62 Newaygo
65 Ogemaw
76 Sanilac
83 Wexford

SHELTER AREA IV

03 Allegan
04 Alpena
05 Antrim
11 Berrien
12 Branch
13 Calhoun
14 Cass
15 Charlevoix
18 Clare
24 Emmet
29 Gratiot
34 Ionia
37 Isabella
52 Marquette
60 Montmorency
72 Roscommon
75 St. Joseph
78 Shiawassee
79 Tuscola
82 Wayne

SHELTER AREA V

08 Barry
09 Bay
19 Clinton
23 Eaton
28 Grand Traverse
39 Kalamazoo
41 Kent
44 Lapeer
45 Leelanau
46 Lenawee
56 Midland
69 Otsego
70 Ottawa
73 Saginaw
80 Van Buren

SHELTER AREA VI

25 Genesee
33 Ingham
47 Livingston
50 Macomb
58 Monroe
63 Oakland
74 St. Clair
81 Washtenaw

TN No. 94-05
Supersedes
TN No. 92-15

Approval Date 4-16-94

Effective Date 01-01-94

MA MONTHLY PROTECTED INCOME LEVELS
By County Shelter Area

Shelter Area	I	II	III	IV	V	VI
Number of Persons	Amount	Amount	Amount	Amount	Amount	Amount
1	341.	341.	350.	375.	391.	408.
2	458.	466.	475.	500.	516.	541.
3	493.	502.	512.	532.	547.	567.
4	528.	538.	548.	563.	578.	593.
5	624.	634.	644.	659.	674.	689.
6	757.	767.	777.	792.	807.	822.
7	833.	843.	853.	868.	883.	898.
8	909.	919.	929.	944.	959.	974.
9	985.	995.	1,005.	1,020.	1,035.	1,050.
10*	1,061.	1,071.	1,081.	1,096.	1,111.	1,126.

* For each additional person, add \$76.

File No. 92-15 Approval Date 10-23-92 Effective Date 01-01-92
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File No. 92-04

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AUGUST 1991

SUPPLEMENT 2 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

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:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u> </u>
<u>2</u>	<u> </u>

b. Optional Groups

☐ Same as SSI resources levels.

☐ Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u> </u>
<u>2</u>	<u> </u>

N/A

TN No. 92-04
Supersedes
TN No. 87-11

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AUGUST 1991

SUPPLEMENT 2 TO ATTACHMENT 2.6-A
Page 2
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

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:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u> </u>
<u>2</u>	<u> </u>
<u>3</u>	<u> </u>
<u>4</u>	<u> </u>
<u>5</u>	<u> </u>
<u>6</u>	<u> </u>
<u>7</u>	<u> </u>
<u>8</u>	<u> </u>
<u>9</u>	<u> </u>
<u>10</u>	<u> </u>

N/A

TN No. 92-04
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TN No. 91-04 Approval Date 5-3-93 Effective Date 1-1-92
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AUGUST 1991

SUPPLEMENT 2 TO ATTACHMENT 2.6-A
Page 3
OMB No.: 0938-

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:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u> </u>
<u>2</u>	<u> </u>
<u>3</u>	<u> </u>
<u>4</u>	<u> </u>
<u>5</u>	<u> </u>
<u>6</u>	<u> </u>
<u>7</u>	<u> </u>
<u>8</u>	<u> </u>
<u>9</u>	<u> </u>
<u>10</u>	<u> </u>

N/A

TN No. 92-04
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TN No. 89-05
Approval Date 5-3-93
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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:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	
<u>2</u>	
<u>3</u>	
<u>4</u>	
<u>5</u>	
<u>6</u>	
<u>7</u>	
<u>8</u>	
<u>9</u>	
<u>10</u>	

N/A

TN No. 92-14
Supersedes Approval Date 04-16-92 Effective Date 01-01-92
TN No. 92-04

State: MICHIGAN

- Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	
<u>2</u>	
<u>3</u>	
<u>4</u>	
<u>5</u>	
<u>6</u>	
<u>7</u>	
<u>8</u>	
<u>9</u>	
10	

NOT APPLICABLE

TN No. 92-25
Supersedes Approval Date 10-28-92 Effective Date 07/01/92
TN No. 92-04

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

SUPPLEMENT 2 TO ATTACHMENT 2.6-A
Page 6
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

4. Aged and Disabled Individuals

☒ Same as SSI resource levels.

☐ More restrictive than SSI levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u> </u>
<u>2</u>	<u> </u>
<u>3</u>	<u> </u>
<u>4</u>	<u> </u>
<u>5</u>	<u> </u>

☐ Same as medically needy resource levels (applicable only if State has a medically needy program)

TN No. 95-01
Supersedes 92-04 Approval Date 6-16-95 Effective Date 01-01-95
TN No. 92-04
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 bellow under the provision of Section 1902(f) of the Act:

<u>Family Size</u>	<u>Resource Level</u>
1	2,000
2	3,000

TN NO.: 06-02

Approval Date: JAN 08 2007

Effective Date: 05/01/2006

Supersedes
TN No.: 97-14

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.

TN NO.: 09-03

Approval Date: MAR 09 2010

Effective Date: 07/01/2009

Supersedes
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AUGUST 1991

SUPPLEMENT 4 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

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. <u>92-04</u>	Approval Date <u>5-3-93</u>	Effective Date <u>1-1-92</u>
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TN No. <u>91-02</u>		

HCFA ID: 7985E

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AUGUST 1991

SUPPLEMENT 5 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

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. 2-04
Supersedes
TN No. 88-17 Approval Date 5-3-93 Effective Date 1-1-92
HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD)
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SUPPLEMENT 5a TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

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

TN No. 93-04
Supersedes
TN No. 88-26

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Effective Date 1-1-93

HCFA ID: 7985E

Standards for Optional State Supplementary Payments

[illegible]

Approval Date 05/16/86 Effective Date 10/01/84

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

Category of Eligible Individuals	<u>Living Arrangements</u>					
	Column A Independent Living	Column B Household of Another	Column C Domiciliary Care	Column D Personal Care	Column E Home for Aged Care	Column F Institutions
Aged	\$494.00	\$329.34	\$581.00	\$651.50	\$673.30	\$37.00
Blind	\$494.00	\$329.34	\$581.00	\$651.50	\$673.30	\$37.00
Disabled	\$494.00	\$329.34	\$581.00	\$651.50	\$673.30	\$37.00
Aged & Aged Spouse	\$741.00	\$494.00	\$1,162.00	\$1,303.00	\$1,346.00	\$74.00
Blind & Blind Spouse	\$741.00	\$494.00	\$1,162.00	\$1,303.00	\$1,346.00	\$74.00
Disab & Disab Spouse	\$741.00	\$494.00	\$1,162.00	\$1,303.00	\$1,346.00	\$74.00
Aged & Blind Spouse	\$741.00	\$494.00	\$1,162.00	\$1,303.00	\$1,346.00	\$74.00
Aged & Disab Spouse	\$741.00	\$494.00	\$1,162.00	\$1,303.00	\$1,346.00	\$74.00
Blind & Disab Spouse	\$741.00	\$494.00	\$1,162.00	\$1,303.00	\$1,346.00	\$74.00

TN No. 98-06
Supersedes
TN No. 97-09

Approval Date

8/20/98

Effective Date 01/01/98

- (*B) 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.
- (*C) 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

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

SUPPLEMENT 7 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

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. <u>92-04</u>	Approval Date <u>5-3-92</u>	Effective Date <u>1-1-92</u>
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TN No. <u>85-07</u>		HCFA ID: 7985E

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AUGUST 1991

SUPPLEMENT 8 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

N/A

TN No. <u>92-04</u>	Approval Date _____	Effective Date <u>10-01-91</u>
Supersedes		
TN No. <u>85-07</u>		HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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TN No.: 04-03

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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:

- ☒ Qualified children and pregnant women under 1902(a)(10)(A)(i)(III).
- ☒ 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)(I) – 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)(XI) – recipients of optional State supplements
 - 1902(a)(10)(A)(ii)(XV) - TWWIIA

NOTE: The Special Income Level Group under 1902(a)(10)(A)(ii)(V), the Individuals Who Would be Eligible if In an Institution Group under 1902(a)(10)(A)(ii)(VI) and the Hospice Group under 1902(a)(10)(A)(ii)(VII) cannot be included in this disregard.

- ☒ Medically Needy under 1902(a)(10)(C)(i)(III).
- All aged, blind or disabled groups in 209(b) states under 1902(f).
- ☒ QMBs, SLMBs and QIs under 1905(p),

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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:

- o Homestead
- o Clothing, household good and personal effects regardless of value
- o One automobile regardless of how it is used or its value
- o 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,

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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.

TN NO.: 04-03 Approval Date: 01/01/2004 Effective Date: 01/01/2004

Supersedes

TN No.: N/A new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

State Long-Term Care Insurance Partnership

1902(r)(2) The following more liberal methodology applies to individuals who are eligible for
1917(b)(1)(C) 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.

TN NO.: 13-015

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TN No.: N/A – new page

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.

TN NO.: 13-015

Approval Date: SEP 19, 2014 Effective Date: 10/01/2013

Supersedes

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

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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 # <u>92-16</u>	Approval	Effective
Supersedes	Date <u>5-1-92</u>	Date <u>3-1-92</u>
TN # <u>92-04</u>		

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:

- X Payments based on a level of care in a nursing facility;
- X Payments based on a nursing facility level of care in a medical institution;
- X 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:

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Supersedes _____ Approval Date 08-20-96 Effective Date 07/01/96
TN No. N/A

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:

State: MICHIGAN

TRANSFER OF ASSETS

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:

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TN No. N/A

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.

X 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:

TN No. 96-011
Supersedes _____ Approval Date 08-20-96 Effective Date 07/01/96
TN No. N/A

State: MICHIGAN

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.

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TN No. N/A

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).

SEP 06 2007

TN NO.: 07-08

Approval Date: _____

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Supersedes

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Transfer of Assets

- ☒ 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;
- ☒ The State uses the firsts 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:

- ☒ 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.

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TN No.: N/A new page

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.

☒ 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)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

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.

TN No. 96-11
Supersedes
TN No. 94-18

Approval Date 08-20-96

Effective Date: 07-01-96

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.
- ☒ 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.
- ☒ 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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Effective Date: 01/01/2005

Supersedes
TN No.: 01-06

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.

TN NO.: 08-13

Approval Date: MAR 18 2009

Effective Date: 10/01/2008

Supersedes
TN No.: 01-06

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.

TN #	01-06	Approval Date	9/21/01	Effective Date	10-01-01
Supersedes TN #	97-10				

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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TN No. 97-09

Approval Date 6/5/97

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TN No. 96-01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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:

TN No. 95-16
Supersedes _____
TN No. N/A

Approval Date 11-13-95 Effective Date 10/01/95

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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TN No.: N/A – New Page

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

TN NO.: 11-05

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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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JUL 20 2007
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State Plan Under Title XIX of the Social Security Act

State: Michigan

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

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.

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TN No.: N/A – New Page

State Plan Under Title XIX of the Social Security Act

State: Michigan

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	Relevant Population Group Income Standard For each population group, indicate the lower of: <ul style="list-style-type: none"> 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
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	<i>Attachment A</i> , 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	<i>Attachment A</i> , 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	<i>Attachment A</i> , 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

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Approval Date: **OCT 9, 2015**

Effective Date: 04/01/2014

Supersedes

TN No.: 14-03

State Plan Under Title XIX of the Social Security Act

State: Michigan

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

Children Age 19 or 20	<i>Attachment A</i> , 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.	Yes	No	No	No
Childless Adults	Not covered	No	No	No	No

TN NO.: 14-010

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TN No.: 14-03

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.

TN NO.: 14-010

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TN No.: 14-03

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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TN No.: 14-03

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

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.

Heading Rev. 04/01/89

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

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. 93-29
Supersedes 93-06 Approval Date 12-7-93 Effective Date 10-01-93
TN No. 93-06

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 NEEDY***

b. Optometrists' services.

☒ Provided: ☐ No Limitations ☒ With Limitations*
☐ Not Provided

c. Chiropractors' services.

☒ Provided: ☐ 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 ☒ With Limitations*

b. Home health aide services provided by a home health agency.

Provided: ☐ No Limitations ☒ 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 ☒ With Limitations*

*Description provided on attachment.

TN NO.: 18-0003

Approval Date: JULY 26, 2018

Effective Date: 07-01-2018

Supersedes
TN No.: 92-32

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

ATTACHMENT 3.1-A
Page 3a
OMB No.: 0938-

State/Territory: MICHIGAN

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 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.

TN No. 92-25
Supersedes N/A Approval Date 04-14-92 Effective Date 10-01-91
TN No. HCFA ID: 7986E

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

☒ Provided ☐ No Limitations ☒ With Limitations*

☐ Not Provided

10. Dental services

☒ Provided ☐ No Limitations ☒ With Limitations*

☐ Not Provided

11. Physical therapy and related services:

a. Physical therapy

☒ Provided ☐ No Limitations ☒ With Limitations*

☐ Not Provided

b. Occupational therapy

☒ Provided ☐ No Limitations ☒ 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)

☒ Provided ☐ No Limitations ☒ 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

AMOUNT, DURATION AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY 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.

 X Provided: No Limitations X With Limitations*
 Not Provided

b. Dentures

 X Provided: No Limitations X With Limitations*
 Not Provided

c. Prosthetic and Orthotic Devices

 X Provided No Limitations X With Limitations*
 Not Provided

d. Eyeglasses

 X Provided No Limitations X With Limitations*
 Not Provided

*Description provided on attachment

TN No. 95-06 Approval Date 10-29-95 Effective Date 04-01-95

Supersedes

TN No. 92-21

HCFA ID: 0069P/0002P

AMOUNT, DURATION AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

*Description provided on attachment

TN No. 88-5
Supersedes
TN No. 85-22

Approval Date 04-06-88

Effective Date 01-01-88

HCFA ID: 0069P/0002P

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

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

c. Preventive services

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

d. Rehabilitative services

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

b. Skilled nursing facility services

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided

c. Intermediate care facility services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ 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

January 1, 2025 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
TN No. _____

Approval Date 03-11-88

Effective Date 04/01/87

HCFA ID: 0069P/0002P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MICHIGAN

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 1905(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 94-11 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).

☒ Provided ☐ No Limitations ☒ 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 ☒ Not Provided

23. Certified pediatric or family nurse practitioners' services.

☒ Provided ☐ No Limitations ☒ With Limitations ☐ Not Provided

TN NO.: 12-18

Approval Date: JAN 13 2013

Effective Date: 10/01/2012

Supersedes

TN No.: 05-05

State/Territory: MICHIGAN

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.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

c. Care and services provided in Christian Science sanatoria.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ 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.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

*Description provided on attachment.

TN No. 92-05
Supersedes 86-05 Approval Date 04-14-92 Effective Date 10-01-91
TN No. 86-05 HCFA ID: 7986E

Revision: HCFA-PM-94-9 (MB)
DECEMBER 1994

ATTACHMENT 3.1-A
Page 10

State: MICHIGAN

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
 X Limitations Described on Attachment

 Not Provided.

TN No. 95-18
Supersedes
TN No. 93-06 Approval Date 12-11-95 Effective Date 10-01-95

State of Michigan
PACE State Plan Amendment Pre-Print

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.

TN No. 00-11

Approval Date 8-3-2001

Effective Date 10/01/00

Supersedes

TN No. N/A – new page

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***

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.

TN NO.: 11-03

Approval Date: OCT 31 2011

Effective Date: 07/01/2011

Supersedes

TN No.: N/A - New Page

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***

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: X

I. General Assurances:**Routine Patient Cost – Section 1905(gg)(1)**

 X Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

 X A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

 X A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN NO.: 22-0001

Approval Date: MAR 23, 2022

Supersedes TN No.: NEW

Effective Date: 01-01-2022

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.

*"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

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

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.

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

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.

10/01/90

Rev. 10/01/90

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.

Heading Rev. 04/01/89

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.

Heading Rev. 04/01/89

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

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.

TN NO.: 06-17

Approval Date: DEC 07 2006

Effective Date: 01/01/2007

Supersedes
TN No.: 02-06

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

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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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. 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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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**

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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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

- 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.

- 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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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

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.

Heading Rev. 04/01/89

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

2. OUTPATIENT HOSPITAL SERVICES

Outpatient Hospital Services are covered as medically necessary in accordance with 42 CFR § 440.20(a) - Outpatient Hospital Services when furnished by hospitals licensed pursuant to the Public Health Code Act 368 of 1978 and who meet the requirements for participation in Medicare as a hospital. Outpatient hospital services include prenatal and postnatal care and preventive, diagnostic, therapeutic, rehabilitative, or palliative services when ordered by and furnished under the direction of a physician (M.D. or D.O.) or dentist and performed by a licensed practitioner within their scope of practice as defined in State law. Outpatient hospital services are limited to the same extent as physicians' services and other specific services listed in 3.1-A when provided in a non-facility setting.

Hemodialysis performed in a patient's home is considered to be an outpatient hospital service.

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.)

Physical therapy and occupational therapy services, provided in accordance with 42 CFR 440.110, and as defined in 1.a of Supplement to Attachment 3.1-A, require prior approval when services exceed time or frequency limits as described in Medicaid policy for:

- initial treatment (144 units in 12 months) or
- maintenance/monitoring (four times, up to 16 units, in the 90-day allowed period)

Speech-Language therapy services, provided in accordance with 42 CFR 440.110, and as defined in 1.a of Supplement to Attachment 3.1-A, require prior approval when services exceed time or frequency limits as described in Medicaid policy for:

- initial treatment (36 visits in 12 months) or
- maintenance/monitoring (four times in the 90-day allowed period)

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***

Reserved Page

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***

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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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***

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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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*

- 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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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***

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 for services, other than specialized maintenance therapy, rendered more than 60 days from the admission date to the facility.
2. Occupational therapy, as defined in 1.a. Prior Authorization is required for services, other than specialized maintenance therapy, rendered more than 60 days from the admission date to the facility.
3. Speech pathology, as defined in 1.a. Prior Authorization is required for services, other than specialized maintenance therapy, rendered more than 60 days from the admission date to the facility.

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.

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**

- 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. Dental visits are recommended according to the periodicity schedule by the American Academy of Pediatric Dentistry.

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.

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.

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***

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;

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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***

4b. EPSDT (continued)

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).

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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***

4b. EPSDT (continued)

Behavioral Health Treatment (BHT) – (continued)

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:
 - Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis);
 - Adapting environments to promote positive behaviors and learning while reducing negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports);
 - Applying reinforcement to change behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction);
 - 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);
 - Teaching parents to provide individualized interventions for their child, for the benefit of the child (e.g., parent implemented intervention);
 - 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
 - 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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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***

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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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***

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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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***

4b. EPSDT (continued)

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.

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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***

4b. EPSDT (continued)
Behavioral Health Treatment (BHT) – (continued)

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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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***

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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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

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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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***

4b. EPSDT (continued)

Parent Support Partner 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 Parent-to-Parent support for parents/caregivers of children with Serious Emotional Disturbance or an Intellectual/Developmental Disability. In accordance with 42 CFR 440.130(d), parent support services are recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law.”

A. Services

- Providing support to parent(s), guardians(s), or caregiver(s) on advocating for their child and family's needs with systems that support youth with mental health, behavioral and emotional needs.
- Fostering empowerment of parent(s), guardian(s), or caregiver(s) through connection around shared lived experience for parent(s), guardian(s), or caregiver(s) of youth with mental health needs and encouraging participation in peer/parent support;
- Modeling self-advocacy and empowerment skill-building support skills for parent(s), guardians(s), or caregiver(s);

B. Provider Criteria

Services are provided by individuals who meet the following criteria:

- Lived experience as a parent or primary caregiver of a child with behavioral or mental health needs and/or intellectual/developmental disability, including autism.
- Willing and able to use their experiences as a peer parent to support others.
- Experience receiving services for their child in a variety of systems (such as child welfare, special education, juvenile justice system, etc.) is preferred.
- Trained in the MDHHS approved curriculum, certification and re-certification model.
- Receives regular supervision by a child mental health professional or qualified intellectual disabilities professional as defined by the State.

C. Prior Authorization

parents, guardians, and caregivers of Medicaid-eligible children can receive parent support partner services when the service is directed exclusively toward the benefit of a Medicaid-eligible child. Parent Support Partner Services are authorized for a period not to exceed 12 months. Medically necessary services may be re-authorized at the request of a clinician within their scope of practice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
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State of Michigan

***Amount, Duration and Scope of Medical and Remedial Care
Services Provided to the Categorically and Medically Needy***

4c. **Family Planning Services 1905(a)(4)(C)**

Family Planning Services and Supplies:

- Office visits for purposes of family planning, including patient history, contraceptive counseling, physical exams, and laboratory tests
- Pharmaceutical supplies and devices to prevent or delay pregnancy, including all methods of contraception approved by the U.S. Food and Drug Administration
- Family planning education, counseling, and referrals
- Limited laboratory examinations and tests for purposes related to family planning; and
- Male and female sterilization procedures provided in accordance with 42 CFR 441, Subpart F.

Family Planning Related Services Provided under the State Eligibility Option:

Outpatient services that are routinely provided as part of, or as follow-up to, a family planning services visit, including, but not limited to:

- Diagnostic procedures, drugs, and follow-up visits to treat an STI or STI-related disorder identified or diagnosed at a routine/periodic family planning visit (other than HIV/ AIDS and hepatitis)
- Diagnostic procedures, drugs and follow-up visits for lower genital tract and genital skin infections and urinary tract infections, when the infection/disorder is identified or diagnosed during a routine/periodic family planning visit
- Family planning-related services associated with sterilization procedures and follow-up care
- PAP screens and treatment for pre-cancerous conditions which commonly originate from a Sexually Transmitted Infection (STI)
- Family planning-related preventive services recommended by the USPSTF, and vaccines to prevent STIs; and
- Treatment of major complications related to family planning services and family planning related procedures.

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***

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:

TN NO.: 11-07

Approval Date: DEC 23 2011

Effective Date: 07/01/2011

Supersedes

TN No.: NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MICHIGAN

***Amount, Duration and Scope of Medical and Remedial Care
Services Provided to the Categorically and Medically Needy***

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.

TN NO.: 12-08

Approval Date: JUL 31 2012

Effective Date: 04/01/2012

Supersedes
TN No.: 92-22

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***

- 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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Effective Date: 01/01/2013

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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***

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.

TN NO.: 09-09

Approval Date: MAR 15, 2010

Effective Date: 04/01/2009

Supersedes

TN No.: N/A new page

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***

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.

TN NO.: 10-24

Approval Date: JUL 18 2012

Effective Date: 10/01/2010

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TN No.: 09-15

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***

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:

~ Clinical Nurse Specialist (CNS)

Services provided by registered nurses certified by the Michigan Board of Nursing as clinical nurse specialists are covered in the inpatient and outpatient setting. Covered services are limited to those allowed under the CNS' scope of practice as defined by State law.

~ 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.

TN NO.: 18-0011

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TN No:16-0003

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

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

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 Needy***

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 July 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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TN No.: 16-0003

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***

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.

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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***

6. Medical Care Furnished by Practitioners within the Scope of their Practice as Defined by State Law
(continued)

d. Other Practitioner Services (continued)

Genetic counseling services - genetic counseling services are covered when furnished by a licensed master's or doctoral level genetic counselor, certified by the American Board of Genetic Counseling, Inc (ABGC) or the American Board of Medical Genetics and Genomics (ABMGG), or by a temporary licensed genetic counselor under the appropriate supervision of a qualified licensed genetic counselor. Covered services are limited to those under the Genetic Counselors scope of practice as defined by State law.

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***

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 or permitted Non-Physician Practitioner (NPP), which is defined as a Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), or Physician Assistant (PA), 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 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 or NPP 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 order from the beneficiary's physician or NPP;
- 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.

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

7. Home Health Care (continued)

Covered services

3. Medical supplies (continued)

Supplies

Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

Certain items require prior authorization.

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

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable. State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment in the Medicare program.

Prior authorization of DME is required for beneficiaries of all ages except where exempted for selected diagnostic codes.

Program coverage for all beneficiaries must be ordered by a physician or permitted Non-Physician Practitioner (NPP), which is defined as a Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), or Physician Assistant (PA), 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.

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***

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 Nacility 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 or Non-Physician Practitioner (NPP).

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TN No.: 18-0003

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***

- 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 or Non-Physician Practitioner (NPP), 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 or Non-Physician Practitioner's (NPP) 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.

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

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.

TN No. 94-01
Supersedes
TN No. 91-14

Approval Date 2-23-94 Effective Date 01/01/94

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

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.

TN No. 94-01
Supersedes
TN No. 91-21

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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***

10. Dental Services

- Services provided by licensed dentists within their scope of practice as defined by state law, are
 - Services provided by licensed dental therapists within their scope of practice as defined by state law and performed under the supervision of a Medicaid-enrolled dentist within the terms of the written practice agreement, 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.

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Approval Date: NOV 18, 2021

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TN No.: 10-24

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***

10. Dental Services (CONTINUED)

- Services provided by licensed dentists within their scope of practice as defined by state law, are
 - Services provided by licensed dental therapists within their scope of practice as defined by state law and performed under the supervision of a Medicaid-enrolled dentist within the terms of the written practice agreement, are
- B. covered for beneficiaries under the EPSDT program:
1. Examinations and preventive services in accordance with the American Academy Of Pediatric Dentistry (AAPD) 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.

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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***

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, up to 16 units, 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, up to 16 units, 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;

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***

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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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***

12. Drug Products, Dentures, Prosthetic and Orthotic Devices, and 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. The preferred drug list is for all State of Michigan Medicaid beneficiaries receiving pharmacy benefits.
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 MOMS program, as in effect on October 2002 and as consistent with 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 benefits 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 iii) other parameters necessary to ensure appropriate utilization or to prevent fraud and abuse.

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***

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)
 - (I) 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.
 - (II) CMS has authorized the State of Michigan to enter into outcomes-based contract arrangements with drug manufacturers for drugs provided to Medicaid beneficiaries. These contracts will be executed on the contract template titled "Outcomes-Based Supplemental Rebate Agreement" submitted to CMS and authorized for use beginning July 31, 2020.
 - (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.
 10. Coverage of selected active pharmaceutical ingredients (APIs) and excipients that are essential to the health of the beneficiary when billed as part of a compounded drug claim.
- 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.

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***

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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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

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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Supersedes

TN No. 90-26

(Page Shift)

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***

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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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

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.

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

Preventive Services - Doula Services

The program covers doula services for pregnant and postpartum beneficiaries as a preventive service consistent with 42 CFR §440.130(c) to promote positive maternal physical and mental health during the perinatal period. Services must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice. Doula services include:

- Prenatal Services
 - Promoting health literacy and knowledge
 - Assisting with the development of a birth plan
 - Supporting personal and cultural preferences around childbirth
 - Providing emotional support and encouraging self-advocacy
 - Reinforcing practices known to promote positive outcomes such as breastfeeding
 - Coordinating referrals or Linkages to community-based support services to address social determinants of health
- Labor and Delivery Services
 - Providing physical comfort measures, information, and emotional support
 - Advocating for beneficiary needs
 - Being an active member of the birth team
- Postpartum Services
 - Educating regarding newborn care, nutrition, and safety
 - Supporting breastfeeding
 - Providing emotional support and encouraging self-care measures
 - Supporting beneficiary in attending recommended medical appointments
 - Coordinating referrals or linkage to community-based support services to address social determinants of health

Provider Criteria

Qualified individuals must be at least 18 years of age, possess a high school diploma or equivalent, and possess a current certification by a doula training program or organization approved by the Michigan Department of Health and Human Services. At a minimum, doula training must include skill development in the following areas:

- Communication including active listening, cross-cultural communication, and interprofessional communication
- Perinatal self-care measures
- Coordination of and linkage to community services and resources
- Labor coping strategies
- Newborn care and supportive measures.

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

13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES

c. Preventive Services (Continued) – Diabetes Prevention

Effective May 1, 2023, the program covers the Michigan Medicaid Diabetes Prevention Program (MiDPP) as a preventive service. MiDPP meets all requirements for the Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program (NDPP) and preventive service requirements in 42 CFR Section 440.130 (c). The NDPP is an evidence-based, educational support program designed to assist at-risk individuals from developing Type 2 diabetes.

The Public Health Administration (PHA) within the Michigan Department of Health and Human Services (MDHHS) ensures provider qualification utilizing CDC recognition requirements. MiDPP providers and lifestyle coaches must be approved by the MDHHS PHA before enrolling with the Michigan Medicaid program. All enrolled lifestyle coaches must be associated with an enrolled MiDPP provider. Services are recommended by a physician or other licensed practitioner of the healing arts within their scope of practice. MiDPP services include:

- Group sessions related to long-term dietary change, increased physical activity and behavior change strategies for weight control.
- Group support and skill building to facilitate the knowledge, skill, and ability necessary to prevent the onset of Type 2 diabetes.

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

13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES

C. PREVENTIVE SERVICES (CONTINUED) – COMMUNITY HEALTH WORKER SERVICES

Effective January 1, 2024, the program covers services of the Community Health Worker (CHW) as a preventive service as defined in 42 CFR 440.130(c), to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and efficiency. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health-related social needs.

DESCRIPTION OF SERVICES:

The following component services are covered when performed by CHWs:

Health System Navigation and Resource Coordination

Health system navigation and resource coordination services include providing information, training, referrals, or support to encourage beneficiary-led efforts to:

- Access covered services, understand, engage, or re-engage in the health care system, or engage in their own care needs.
- Connect to relevant community resources necessary to promote health, address health care barriers, or address health-related social needs.

Health Promotion and Education

Health education to promote the beneficiary's health or address barriers to physical and mental health care, including providing information, instruction, methods, and measures on health topics that have been proven effective in preventing disease, disability, and other health conditions or their progression; prolonging life; and/or promoting physical and mental health and efficiency. The content of health promotion and education services must be consistent with established or recognized health care standards and best practices. Health education may include coaching and goal-setting to improve a beneficiary's health or ability to self-manage health conditions.

Screening and Assessment

Screening and assessment services include the use of standardized, validated tools that do not require a license and that support the identification of needed services.

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

COVERAGE LIMITATIONS:

CHW services are limited to 2 hours (8 units) per day and 16 visits per month, for a maximum of 32 hours (128 units) per month, per beneficiary. This limit may be exceeded based on medical necessity determined in collaboration with the recommending licensed provider and require prior authorization. Group services are limited to eight unique beneficiaries at one time. There are no Place of Service restrictions for CHW services.

PROVIDER QUALIFICATIONS:

An individual meeting the qualifications set by MDHHS and verified by the certifying vendor contracted with MDHHS is eligible to deliver CHW services and seek Medicaid reimbursement. Minimum qualifications required include:

- Have completed a skills-based Community Health Worker training program or curriculum.
- Continuing Education - Community Health Workers must complete a minimum of 6 hours of continuing education training annually.

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***

(Moved from Supplement to Attachment 3.1-A Page 26)

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:

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

- 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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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***

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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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

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.

04/01/91

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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
AND
SERVICES PROVIDED TO THE CATEGORICALLY AND MEDICALLY NEEDY

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 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)**

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.

TN No. 93-22
Supersedes
TN No. 91-23

Approval Date 10-22-93 Effective Date 07/01/93

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***

13d. 7)

Peer-Delivered or -Operated Support Services	<p>Peers are self-identified consumers in recovery from, serious mental illness, serious emotional disturbance, substance use disorders, and/or lived experience with intellectual and developmental disabilities; or a parent/adult with personal experience on-going or in the past of a child or family member with similar mental illness, intellectual and developmental disabilities, and/or substance use; and have experience and perspectives with navigating human service systems and supports.</p> <p>Peer support providers must complete the approved MDHHS training, application and certification requirements, demonstrate competencies necessary to perform the peer support service function, and complete ongoing peer continuing education trainings to maintain skills, expand knowledge base, and remain up to date on best practices/supports within the human service system of care. Individuals providing Peer support services must be able to demonstrate their experience in relationship to the types of guidance, support and mentoring activities they will provide. Peer support providers are supervised by licensed mental health Professionals working within their scope of practice and applicable state law.</p> <p><u>Components</u></p> <ul style="list-style-type: none">• Empowering individuals to take an active role in the development, amending, and implementation of their person-centered plan to promote self-advocacy, self-reliance, and confidence.• Promoting skills for self-determination to assist in community inclusion/participation, independence, and productivity.• Assisting individuals and families in the use of strategies for coping, recovery, resiliency, advocacy, symptom management, crisis support, and recovery.• Building capacity and Providing support to individuals and families so they have new competencies and understanding of the persons individual needs, human service system navigation, and staying actively engaged in the recovery process. Serving as an advocate, mentor, or facilitator for barriers and skill necessary to increase the health and outcomes of the individual with serious mental illness, intellectual and developmental disability, serious emotional disturbance, and/or substance use disorder.
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TN NO.: 19-0004

Approval Date: JULY 9, 2019

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Supersedes
TN No.: 07-03

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***

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.

TN No.: 05-06

Approval Date: NOV 30 2004

Effective Date: 01/01/2005

Supersedes

TN No. N/A new page 03-06

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***

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.

TN No.: 05-06

Approval Date: NOV 1 2004

Effective Date: 01/01/2005

Supersedes

TN No. N/A new page

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

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.

TN No. 95-10
Supersedes
TN No. N/A

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Effective Date : 08-01-95

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***

Moved to Section 11 – Physical Therapy and Related Services.

TN NO.: 17-0001

Approval Date: AUG 6, 2018

Effective Date: 1/01/2018

Supersedes

TN No.: 14-0016

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***

Moved to Section 11 – Physical Therapy and Related Services.

TN NO.: 17-0001

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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.

TN No. 94-25 Approval Date 12-13-94 Effective Date 10/01/94
Supersedes
TN No. 89-07

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**

- 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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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***

- 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.

TN NO.: 10-01

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Effective Date: 04/01/2010

Supersedes
TN No.: 94-25

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***

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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TN No.: 97-11

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**

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.

10/01/94

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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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***

16. Inpatient Psychiatric Hospital Services for Individuals Under 22 (Continued)

Psychiatric Residential Treatment Facility (PRTF)

Inpatient psychiatric hospital services may also be provided in a Psychiatric Residential Treatment Facility (PRTF) that meets the following requirements:

- 1) Accredited in accordance with the requirements of 42 CFR § 441.151;
- 2) Certified by MDHHS as complying with the requirements of 42 CFR 441 Subpart D and the conditions of participation at 42 CFR 483 Subpart G; and
- 3) Enrolled as a Title XIX provider with MDHHS.

Inpatient psychiatric facility services in a PRTF are limited to those provided for those participants who are medically certified as requiring this level of care in accordance with 42 CFR §441.152. Services are limited to individuals under the age of 21, or if receiving the services immediately before attaining the age of 21, not to extend beyond the earlier of:

- 1) The date the services are no longer required; or
- 2) The date directly prior to the individual reaching the age of 22.

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***

17. Nurse-Midwife Services

Certified nurse midwife services are covered when medically necessary and provided by a qualified, licensed provider within their scope of practice as defined by State law.

Covered services include: obstetric and newborn care, women's primary health care, and gynecological and family planning services. Services must be furnished within an alliance agreement that provides for physician consultation, collaboration, and referral as indicated by the health of the beneficiary.

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Approval Date: MAR 5, 2019

Effective Date: 4/01/19

Supersedes

TN No.: SPA page dated 04/01/1989

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***

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.

TN NO.: 10-06

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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***

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.

TN NO.: 09-07

Approval Date: SEP 24 2009

Effective Date: 01/01/2009

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TN No.: 05-05

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***

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 Non-Emergency Medical Transportation (NEMT) program includes transportation for all beneficiaries. The Michigan Department of Health and Human Services (MDHHS) administers the provision of Fee For Service (FFS) NEMT. MDHHS administers NEMT in all Michigan counties except Wayne, Oakland, and Macomb, where NEMT is administered through a brokerage program.

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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

Transportation is requested through the county MDHHS office. MDHHS reviews the request for appropriateness and approves accordingly. MDHHS 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. MDHHS administrative oversight includes examination and evaluation of monthly and quarterly financial reports; 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.

☐ WITHOUT LIMITATIONS ☐ WITH LIMITATIONS

- ☒ 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).

MDHHS 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.
☐ (10)(B) comparability
☒ (23) freedom of choice

- 2) Transportation services provided will include:

- ☒ wheelchair van
☒ taxi
☐ stretcher car
☒ bus passes
☒ tickets
-

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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***

- ☐ 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)

TN NO.: 10-10

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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***

- ☒ 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

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***

- ☐ 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.

TN NO.: 14-07

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TN No.: 10-10

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***

- ☒ (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.

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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***

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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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***

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.

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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***

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.

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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

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:

SHOPPING	5 HOURS
LIGHT HOUSEKEEPING	6 HOURS
LAUNDRY	7 HOURS
MEAL PREPARATION	25 HOURS

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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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***

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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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

- 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

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***

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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
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State of Michigan

***Amount, Duration and Scope of Medical and Remedial Care
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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 And
Services Provided to the Categorically and Medically Needy***

29. 1905(a)(29) Medication-Assisted Treatment (MAT)

1905(a)(29) X MAT as described and limited in Supplement to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

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***

29. 1905(a)(29) Medication-Assisted Treatment (MAT) – Continued

- i. General Assurance
MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020, and ending September 30, 2025.
- ii. Assurances
 - a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).
 - b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.
 - c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).
- iii. Service Package
The state covers the following counseling services and behavioral health therapies as part of MAT.
 - A) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

From October 1, 2020, through September 30, 2025, the state assures that MAT to treat OUD as defined at section 1905(ee)(1) of the Social Security Act (the Act) is covered exclusively under section 1905(a)(29) of the Act.

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***

29. 1905(a)(29) Medication-Assisted Treatment (MAT) – Continued

Service Components	description
Medication Management	Assessing, ordering, administering, reassessing, and regulating medication and dose levels appropriate to the individual, and overseeing and facilitating access to appropriate treatment for opioid use disorder
Individual, Group, and/or Family Therapy	Helps patients identify treatment goals and potential solutions to problems that cause emotional stress and trigger opioid use; seeks to restore communication and coping skills; strengthens self-esteem; builds recovery capital and promotes behavior change and sustained recovery. Individual, group, and/or family therapy that involves the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. there may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service
Psychotherapy	Behavioral cognitive services and other opioid use disorder-focused counseling
Care Coordination	Includes integrating behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring beneficiary progress and tracking beneficiary outcomes; linking beneficiaries with community resources to facilitate referrals and respond to peer supports; and tracking and supporting beneficiaries when they obtain medical or behavioral health outside the practice.
Peer Recovery Support Services	Nonmedical peer-to-peer activities that engage and support an individual's and as applicable the caregiver's self-help efforts to improve health recovery, resiliency, and wellness. Peer Recovery Support Services that involve the participation of a non-Medicaid eligible is for the direct benefit of the beneficiary. The service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service

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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 And
Services Provided to the Categorically and Medically Needy***

29. 1905(a)(29) Medication-Assisted Treatment (MAT) – Continued

- B) Please include each practitioner and provider entity that furnishes each service and component service.

Service Component	Practitioner and Provider Entity that Furnishes Each Service and Component Service
Medication Management	Physician, Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse Midwife, Physician Assistant
Individual, Group and/or Family Therapy	SUD Treatment Professional
Psychotherapy	SUD Treatment Professional
Care Coordination	Peer Recovery Coach, Physician, Pharmacist, Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse Midwife, Physician Assistant, Registered Nurse, or Practical Nurse
Peer Recovery Support Services	Peer Recovery Coach

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***

29. 1905(a)(29) Medication-Assisted Treatment (MAT) – Continued

- C) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.
1. SUD treatment professional – Certified Addiction Treatment Professional, Certified Alcohol and Drug Counselor (CADC), Certified Advanced Alcohol and Drug Counselor (CAADC), Certified Clinical Supervisor (CCS), appropriately supervised individuals with development plans for these International Certification & Reciprocity Consortium (IC&RC) certifications and Other providers who, Working within their Scope of practice, are Licensed or certified to render behavioral and counseling services.
 2. Peer Recovery coach – Certified through the MDHHS peer recovery coach certification program
 3. Practitioner, including Physician, Pharmacist, Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse Midwife, Physician Assistant, Registered Nurse, or Practical Nurse – Licensed, Buprenorphine-waivered, And Enrolled in the program

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***

29. 1905(a)(29) Medication-Assisted Treatment (MAT) – Continued

iv. Utilization Controls

☒ The state has drug utilization controls in place. (Check each of the following that apply)

- ☐ Generic first policy
☒ Preferred drug lists
☒ Clinical criteria
☒ Quantity limits

☐ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

Clinical prior authorization is required on claims for MAT drugs that exceed quantity limits, and for products that do not have a Federal Medicaid Drug Rebate.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Target Group A: The target 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.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 **[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):

- X** Entire State
 _____ Only in the following geographic areas: **[Specify areas]**

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;

It is required 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;

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State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

- 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. The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

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)):

Case Management Provider Organizations - Must be certified by the single state agency as meeting the following criteria:

- a. demonstrate a capacity to provide all core elements of case management services including
 - Comprehensive client assessment
 - Comprehensive care/service plan development

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State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

- Linking/coordination of services
- Monitoring and follow-up of services
- Reassessment of the client's status and need
- b. demonstrated case management experience in coordinating and linking such community resources as required by the target population
- c. demonstrated experience with the target population
- d. a sufficient number of staff to meet the case management service needs of the target population
- e. an administrative capacity to ensure quality of services in accordance with State and federal requirements
- f. a financial management capacity and system that provides documentation of services and costs.
- g. capacity to document and maintain individual case records in accordance with State and federal requirements.

Qualified Intellectual Disability Professional (QIDP) - Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) or one year experience in treating or working with a person who has intellectual disability; **and** is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietitian, therapeutic recreation specialist, or a licensed or limited-licensed professional counselor or a human services professional with **at least** a bachelor's degree or higher in a human services field.

Qualified Mental Health Professional (QMHP) - Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year experience in treating or working with a person who has mental illness; **and** is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited licensed marriage and family therapist, or a licensed physician's assistant or a human services professional with **at least** a bachelor's degree or higher in a human services field.

Primary Case Manager: Must be a qualified mental health or intellectual disability professional (QMHP or QIDP) or, if the case manager has only a bachelor's degree but without the specialized training or experience, they must be supervised by a QMHP or QIDP who does possess the training or experience. Services to a child with serious emotional disturbance must be provided by a QMHP who is also a child mental health professional. Services to children with developmental disabilities must be provided by a QIDP.

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State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Supports Coordinator: A minimum of a bachelor's degree in a human services field and one year of experience working with people with developmental disabilities if supporting that population; or a bachelor's degree in a human services field and one year of experience with people with mental illness if supporting that population.

Supports Coordinator Assistants: Minimum of a high school diploma and equivalent experience (i.e., possesses knowledge, skills and abilities similar to supports coordinator qualifications) and functions under the supervision of a qualified supports coordinator.

Independent Services and Supports Brokers: Minimum of a high school diploma and equivalent experience (i.e., possesses knowledge, skills and abilities similar to supports coordinator qualifications) function under the guidance and oversight of a qualified supports coordinator or case manager.

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. Individuals will not be compelled to receive case services, condition receipt of case management (or targeted case management)/supports coordination 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.

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State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

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)).

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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

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Supersedes
TN No.: 92-24

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

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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

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State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Target Group C 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 service needs and a lack of capacity and support systems to address those needs without case management.

____ 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):

X Entire State

____ Only in the following geographic areas: **[Specify areas]**

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;
 - completing comprehensive initial assessments and periodic reassessments that evaluate a range of service needs to help establish and update what is important for the individual in a way that is important to the individual, with the following frequency:
 - a. an initial assessment
 - b. re-assessment 90 days after the initial assessment
 - c. a reassessment, or a face to face, person centered planning meeting 180 days after the first/previous re-assessment

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

- d. a re-assessment 180 days after the previous reassessment or person centered planning meeting
 - e. repeat the 180 day assessment cycle as listed in c) and d)
 - f. a reassessment is conducted sooner when there are significant changes in the individual's health or functional status, or significant changes in the individual's network of allies (i.e. death of a primary caregiver)
- ❖ 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 a face to face encounter and is provided on at least a monthly basis, unless otherwise indicated by 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))

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Case management may include coordinated care planning for enrolled individuals when they need to go into a nursing home or medical setting or for new individuals in such facilities, to assure a smooth transition into the community.

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. Case Management Provider Organizations must be certified by the single state agency as meeting the following criteria:
 - a. demonstrate a capacity to provide all core elements of case management services including
 - comprehensive client assessment
 - comprehensive care/service plan development
 - linking/coordination of services
 - monitoring and follow-up of services
 - reassessment of the client's status and need
 - b. demonstrated case management experience in coordinating and linking such community resources as required by the target population
 - c. demonstrated experience with the target population
 - d. a sufficient number of staff to meet the case management service needs of the target population
 - e. an administrative capacity to ensure quality of services in accordance with State and federal requirements
 - f. a financial management capacity and system that provides documentation of services and costs.
 - g. capacity to document and maintain individual case records in accordance with State and federal requirements.
2. Qualified case management staff include:
 - a. a Registered Nurse, Licensed to practice in the state of Michigan
 - b. a Social Worker, Licensed to practice in the State of Michigan
 - c. an individual with a minimum of two years case management experience

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.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

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.
- 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

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

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.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Target Group D consists of persons who are:

1. aged 0 through 25 with a Michigan Department of Health and Human Services (MDHHS), Children's Special Health Care Services (CSHCS) medically eligible diagnosis, or
2. SSI-Disabled Children's Program clients age 0-16, or
3. Aged 26 and over with cystic fibrosis, inherited red blood cell disorders, or coagulation defects.

_____ 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

_____ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

_____ Services are provided in accordance with §1902(a)(10)(B) of the Act.

☒ 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;

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;

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

- 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.
- ❖ 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 visit, 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 involve either face-to-face or telephone and is limited to 6 visits per year unless additional visits are justified based on the needs and circumstances of the individual and/or family. The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the comprehensive plan of care (POC). All services must relate to objectives/goals documented in the POC.

 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)):

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State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

1. Case Management Provider Organizations must be certified by the single state agency as meeting the following criteria:

- a. Currently enrolled as a MI Medicaid Provider
- b. Demonstrate a capacity to provide all core elements of case management services including:
 - Comprehensive client assessment
 - Comprehensive care/service plan development
 - Linking/coordination of services
 - Monitoring and follow-up of services
 - Reassessment of the client's status and need
- c. Demonstrated case management experience in coordinating and linking such community resources as required by the target population
- d. Demonstrated experience with the target population
- e. A sufficient number of staff to meet the case management service needs of the target population.
- f. Willingness and capability to coordinate with the individual's Medicaid Health Plan, if applicable, to maximize effectiveness and avoid duplication of services.
- g. An administrative capacity to ensure quality of services in accordance with State and federal requirements
- h. A financial management capacity and system that provides documentation of services and costs.
- i. Capacity to document and maintain individual case records in accordance with State and federal requirements.

2. A case manager must be:

- a. Licensed to practice as a registered professional nurse in the State of Michigan and be employed by or contracted with a local health department at the entry level or above or
- b. Able to demonstrate to MDHHS that comparable professional qualifications are met.

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.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

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.
- 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

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State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

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))

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State Plan under Title XIX of the Social Security Act
State of Michigan

TARGETED CASE MANAGEMENT SERVICES
Target Group E

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
Target Group E consists of

1. individuals under 21 years of age and determined by an individualized educational program committee or a hearing officer to have mental retardation, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional disturbance (referred to in this part as "emotional disturbance"), an orthopedic impairment, autism, traumatic brain injury, another health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services, or
2. individuals from birth through age two who have been determined by an individualized family service plan team as experiencing developmental delay or have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay including children having mental retardation, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional disturbance (referred to in this part as "emotional disturbance"), an orthopedic impairment, autism, traumatic brain injury, another health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services.

___ 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):

X Entire State

___ Only in the following geographic areas: **[Specify areas]**

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)).

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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 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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**State Plan under Title XIX of the Social Security Act
State of Michigan**

**TARGETED CASE MANAGEMENT SERVICES
Target Group E**

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;

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.The case manager must determine, on an ongoing basis, if the services

TN# 08-10

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**State Plan under Title XIX of the Social Security Act
State of Michigan**

**TARGETED CASE MANAGEMENT SERVICES
Target Group E**

- and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

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)):

1. Case Management provider organizations must be certified by the single state agency as follows:
 - a. to provide special rehabilitation services as prescribed by professionals acting within their scope of practice as defined by state law; and,
 - b. to provide special rehabilitation services in the least restrictive environment; and
 - c. to comply with the provisions for quality assurance specified in elsewhere in this State Plan; and
 - d. to maintain and submit all records and reports to ensure compliance with the Michigan Revised Administrative Rules for Special Education.
 - e. an administrative capacity to ensure quality of services in accordance with State and federal requirements
 - f. a financial management capacity and system that provides documentation of services and costs.
 - g. capacity to document and maintain individual case records in accordance with State and federal requirements.
2. A case manager must
 - a. be a registered nurse with a valid Michigan license, or
 - b. have a 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
 - c. three years personal experience in the direct care of a child with special needs, or

TN# 08-10

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State Plan under Title XIX of the Social Security Act
State of Michigan

TARGETED CASE MANAGEMENT SERVICES
Target Group E

- d. demonstrated knowledge and understanding about:
- infants and toddlers who are eligible under IDEA; and
 - Part H of the IDEA and the regulations; and
 - the nature and scope of services covered under IDEA, systems of payments for services and other pertinent information; and
 - providing direct care of a child with special needs; and
 - providing culturally competent services within the culture of the community being served.

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.
- 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)):

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**State Plan under Title XIX of the Social Security Act
State of Michigan**

**TARGETED CASE MANAGEMENT SERVICES
Target Group E**

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))

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State Plan under Title XIX of the Social Security Act
State of Michigan

TARGETED CASE MANAGEMENT SERVICES

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;

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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

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Supersedes TN# New Page

State Plan under Title XIX of the Social Security Act
State of Michigan

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

Supersedes TN# New Page

**State Plan under Title XIX of the Social Security Act
State of Michigan**

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

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Supersedes TN# New Page

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Target Group is any individual who is 18 years of age and older; meets Medicaid eligibility requirements; has a chronic or complex physical or behavioral health care need; and were a recent inmate or was involuntarily residing in a prison or jail. An inmate is an individual who was in custody and held involuntarily through operation of law enforcement authorities in a public institution which is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ 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):

- X Entire State
___ Only in the following geographic areas:

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.

A qualified case manager should perform an in-person comprehensive assessment visit with an individual following their recent release from a prison or jail. The comprehensive assessment visit is limited to 1 visit per individual throughout each period of eligibility.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

- ❖ 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.

The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the individual. Frequency and scope of case management monitoring activities must reflect the intensity of the individual's physical health, behavioral health, and welfare needs identified in the individual's specific care plan.

Individuals are eligible for targeted case management services for one year following release from a prison or jail. Monitoring and follow-up activities may or may not require face-to-face interaction and is limited to 11 monitoring visits and 11 follow-up patient education and supports visits throughout each period of eligibility. Additional monitoring visits and follow up activities and extending beyond the year limit may be prior authorized if medically necessary.

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))

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Targeted Case Management Provider

The targeted case management provider must be enrolled as a Michigan Medicaid provider and have the ability to demonstrate the following criteria:

- a. the capacity to provide all core elements of case management services including:
 - comprehensive client assessment
 - comprehensive care/service plan development
 - linking/coordination of services
 - monitoring and follow-up of services
 - reassessment of the client's status and needs;
- b. case management experience in coordinating and linking such community resources as required by the target population;
- c. experience with the target population;
- d. the sufficient number of staff to meet the case management service needs of the target population;
- e. an administrative capacity to ensure quality of services in accordance with State and Federal requirements;
- f. a financial management capacity and system that provides a record of services and costs; and
- g. the capacity to document and maintain individual case records in accordance with State and Federal requirements.

The targeted case management provider may be a:

- Community Mental Health Services Program (CMHSP);
- Federally Qualified Health Center (FQHC);
- Rural Health Center (RHC);
- Tribal Health Center (THC);
- Tribal Federally Qualified Health Center (Tribal FQHC); or
- other any qualified provider, not otherwise funded to provide similar services.

The targeted case management provider must have the capability to coordinate with the individual's health plan and the individual facilitating the re-entry from the prison or jail. The targeted case management provider must employ a qualified case manager who is licensed to practice in accordance with Michigan law. Documentation of the provider's qualifications and credentials must be maintained by the targeted case management provider.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Qualified Case Manager

Qualified case managers may provide all components of targeted case management within their scope of practice. A qualified 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 or case management services; or
- Licensure as a fully licensed Clinical Social Worker by the Michigan Department of Licensing and Regulatory Affairs and at least one year of experience providing social work or case management services.

Physician or Non-Physician Practitioner (NPP)

A Medicaid enrolled physician or NPP licensed by the Michigan Department of Licensing and Regulatory Affairs must provide general supervision of the case manager. An NPP is a healthcare professional licensed as a nurse practitioner, physician assistant, or a clinical nurse specialist.

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:

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.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

- 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))

Federal Financial Participation (FFP) is not available in expenditures for services provided to individuals who are inmates of public institutions.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Target group consists of medically complex individuals, under 21 years of age:

- not incarcerated in a public institution, receiving hospice services, or receiving case management services from another provider;
- have experienced in the previous 12 months:
 - one or more hospital admissions with at least one hospital stay of five or more days; or
 - ten or more visits with a medical or surgical specialist at a pediatric specialty clinic;
- receive treatment from three or more different medical and/or surgical specialties at a hospital or medical university; and
- also meet all the following criteria:
 - have at least one Michigan Department of Health and Human Services (MDHHS), Children's Special Health Care Services (CSHCS) medically eligible condition that involves three or more organ systems; and
 - have functional limitations, are technologically dependent and/or a transplant candidate.
- Children who are recent NICU/PICU graduates have the same eligibility criteria as above, except that their tertiary center use is anticipated by clinicians to be high, and they are not required to meet the criteria for 10 or more clinic visits.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 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):

- X Entire State
 Only in the following geographic areas:

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:

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

- ❖ 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.

Comprehensive assessments are covered no more than once per year, unless otherwise approved by MDHHS.

- ❖ 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;

At a minimum, care plans must be comprehensive and individualized and reflect the beneficiary's and/or parent's/guardian's preferences.

- ❖ 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.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Monitoring and follow-up activities shall occur monthly, and more often if needed, to ensure individual needs are met; as well as to maintain a continuing relationship between the individual, parent and/or guardian, providers, and any entities responsible for services. Monitoring and follow-up activities include face-to-face encounters, and/or reciprocal telephonic or written contact with, or on behalf of the beneficiary/parent/guardian.

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)):

Targeted Case Management Entity Provider Qualifications:

The state Medicaid agency must approve the case management entity as qualified to render the outpatient CMC TCM services before such provider may render services. For the state to approve the case management entity, the case management entity must be an enrolled Medicaid provider that is not otherwise funded to provide similar services. A case management entity must be willing, qualified and able to demonstrate it meets the following criteria:

- a. the capacity to provide all core elements of case management services outlined in 42 CFR 440.169.
- b. case management experience in coordinating and linking such community resources as required by the target population;
- c. the sufficient number of staff to meet the case management service needs of the target population;
- d. an administrative capacity to ensure quality of services in accordance with State and Federal requirements;
- e. a financial management capacity and system that provides a record of services and costs;
- f. the capacity to document and maintain individual case records in accordance with State and Federal requirements; and
- g. provide an interdisciplinary team which meets the targeted case management team qualifications described below.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Targeted Case Management Team Qualifications:

Case Management must be provided by a multi-disciplinary team working under the authority of a targeted case management entity/provider that consists of unlicensed staff and licensed health professionals operating within their State law-defined scope of practice. Teams must have adequate knowledge and experience to provide comprehensive and specialized case management services to children with very complex medical needs. The team must provide 24/7 on-call coverage to respond to medical and care coordination needs and demonstrate referral and effective working relationships with specialists/subspecialists and other health care and social service providers who are essential to the care of beneficiaries with very complex medical needs.

At a minimum, the team must include the following:

- At least one provider with medical/surgical experience delivering pediatric hospital or specialty clinic services to medically complex individuals under the age of 21 who regularly experience hospitalization and/or surgery;
- At least one Medicaid enrolled, licensed pediatrician in possession of or eligible for pediatric specialty board certification. Experience and/or training in palliative care recommended;
- At least one Medicaid enrolled, licensed NPP with at least two years of professional pediatric experience. A NPP is a healthcare professional licensed as a nurse practitioner, physician assistant, or a clinical nurse specialist;
- At least one licensed master's prepared Clinical Social Worker with at least two years of professional pediatric experience; and
- At least one licensed Registered Nurse with at least two years of professional pediatric experience;
- At least one individual with Bachelor of Arts or science in an academic, business, or medical discipline with experience as a hospital or clinic coordinator with a background in health care who is knowledgeable about case management or care coordination services for individuals with complex health needs who have hospital admissions or have had/need surgery; and
- A program assistant with a background in health care operations, referrals, scheduling, and patient services.

A licensed pediatric behavioral health provider is recommended to be part of this team as case management will identify and require case management for all needs including psychosocial needs.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

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:

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.
- 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.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

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)).

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

The target group consists of children under 21 years of age with a serious mental illness (SMI), serious emotional disturbance (SED), or intellectual or developmental disability (I/DD), with most intensive behavioral health and other physical health or health-related social needs as identified by the TCM who may be served by multiple child-serving systems, and/or may be at risk of out-of-home placement if not for the provision of TCM.

TCM for this target group is provided at a higher intensity and frequency than TCM for Target Group A, and it is expected that individuals may be referred to this TCM when higher intensity and/or frequency is needed or higher level need is identified. It is also expected that individuals may continue TCM in target group A if their level of need or intensity decrease as a result of being connected to services and resources.

This comprehensive and intensive TCM in combination with any identified or current "wraparound services" is often referred to by the Michigan Department of Health and Human Services (MDHHS) Medicaid Program as Intensive Care Coordination with Wraparound (ICCW). This TCM represents the case management component only which includes assessment, care plan development and updating, monitoring, referral to services and related activities in accordance with 42 CFR § 440.169.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 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):

X Entire State

 Only in the following geographic areas:

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

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

- taking client history;
- identifying the individual's needs and completing related documentation; and
- gathering information from other sources such as family members, medical providers, community service agencies, and educational professionals (if necessary), to form a complete assessment of the eligible individual;

Assessments will be conducted no less than quarterly or more based on the needs and circumstances of the child, youth, or young adult and their families including, but not limited to, whenever there is a significant change in need or circumstance.

- ❖ 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, including services which are for the direct benefit of the child
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's appropriate legal representative) 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 including those for the direct benefit of the child as noted above; 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 is conducted at a minimum, once per month, to determine if the services and supports have been delivered, and if they are adequate to meet the needs of the child/youth/young adult and their family. Monitoring may be conducted telephonically or in person.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

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)):

Targeted Case Management Entity Provider Qualifications:

Given the complexity of this target group, and the likelihood of needed behavioral health services, MDHHS requires that TCM organizations who are providers of this TCM include case managers and supervisors referred to as facilitators and supervisors of ICCW as well as Child Mental Health Professionals (CMHPs) and Qualified Intellectual Disability Professionals (QIDPs) as part of the interdisciplinary team which meets the qualifications described below.

Facilitators:

- Must achieve and maintain MDHHS ICCW certification (provisional approval may be granted to facilitators through a MDHHS provisional approval process);
- Must complete Person-Centered Planning and Self-Determination trainings; and
- Must hold a bachelor's degree in any field and be supervised by a Child Mental Health Professional (CMHP) when providing TCM to youth with SED, SMI, or Qualified Intellectual Disability Professional (QIDP) when providing TCM to youth with I/DD.

Supervisors:

- Must achieve and maintain MDHHS ICCW certification;
- Must complete Person-Centered Planning and Self-Determination trainings; and
- Must be a CMHP for TCM of youth with SED, SMI, or QIDP for TCM of youth with I/DD.

CMHP Supervisors:

- Must have:
 - specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families.
- Must be:
 - a physician, licensed or limited license psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or
 - an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or
 - an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

QIDP Supervisors:

- Must have:
 - specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons with intellectual or developmental disabilities as part of that experience); or
 - one year of experience in treating or working with a person who has intellectual disability;
- Must be:
 - a licensed or limited licensed psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, dietician, therapeutic recreation specialist, a licensed/limited-licensed professional counselor; or
 - a human services professional with at least a bachelor's degree in a human services field.

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)):

X 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.

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.
- 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

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

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))

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Target Group consists of unhoused beneficiaries over the age of 18 who are discharging from an inpatient hospital admission for an acute condition and not continuing care through an extended hospital admission, skilled nursing facility admission, in-patient psychiatric admission, or other Medicaid inpatient services who meet all the following criteria:

- homeless as defined by Housing and Urban Development as homeless category 1: literally homeless
- has an acute condition that can be addressed in a less than a year.
- medically stable, independently mobile, and be able to perform their own activities of daily living (ADLs).
- able to manage medications and durable medical equipment independently.
- have a need for short-term supportive services and intensive case coordination.
- be at risk for re-hospitalization or severe complications without the support of recuperative care services.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ 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):

___X Entire State

___ Only in the following geographic areas: **[Specify areas]**

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/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

- completing initial assessments and periodic reassessments that evaluate a range of service needs to help establish and update what is important for the individual in a way that is important to the individual, with the following frequency:
 - an initial assessment is conducted upon discharge from an inpatient admission
 - a reassessment is conducted at least quarterly or when there are significant changes in the individual's health or functional status, or significant changes in the individual's network of allies (i.e. death of a primary caregiver)
- ❖ 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 an in-person encounter and is provided on at least a weekly basis, unless otherwise indicated by the needs and circumstances of the individual and/or family.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

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)):

Case Management Provider Organizations - Must be enrolled as a Michigan Medicaid provider and can demonstrate the following criteria:

- a. the capacity to provide all core elements of case management services including:
 - comprehensive client assessment
 - comprehensive care/service plan development
 - linking/coordination of services
 - monitoring and follow-up of services
 - reassessment of the client's status and needs
- b. case management experience in coordinating and linking such community resources as required by the target population;
- c. experience with the target population;
- d. the sufficient number of staff to meet the case management service needs of the target population;
- e. an administrative capacity to ensure quality of services in accordance with State and Federal requirements;
- f. a financial management capacity and system that provides a record of services and costs; and
- g. the capacity to document and maintain individual case records in accordance with State and Federal requirements.

The targeted case management provider must have the capability to coordinate with the individual's health plan and the individual facilitating discharge post-hospitalization. The targeted case management provider must employ a qualified case manager who is licensed to practice in accordance with Michigan law. Documentation of the provider's qualifications and credentials must be maintained by the targeted case management provider.

Qualified Case Manager

Qualified case managers may provide all components of targeted case management within their scope of practice. A qualified 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 or case management services; or
- Licensure as a fully licensed Clinical Social Worker by the Michigan Department of Licensing and Regulatory Affairs and at least one year of experience providing social work or case management services.

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

Physician or Non-Physician Practitioner (NPP)

A Medicaid enrolled physician or NPP licensed by the Michigan Department of Licensing and Regulatory Affairs must provide general supervision of the case manager. An NPP is a healthcare professional licensed as a nurse practitioner, physician assistant, or a clinical nurse specialist.

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.
- 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

State Plan under Title XIX of the Social Security Act
State/Territory: Michigan

TARGETED CASE MANAGEMENT SERVICES

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))

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. 92-24 Approval Date 8-6-92 Effective Date 07-01-92

Supersedes

TN No. 86-5

State of Michigan
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

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)

TN No.: 18-0002

Approval Date: May 31, 2018

Effective Date: 1/01/18

Supersedes

TN NO.: 00-11

State of Michigan
PACE State Plan Amendment Pre-Print

I. Eligibility

B. The applicable institutional eligibility groups the State has elected to cover, identified by statutory and/or regulatory reference.

Eligibility Groups	Statutory and/or Regulatory Reference
A special income level equal to 300% of the SSI Federal benefit.	42 CFR 435.236 42 CFR 435.17
Medically needy without spend down in States which also provide Medicaid to recipients of SSI.	42 CFR 435.320 42 CFR 435.322 42 CFR 435.324
Aged and disabled who have income at 100% of the Federal Poverty Level (FPL.)	Social Security Act Section 1902 (m)1902(r)(2.)

TN No. 00-11

Approval Date 8-3-2001

Effective Date 10/01/00

Supersedes

TN No. N/A – new page

C. X 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).

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.

- 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.

- ### 3. Medically Needy Income Standard

January 1, 2025 Version. . . . This plan is provided for informational use only and does not replace the original version.

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):

TN No. 00-11

Approval Date 8-3-2001

Effective Date 10/01/00

Supersedes

TN No. N/A -- new page

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 8-3-2007

Effective Date 10/01/00

Supersedes

TN No. N/A - new page

State of Michigan
PACE State Plan Amendment Pre-Print

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:

TN No. 00-11

Approval Date 8-3-2001

Effective Date 10/01/00

Supersedes

TN No. N/A - new page

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Program of All-Inclusive Care for the Elderly (PACE)

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.

TN No.: 18-0002

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Supersedes

TN NO.: 11-02

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.

REGION CONFIGURATION	
REGION	COUNTY
1	Wayne
2	Oakland
3	Lapeer, Macomb, Saint Clair, Sanilac
4	Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw
5	Barry, Clinton, Eaton, Gratiot, Ingham, Ionia, Shiawassee
6	Arenac, Bay, Genesee, Huron, Midland Saginaw, Tuscola
7	Berrien, Branch, Calhoun, Cass, Kalamazoo, Saint Joseph, Van Buren
8	Kent
9	Allegan, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Ottawa
10	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
11	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft

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.

TN NO.: 11-02 Approval Date: OCT 20 2011 Effective Date: 10/01/2011

Supersedes
04-11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Program of All-Inclusive Care for the Elderly (PACE)

- C. X 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.

TN No.: 18-0002

Approval Date: May 31, 2018

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Supersedes

TN NO.: 04-11

STATE OF MICHIGAN
PACE State Plan Amendment Pre-Print
Enrollment and Disenrollment (cont)

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PACE State Plan Amendment Pre-Print

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MICHIGAN

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TN No.: 05-01

State of Michigan
PACE State Plan Amendment Pre-Print
Enrollment and Disenrollment (cont.)

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PACE State Plan Amendment Pre-Print

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Supersedes

TN NO.: 00-11

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***

Citation(s)	Provision(s)
1935(d)(1)	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.

TN NO.: 05-19 Approval Date: FEB 24 2006 Effective Date: 1/1/2006
Supersedes
TN No.: N/A new page

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***

Citation(s)	Provision(s)
1927(d)(2) and 1935(d)(2)	<p>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</p> <p><input checked="" type="checkbox"/> The following excluded drugs are covered:</p> <p><input checked="" type="checkbox"/> (a) select agents when used for anorexia, weight loss, weight gain as listed on the MDHHS website</p> <p><input type="checkbox"/> (b) agents when used to promote fertility</p> <p><input type="checkbox"/> (c) agents when used for the symptomatic relief cough and colds</p> <p><input checked="" type="checkbox"/> (d) select prescription vitamins and mineral products, except prenatal vitamins and fluoride as listed on the MDHHS website</p> <p><input checked="" type="checkbox"/> (e) select nonprescription drugs as listed on the MDHHS website</p> <p><input type="checkbox"/> (f) 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</p> <p><input type="checkbox"/> No excluded drugs are covered</p>

TN NO.: 23-0022

Approval Date: NOV 29, 2023

Effective Date: 07/1/2023

Supersedes
TN No.: 21-0018

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.

10/1/84

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
REFERS TO BOTH OF THESE CATEGORIES.

Eff. 04/01/89

State of MICHIGAN

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

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 licensed and treating provider if the beneficiary requires special transportation.
- 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 DHHS volunteer services program provide transportation for many beneficiaries in need of such service and are paid as administrative costs.
- f) For all eligible beneficiaries, the DHHS 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.

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 DHHS office and the transportation service is screened and approved.

TN NO.: 19-0010

Approval Date: NOV 12, 2019

Effective Date: 10/01/2019

Supersedes

TN No.: 10-10

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 DHHS offices. DHHS 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.

MDHHS attests that all the minimum requirements outlined in 1902(a)(87) of the Social Security Act are met for non-emergency transportation services provided in accordance with 42 CFR 431.53 as administrative services, and non-emergency transportation services provided through a brokerage program in accordance with 42 CFR 440.170(a)(4).

TN NO.: 22-0008

Approval Date: OCT 4, 2022

Effective Date: 9/01/2022

Supersedes

TN No.: 19-0010

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Standards for the Coverage of Organ Transplant Services

Coverage of Organ and Tissue Transplant Services

Organ and tissue transplant services, including inpatient and outpatient pre-and post-operative medical, surgical, hospital, and related transportation services, are covered for eligible beneficiaries when medically necessary. For purposes of this coverage, the term organ is defined as kidney, liver, heart, lung, pancreas, intestine (including the esophagus, stomach, small and/or large intestine, or any portion of the gastrointestinal tract), any vascularized composite allograft, or other organ defined in The National Organ Transplant Act of 1984, as amended, and Hematopoietic stem/progenitor cells, cornea, bone, and skin.

Coverage Criteria

Medically necessary transplant services are covered when the transplant is likely to prolong life and restore a range of physical and social function to activities of daily living. All other medical and surgical therapies that might be expected to affect short- and long-term survival must have been tried or considered. The following criteria must be satisfied for the coverage of organ transplant services:

- Transplant services meet the requirements contained in Section 1138(b) of the Social Security Act, Hospital Protocols for Organ Procurement, Food and Drug administration regulations, and Standards for Organ Procurement Agencies.
- Transplant services meet the general requirements for physician and hospital services.
- In making the selection of beneficiaries undergoing the procedure, similarly situated individuals are treated alike.
- Transplant Services must be reasonable in amount, duration, and scope to achieve their purpose.

Facility Requirements

Transplant services for organs defined in the national organ transplant act of 1984, as amended, must be provided in a facility that is a member of the organ procurement and transplantation network (OPTN) where applicable to the transplanted organ.

Prior Authorization

Prior authorization for organ transplant services is required for all beneficiaries, donors, and potential donor services related to organ transplants, with the exception of cornea and kidney. Prior authorization for transplant services, where applicable, is reviewed on a case-by-case basis. Approval is based on critical medical need for transplantation and a maximum likelihood of successful clinical outcomes.

Organ Procurement Services

Donor expenses, including facility costs and physician services, lodging, and transportation, incurred directly in connection with and immediately attributed to the transplant surgery, may be covered. The donor must exhaust all possible insurance sources before Medicaid is billed for the services.

1915(i) State plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. **Services.** (Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):

Transition Navigator Case Management Services, Community Transition Services, Non-Medical (Non-Emergency) Transportation, Home Modifications, HCBS Personal Care

2. **Concurrent Operation with Other Programs.** (Indicate whether this benefit will operate concurrently with another Medicaid authority):

Select one:

<input checked="checked" type="radio"/>	Not applicable		
<input type="radio"/>	Applicable		
Check the applicable authority or authorities:			
<input type="checkbox"/>	Services furnished under the provisions of §1915(a)(1)(a) of the Act. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. <i>Specify:</i> (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the specific 1915(i) State plan HCBS furnished by these plans; (d) how payments are made to the health plans; and (e) whether the 1915(a) contract has been submitted or previously approved.		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):			
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)

<input type="checkbox"/>	A program operated under §1932(a) of the Act. <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</i>
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one):*

<input checked="" type="checkbox"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program <i>(select one)</i> :	
<input type="radio"/>	The Medical Assistance Unit <i>(name of unit)</i> :	
<input checked="" type="checkbox"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	<i>(name of division/unit)</i> <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	Behavioral and Physical Health and Aging Services Administration Bureau of Aging and Community Living Services Aging and Community-Services Division Home and Community Based Services Section
<input type="radio"/>	The State plan HCBS benefit is operated by <i>(name of agency)</i>	
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State plan HCBS Operational and Administrative Functions.

- ✓ (By checking this box the state assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(Check all agencies and/or entities that perform each function):

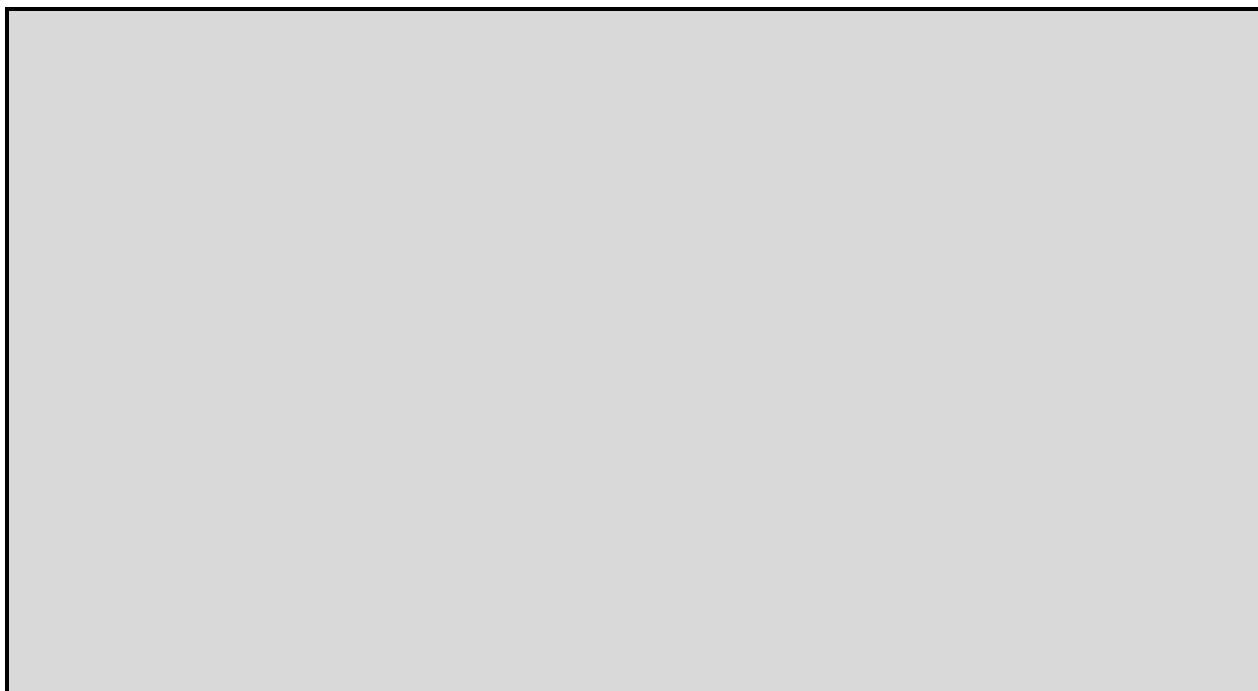
Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Eligibility evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Michigan Department of Health and Human Services (MDHHS), local offices establish Medicaid eligibility. MDHHS is the State Medicaid Agency. MDHHS uses contracted entities to conduct participant satisfaction and quality of life surveys. Local non-state entities that provide 1915(i) services will ensure the quality of staff and their client records and implement corrective action plans as required.

(By checking the following boxes the State assures that):

5. ☒ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
 - financially responsible for the individual
 - empowered to make financial or health-related decisions on behalf of the individual
 - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*



6. ☒ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. ☒ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8. ☒ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	10/1/2023	9/30/2024	2150
Year 2	10/1/2024	9/30/2025	2175
Year 3	10/1/2025	9/30/2026	2225
Year 4	10/1/2026	9/30/2027	2275
Year 5	10/1/2027	9/30/2028	2300

- 2. ☒ Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

- 1. ☒ Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. Medically Needy (Select one):

☐ The State does not provide State plan HCBS to the medically needy.

☒ The State provides State plan HCBS to the medically needy. *(Select one):*

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☒ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

- 1. Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed *(Select one):*

<input checked="checked" type="checkbox"/>	Directly by the Medicaid agency
<input type="checkbox"/>	By Other (<i>specify State agency or entity under contract with the State Medicaid agency</i>):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. (*Specify qualifications*):

MDHHS staff must have a bachelor's degree, preferably in a health or social services field. Staff are trained in the needs-based criteria outlined for these State Plan services so that they can evaluate documentation and determine whether each applicant meets these criteria.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Transition Navigators obtain information from applicants using the Community Transition Assessment tool, which is the instrument used to make this determination. Through completion of this tool, the transition navigator assesses the individuals' needs. The assessment tool contains information about the individual's ability to perform ADLs and IADLs, informal support network, goals for community living, and available resources. MDHHS staff review the assessments to verify the individual has Medicaid eligibility and to determine if the individual meets the needs-based criteria.

When MDHHS does not have enough information to make an eligibility determination, MDHHS staff requests additional information from the Transition Navigator. MDHHS reserves the right to evaluate the applicant in person to confirm the individual meets all eligibility requirements for 1915(i) services.

During the reevaluation, transition navigators update the Community Transition Assessment Tool. MDHHS staff review the assessment to verify the individual continues to have Medicaid eligibility and to determine if the individual meets the needs-based criteria for continued receipt of 1915(i) service(s).

4. ☒ **Reevaluation Schedule.** (*By checking this box the state assures that*): Needs-based eligibility reevaluations are conducted at least every twelve months.
5. ☒ **Needs-based HCBS Eligibility Criteria.** (*By checking this box the state assures that*): Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: (*Specify the needs-based criteria*):

To be eligible for 1915(i) services an individual must minimally meet one of the criteria listed below:

Door A: “Activities of Daily Living” - The individual requires assistance to perform at least one activity of daily living or instrumental activity of daily living. Activities of daily living include bed mobility, transfers, toilet use, eating, dressing, personal hygiene, bathing, and locomotion. Instrumental activities of daily living include shopping, cooking, managing medications, using the phone, housework, laundry, public transportation, and managing finances; **OR**

Door B: “Cognitive Performance” - The individual meets one of the following:
Needs minimal assistance in making safe decisions in familiar situations, but experiences some difficulty in decision-making when faced with new tasks or situations due to a short-term memory problem; or
Is assessed with some difficulty making decisions in new situations or makes poor or unsafe decisions in recurring situations; or
Is assessed to be usually understood and needs assistance (i.e. little or no prompting) finding the right words or finishing thoughts due to a short-term memory problem; **OR**

Door C: “Behavior” - The individual is assessed to have required assistance managing one of the following challenging behaviors in the last seven (7) days: wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, or resisted care.

The individual who minimally meets the needs-based criteria above must also either:

- 1) Be at risk of inappropriate institutionalization because the individual is being served in an institution, but does not meet the level of care for that institution. **OR**
- 2) Indicate they have changed their minds about where they choose to receive long-term services and supports by indicating they no longer choose to receive services in the institutional setting on a Freedom of Choice form. **OR**
- 3) The beneficiary does not currently reside in a nursing facility or other institution but is at risk of returning to the nursing facility without the provision of services in this 1915(i) benefit.

AND have at least one of the following risk factors:

1. History or at risk of inability to secure or retain housing in the community.
2. History or at risk of inability to secure home and community-based services without assistance.
3. History or at risk of inability to secure documentation needed for independent living without assistance, including identification cards, health insurance cards, birth certificate, etc.
4. History of an unsafe or inaccessible living environment.

6. ☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
See #5 above:	<p>Must meet nursing facility level of care, e.g. demonstrate</p> <ol style="list-style-type: none"> 1) Need for assistance with ADLs of bed mobility, transfers, toilet use, or eating, OR 2) Cognitive Performance deficits, <ol style="list-style-type: none"> a. Severely impaired in decision making, b. Short-term memory problem and at least moderately impaired in decision making, c. Short-term memory problem and is sometimes or rarely understood OR 3) Physician involvement with unstable medical condition within the last 14 days, OR 4) Have at least one treatment or condition in the last 14 days including: stage 3-4 pressure ulcers, intravenous or parenteral feedings, intravenous medications, end-stage care, daily tracheostomy, respiratory, or suctioning care, pneumonia, daily oxygen therapy, daily insulin with 2 order changes, or peritoneal or hemodialysis, OR 	<p>Must meet ICF/IID level of care, e.g. current assessments of the beneficiary reflect evidence of a developmental disability and/or serious mental illness. The beneficiary's intellectual or functional limitations indicate that he/she would be eligible for health, habilitative, and active treatment services provided at the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care [U.S. PL 111-256.</p>	<p>Must meet long-term acute care hospital (LTACH) level of care, e.g. 1) have a medically complex condition, 2) demonstrate active comorbidities that require complex medical management and a multidisciplinary treatment plan to promote medical and functional improvement lead by a medical practitioner; and 3) have a reasonable potential to benefit from an intense medical treatment program.</p>

	5) Received at least 45 minutes of skilled speech, occupational or physical rehabilitation therapies in the last 7 days, OR 6) Have displayed challenging behaviors (wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, resisted care in 4 of the last 7 days, or had delusions or hallucinations in the last 7 days. OR 7) Be an LTSS participant for a year or more and have service dependency, OR 8) Be determined medically frail.		
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*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☒ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Aged and Disabled Group:

- Aged = persons aged 65 and older
- Disabled = persons aged 18 through 64 with a physical disability

When individuals initially qualify as disabled, they will automatically qualify as aged upon their 65th birthday.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (*Specify the phase-in plan*):

(By checking the following box the State assures that):

8. ☒ **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	Minimum number of services. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is:	
	<input type="text" value="one"/>	
ii.	Frequency of services. The state requires (select one):	
	<input type="radio"/>	The provision of 1915(i) services at least monthly
	<input checked="" type="radio"/>	Monthly monitoring of the individual when services are furnished on a less than monthly basis If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: At least one 1915(i) service every three months in addition to monthly monitoring.

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

(Note: In the *Quality Improvement Strategy (QIS)* portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

Home and Community-Based Settings are applicable to individuals receiving the Community Transition Services in this 1915(i) benefit after they have transitioned out of the nursing facility. Individuals who transition out of the nursing facility may move into any of the following residential provider-controlled settings: Licensed Adult Foster Care Home, Licensed Home for the Aged, or an unlicensed Assisted Living Facility. The services in this 1915(i) benefit do not include provider controlled or operated non-residential settings. When an individual decides to move to one of these provider-controlled or operated settings, the transition navigator must first check with MDHHS to determine if the setting has already been determined to be compliant with the HCBS rule. If so, the individual may move to the setting and continue to receive 1915(i) benefits if they remain eligible for them.

In many cases, the individual will enroll in a different home and community-based services program upon transitioning out of the nursing facility. When this happens, the HCBS program maintains responsibility for assuring the residential setting maintains compliance with the HCBS rule and for ongoing monitoring. When individuals enroll in a HCBS program upon transition, community transition services end within 30 days of the transition.

When the setting in which the individual wishes to reside is not already deemed compliant with the HCBS rule AND the individual is not enrolling in a different HCBS program, the transition navigation agency will visit the residential setting and complete the “Residential Survey for MI Choice Waiver” to assess compliance to the HCBS Rule. This survey is available here: <https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/programs/progbens/mi-choice-waiver-program> which includes all the required settings criteria and has been approved by CMS. Once the transition navigation agency completes its assessment and the survey, it sends the completed survey to MDHHS for review and approval. Upon receipt, MDHHS reviews the survey results to determine compliance based upon the responses within the survey. If any questions arise, or if for any reason MDHHS cannot determine compliance, MDHHS will contact the setting and if needed, conduct its own on-site visit. Once MDHHS is satisfied that the setting is compliant with the Federal home and community-based settings requirements, it will deem the setting compliant and notify the transition navigator.

The transition navigator is responsible for assuring continued compliance of the setting if there is a participant receiving services within these 1915(i) benefits. Minimally, the transition agency will reassess each provider controlled or owned setting annually and submit the results to MDHHS to affirm continued compliance. If for any reason, at any time, the setting is no longer compliant, immediate corrective action is required. The setting will have up to 30 days to return to compliance. The transition navigator will immediately inform the participant(s) residing in the setting of their option to remain in a non-compliant setting and terminate their 1915(i) benefits or move to a compliant setting. If the participant chooses to move, the transition navigator will assist with the relocation efforts. If the setting regains compliance, the participant may remain in the setting.

If needed, the setting will go through the heightened scrutiny process. Additional information about approval of new settings is detailed in Section 3 of the Home and Community Based Services Chapter of the Medicaid Provider Manual, available here: <https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>.

If the chosen setting does not wish to comply with the HCBS rule, the transition navigator will provide information on other settings in the area that meet compliance. If the individual still chooses to move to a non-compliant setting, the transition navigator will explain to the individual that 1915(i) benefits will need to end upon moving to that setting.

When an individual moves to a setting that is compliant with the HCBS Rule, does not enroll in a different HCBS program, and continues to be eligible for 1915(i) benefits, the transition navigator will monitor the setting for continued compliance at least annually using the “Residential Survey for MI Choice Waiver” tool and as defined in the Home and Community-Based Services Chapter of the Medicaid Provider Manual. All residential settings that are found to be out of compliance will require immediate corrective action to regain compliance.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.
2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).
3. ☒ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.
4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.**
There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Transition Navigators are qualified as a:

- 1) Registered Nurse licensed in the State of Michigan, or
- 2) Social Worker licensed in the State of Michigan, or
- 3) Non-licensed or other licensed health care professionals with the following qualifications:
 - i. A bachelor's degree in a health or human services field or Community Health Worker certification, and
 - ii. At least three years of experience in the provision of health or social services.

Transition Navigators must be knowledgeable in person-centered planning, how to access long-term and HCBS services and supports within the community they serve, how to address barriers to discharge, and eligibility requirements for HCBS services and supports.

- 5. Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Transition Navigators are qualified as a:

- 1) Registered Nurse licensed in the State of Michigan, or
- 2) Social Worker licensed in the State of Michigan, or
- 3) Non-licensed or other licensed health care professionals with the following qualifications:
 - iii. A bachelor's degree in a health or human services field or Community Health Worker certification, and
 - iv. At least three years of experience in the provision of health or social services.

Transition Navigators must be knowledgeable in person-centered planning, how to access long-term and HCBS services and supports within the community they serve, how to address barriers to discharge, and eligibility requirements for HCBS services and supports.

- 6. Supporting the Participant in Development of Person-Centered Service Plan.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

- a) The Transition Navigator informs the individual of service options available to assist with a community transition and potentially available to the individual in the community. The Community Transition Assessment (CTA) is comprehensive and includes the identification of barriers, how the individual would like to overcome those barriers, what the individual's goals for community living are, how those goals will be achieved, and examines HCBS that are available to the individual. The Transition Navigator discusses options with the individual. The Transition Navigator also serves to link the individual with other specialists who may assist with specific barriers, such as locating affordable housing options, or accessing specific services (e.g. Veteran's Benefits). The Transition Navigator describes the services and supports available through the community transition services and informs the individual of issues that should be addressed as identified through the assessment process. During the completion of the CTA, the Transition Navigator is responsible for discussing options for the participant to receive services identified on the person-centered service plan and recording the participant's goals and preferences.
- b) The participant has full authority to determine who facilitates the person-centered plan, who to include in the person-centered planning process, who to exclude from the process, and ultimately what services, goals, and outcomes are included in the person-centered service plan. All providers responsible for implementation of the

person-centered service plan will sign and receive a copy of the plan, or of their portion of the plan (as preferred by the participant).

The Transition Navigator works with the individual and their representatives to develop the initial person-centered service plan. The first person-centered planning meeting occurs when the participant is not in crisis and at a time of the participant's choice.

A pre-planning session may occur before the first person-centered planning meeting. During pre-planning, the participant chooses dreams, goals and any topics to discuss, who to invite, who will facilitate and record the meeting, as well as a time and location that meets the needs of all individuals involved in the process. The participant and selected allies design the agenda for the person-centered planning meeting. The person-centered service plan is based on the expressed needs and desires of the participant and is updated upon request of the participant. Regular updates to the service plan occur when the need for services or participant circumstances change, but at least once every year.

MDHHS has a person-centered planning practice guide. The document is available on the MDHHS website (https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder4/Folder41/Folder3/Folder141/Folder2/Folder241/Folder1/Folder341/Person-Centered_Planning_Practice_Guidance.pdf?rev=6cb6ae07af704dab85f08481447ab5c4&hash=67A902B1991E8ECBD8DEF078FA9C9EE8) to assist Transition Navigators in ensuring that the person-centered service plan clearly identifies the individual's needs, goals and preferences with the services specified to meet them.

The Transition Navigator and participant base the person-centered service plan upon participant preferences, goals, and needs identified through the person-centered planning process. A written person-centered service plan is developed with each participant and includes the participant's identified or expressed needs, goals, expected outcomes, and planned interventions, regardless of funding source. This document includes all services and supports provided to or needed by the individual to implement their service plan and community living goals. Transition Navigators arrange services and supports based upon the individual's choice and approval. The individual and Transition Navigator explore other funding options and intervention opportunities when personal goals include things beyond the scope of Medicaid-funded services.

The service plan clearly identifies the types of services and supports needed from both paid and non-paid providers. The amount (units), frequency, and duration of each service are included in the person-centered service plan. The individual chooses the services that best meet their needs. The Transition Navigator ensures implementation and provision of the services and supports according to the person-centered service plan. Transition Navigators oversee the coordination of State Plan and other services included in the person-centered service plan. This oversight

ensures that services and supports included in the person-centered service plan are not duplicative.

The assignment of responsibilities to implement the service plan are determined through person-centered planning and may be delegated to the individual, Transition Navigator, or others designated by the individual. The Transition Navigator and the individual, to the extent the individual chooses, are responsible for monitoring the person-centered service plan. This occurs through periodic case reviews, monthly contacts, individual requests, reassessments, and routine monitoring.

Transition Navigators periodically meet with the individual for a reassessment to identify changes that may have occurred since the initial assessment or the last meeting and to measure progress toward meeting specific goals outlined in the individual's service plan. The individual may choose to have additional face-to-face meetings to focus specifically on the person-centered service plan at any time. The service plan is reviewed and updated during this process, based upon reassessment findings and participant preferences. The service plan is updated after changes in status and upon request.

Transition Navigators identify and discuss potential risks to the individual during the assessments, reassessments, and planning meetings. The person-centered planning process specifies risks and methods of monitoring their potential impact in conjunction with the individual. The Transition Navigator, or other qualified individuals, fully discuss strategies to mitigate risks with the individual and allies, family, and relevant others during person-centered planning. Risk strategies approved by the individual are written into the person-centered service plan. Individuals may be required to acknowledge situations in which their choices pose risks for their health and welfare. The Transition Navigator is not obligated to authorize services or supports believed to be harmful to the participant. Negotiations of such issues are initiated in the person-centered planning process. Transition Navigators assess and inform individuals of their identified potential risk(s) to assist them in making informed choices regarding these risks.

7. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

MDHHS established a toll-free number for information about 1915(i) services. MDHHS and its contracted providers-distribute marketing materials about the program. The toll-free number is answered by a third-party vendor, Mi ENROLLS. Individuals who call the number are provided basic information about 1915(i) services and offered information about transition agencies that serve their county. Contact information may be given over the telephone or mailed to the individual based upon their preferences. If the caller wishes to have more detailed information, MDHHS staff provide that information to the caller with a return call.

This toll-free number also takes complaints from callers, which are followed up by MDHHS staff. This number is published on State-approved brochures and the MDHHS website regarding these services and will be disseminated widely.

Additionally, the Transition Navigator informs the individual of available 1915(i) services to overcome barriers to discharging from the nursing facility. This occurs through direct communication and written information (approved by MDHHS) provided to the individual regarding 1915(i) services and other HCBS programs. The individual receives information on all potential service providers. The individual specifies how he/she wishes to receive services and from whom, and this is included in the person-centered service plan.

MDHHS has Medicaid provider agreements with community-based organizations (CBOs) to deliver transition navigation services to interested individuals. CBOs are non-governmental agencies such as Area Agencies on Aging, Centers for Independent Living, and other community-based organizations. These entities employ qualified transition navigators to act as case managers for these 1915(i) benefits. Each transition navigator is a Medicaid-enrolled provider and MDHHS approves each enrollment only upon confirmation of their qualifications. The transition navigators are not required to be a part of the CBO.

Each transition navigation provider including CBOs may also directly provide 1915(i) Community Transition Services. Typically, the transition navigators arrange for the direct purchase of goods and services by their CBO for items and services that fall within the Community Transition Services benefit as there would be no other way to pay for the items and services included within the service definition since entities that offer these items and services are not Medicaid-enrolled providers and therefore cannot bill for reimbursement directly. This includes retail stores, utility companies, proprietors, pest control agencies, etc. Participants choose the items they prefer by making selections online, discussing preferences during person-centered planning meetings, making lists with the transition navigator, and/or accompanying the transition navigator to the retail store.

The CBOs also have Medicaid provider agreements to operate as an organized health care delivery system (OHCDS) pursuant to 42 CFR §447.10. Under this arrangement, they contract with other providers that furnish 1915(i) home modifications, non-medical non-emergency transportation, and personal care services so that the CBO will reimburse the entity performing the service and then submit a claim to MDHHS for the services provided. Upon approval of the claim, MDHHS then reimburses the CBO. The CBO assures the services are furnished by qualified providers and according to the person-centered service plan. The CBOs are required to offer beneficiaries free choice of provider and are prohibited from contracting with entities who are directly affiliated with or subsidiaries of the CBO.

All 1915(i) providers may directly enroll with, submit claims to, and receive payment from MDHHS if they do not wish to work with the CBO OHCDS. Beneficiaries are allowed to choose from any enrolled provider for each 1915(i) service on the person-

centered service plan. If a participant prefers a provider that does not work with the CBO/OHCDS, MDHHS will work directly with the chosen provider to ensure the provider is qualified and enrolled in CHAMPS (Michigan's MMIS). MDHHS may also provide listings of enrolled providers to participants as needed.

MDHHS also has a Community Transition Services Participant Handbook that is provided to each beneficiary. The handbook and other program information is located at the Community Transition Services webpage: <https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/community-transition-services>. This handbook includes information on how to file complaints, grievances, how to request a State Fair Hearing, and how to access the Community Transition Services Ombudsman Program. Furthermore, there is information on how to file a Section 1557 complaint and a US DHHS complaint. These are all forms of accessible alternative dispute resolution processes.

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.
(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):

MDHHS has a NFT Portal to manage all individuals who receive 1915(i) services. Transition Navigators upload the CTA and person-centered service plan in the secure portal for MDHHS review and approval. MDHHS staff compare the person-centered service plan to the individual's needs and goals identified in the assessment, assure that all other resources are used before Medicaid and the plan meets State and Federal requirements, before issuing approval of the plan. All services are prior authorized to assure their appropriateness before they are furnished. State staff review prior authorization requests and approve requests that are deemed appropriate.

MDHHS staff conduct record reviews continuously through the prior authorization process on all case records for 1915(i) services. This review focuses on the appropriateness of 1915(i) services included in the person-centered service plan and provided to the individual. Any services found to be inappropriate will not be prior authorized and may be subject to recovery through this process.

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (check each that applies):

<input type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (specify):				

Services

1. State plan HCBS. (Complete the following table for each service. Copy table as needed):

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):	
Service Title:	Transition Navigator Case Management Services
Service Definition (Scope):	
<p><i>This service is available while in the institution and the community. Participants may receive transition navigator services up to 180 consecutive days prior to discharge, but FFP will not be claimed until the individual transitions from the nursing home</i></p> <p>Transition Navigator services are provided to assure the delivery of supports and services needed to meet the individual's goals for living in the community after an institutionalization. Without these supports and services, the individual may be at risk of inappropriate institutionalization because the individual does not meet the level of care for that institution or because the individual has chosen a different setting in which to receive their long term services and supports. The Transition Navigator functions to be performed and the frequency of face-to-face and other contacts are specified in the individual's person-centered service plan. The frequency and scope of Transition Navigation contacts must take into consideration health and welfare needs of the individual. Transition Navigation may include the direct provision of Community Transition Services as specified in the person-centered service plan.</p> <p>Functions performed by a Transition Navigator include the following:</p> <ol style="list-style-type: none">1. Conducting the initial and subsequent needs-based criteria evaluation and community transition assessment and providing that evaluation to MDHHS for approval.2. Supporting a person-centered planning process that is<ol style="list-style-type: none">a. focused on the individual's preferences,b. includes family and other allies as determined by the individual,c. identifies the individual's goals, preferences and needs,d. provides information about options, ande. engages the individual in monitoring and evaluating services and supports.3. Developing a person-centered service plan with the beneficiary using the person-centered planning process, including revisions to the plan at the individual's initiation or as changes in the individual's circumstances may warrant.4. Referral to and coordination with providers of home and community-based services and supports, including non-Medicaid services and informal supports. This may include helping with access to entitlements or legal representation.5. Monitoring of the services and supports identified in the person-centered service plan for achievement of the individual's goals. Monitoring includes opportunities	

- for the individual to evaluate the quality of services received and whether those services achieved desired outcomes. This activity includes the individual and other key sources of information as determined by the individual.
6. Providing social and emotional support to the individual and allies to facilitate life adjustments and reinforce the individual's sources of support. This may include arranging services to meet those needs.
 7. Providing advocacy in support of the individual's access to benefits, assuring the individual's rights as a Medicaid beneficiary, and supporting the individual's decisions.
 8. Monitoring the individual after the community transition to assure a successful adjustment to community life, including assuring access to and enrollment in needed HCBS programs.
 9. Maintaining documentation of the above listed activities to ensure successful support of the individual, comply with Medicaid and other relevant policies, and meet quality assurance and quality improvement requirements.
 10. Conducting a tenant screening and housing assessment with the beneficiary that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.
 11. Developing an individualized housing support plan with the beneficiary based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
 12. Assisting the individual with the housing search and application process.
 13. Assisting the individual with identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses.
 14. Ensuring that the living environment is safe and ready for move-in.
 15. Assisting the individual in arranging for and supporting the details of the move.
 16. Developing a housing support crisis plan with the beneficiary that includes prevention and early intervention services when housing is jeopardized.
 17. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
 18. Providing education and training on the role, rights and responsibilities of the tenant and landlord.
 19. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
 20. Assisting the individual in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
 21. Assisting the individual with advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
 22. Assisting the individual with the housing recertification process.
 23. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

24. Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.			
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):			
<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Nurse	RN		
Social Worker	LLSW, BSW, MSW		
Transition Navigator			Non-licensed or other licensed health care professionals with the following qualifications: a) A bachelor's degree in a health or human services field or Community Health Worker certification, and b) At least three years of experience in the provision of health or social services.
Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):		Frequency of Verification (<i>Specify</i>):
RN	LARA, CHAMPS		Annually
SW	LARA, CHAMPS		Annually
Transition Navigator	CHAMPS		Annually
Service Delivery Method. (<i>Check each that applies</i>):			
<input type="checkbox"/>	Participant-directed		<input checked="" type="checkbox"/>
			Provider managed

2. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	Community Transition Services
Service Definition (Scope):	
<p>Community Transition Services are non-reoccurring expenses necessary to enable an individual who is transitioning from a nursing facility or other institutional setting to the community to establish a basic household and do not constitute room and board. This service is available while in the institution to prepare the individual's chosen home and to accommodate a successful transition-to the community. This service may be available in the community when additional needs that were not accounted for prior to transition-are identified. Expenses for these additional needs must be directly related to the individual's transition to the community from a nursing facility. MDDS will not claim FFP for this service until the individual transitions from the nursing facility.</p> <p>These services include the following:</p> <ul style="list-style-type: none">• Security deposits and fees to obtain a lease on an apartment or home,• Set-up fees for utilities or service access, including telephone, electricity, heating and water,• Essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens,• Services necessary for the individual's health and safety such as pest eradication, allergen control, and one-time cleaning prior to occupancy.	
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.	
<i>(Choose each that applies):</i>	
✓	Categorically needy <i>(specify limits)</i> :
	Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the person-centered service plan development process, clearly identified in the person-centered service plan and only when the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.
✓	Medically needy <i>(specify limits)</i> :

<p>Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the person-centered service plan development process, clearly identified in the person-centered service plan and only when the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.</p>			
<p>Provider Qualifications <i>(For each type of provider. Copy rows as needed):</i></p>			
Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Center for Independent Living			Enrolled as Medicaid Provider for 1915(i) services in CHAMPS
Area Agency on Aging			Enrolled as Medicaid Provider for 1915(i) services in CHAMPS
Community-Based Organization			Enrolled as Medicaid Provider for 1915(i) services in CHAMPS
Retail Stores			Items purchased from retail stores must meet the community transition services definition.
Contractor, Builder	Contractor's License, Builder's License		Must be licensed in Michigan
<p>Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i></p>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>		Frequency of Verification <i>(Specify):</i>
Center for Independent Living	CHAMPS		Annually
Area Agency on Aging	CHAMPS		Annually
Community Based Organization	CHAMPS		Annually
Retail Stores	Center for Independent Living, Area Agency on Aging, or other Community Based Organization		Prior to furnishing services and annually thereafter.

Contractor, Builder	LARA	Annually
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

3. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	Non-Medical (Non-Emergency) Transportation
Service Definition (Scope):	
<p>Non-medical (Non-Emergency) transportation (NMNET) is offered to enable individuals to gain access to community services, activities and resources, specified by the individual's person-centered service plan. This service is available while in the community.</p> <p>Whenever possible, family, neighbors, friends, or community agencies that can provide transportation services without charge must be utilized before authorizing this transition service.</p> <p>NMNET Services may be provided while in the community to address issues identified on the person-centered service plan. This may include going to the grocery store, religious services, volunteering, or work.</p> <p>Non-Medical (Non-Emergency) Transportation services offered are not available through the State Plan and are in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a).</p>	
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :	
<p>Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.</p> <p><i>(Choose each that applies):</i></p>	
<input checked="" type="checkbox"/>	Categorically needy <i>(specify limits):</i>

	<ol style="list-style-type: none"> 1. The participant must use other available providers, including informal supports before non-medical transportation may be authorized. 2. This service does not include purchasing, leasing, repair, or maintenance on vehicles. 3. This service may not be authorized to reimburse caregivers to run errands for participants when the participant does not accompany the driver of the vehicle. The purpose of this service is to enable the participant to gain access to their community services, activities, and resources. 4. Reimbursement does not include expenses for meals or lodging incurred while traveling. 		
✓	Medically needy (<i>specify limits</i>):		
	Same as Categorically needy.		
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Individual (paid or volunteer)	Driver's license		<p>Must be a licensed driver with a valid driver's license issued by the Michigan Secretary of State.</p> <p>All drivers must have vehicle insurance as required by the State of Michigan.</p> <p>All drivers must follow all motor vehicle laws.</p> <p>All passengers must comply with seat belt laws.</p>
Public Transit	Driver's License for each driver		<p>Must follow all applicable laws including licensure, inspections, and vehicle maintenance, etc.</p>
Private Transportation Company	Driver's License for each driver		<p>Must follow all applicable laws including licensure, inspections, insurance, and vehicle maintenance.</p> <p>Must include passenger assistance in the provision of service, when needed by passenger</p>
Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):		Frequency of Verification (<i>Specify</i>):

Individual	Center for Independent Living, Area Agency on Aging, or other Community Based Organization	Annually
Individual Drivers	Secretary of State	Every 4 years (renewal of Driver's License)
Public Transit	Secretary of State	Annually
Private Transportation Company	Secretary of State	Annually
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/> Provider managed

4. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	Home Modifications
Service Definition (Scope):	
<p>Home Modifications include physical adaptations to the home required by the participant's PCSP that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home. Assessments and specialized training needed in conjunction with the home modification are included as a part of the cost of the service.</p> <p>This service is available while in the institution to prepare the individual's chosen home and to accommodate a successful discharge to the community. This service may be available in the community when additional needs that were not accounted for prior to transition are identified. MDHHS authorizes home modifications up to 180 consecutive days in advance of community transition from the nursing facility and will not claim FFP for this service until the individual transitions from the nursing facility.</p> <p>The services under the home modification service are limited to additional services not otherwise covered under the state plan, including EPSDT.</p>	
Additional needs-based criteria for receiving the service, if applicable <i>(specify)</i> :	
<p>Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.</p> <p><i>(Choose each that applies):</i></p>	

✓	<p data-bbox="300 254 727 289">Categorically needy (<i>specify limits</i>):</p> <p data-bbox="321 302 768 333">Home modifications are limited to:</p> <ul data-bbox="350 342 1422 747" style="list-style-type: none"><li data-bbox="350 342 902 373">• The installation of ramps and grab bars;<li data-bbox="350 380 1422 447">• Widening of doorways to accommodate medical equipment such as a wheelchair or walker;<li data-bbox="350 453 1395 485">• Modification of bathroom facilities to make them accessible to the participant;<li data-bbox="350 491 1367 522">• Modification of kitchen facilities to make them accessible to the participant;<li data-bbox="350 529 1422 638">• Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant; and<li data-bbox="350 644 1422 747">• Environmental control devices that replace the need for paid staff and increase the participant's ability to live independently, such as automatic door openers or locks. <p data-bbox="321 789 1422 968">The case record must contain documented evidence that the modification is the most cost-effective and reasonable alternative to meet the participant's need. An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use, or function of a room within the home or finding alternative housing.</p> <p data-bbox="321 1010 1422 1115">Home modifications will not be approved for rental properties without a close examination of the rental agreement and the proprietor's responsibility to furnish the modification.</p> <p data-bbox="321 1157 1216 1188">The provider must comply with all local building codes, as applicable.</p> <p data-bbox="321 1230 1422 1335">Home modifications are not available for condemned structures and must not result in valuation of the structure significantly above comparable neighborhood real estate values.</p> <p data-bbox="321 1377 1195 1409">Home modifications cannot increase the square footage of the home.</p> <p data-bbox="321 1451 889 1482">Excluded home modifications are those that:</p> <ul data-bbox="350 1491 1422 1787" style="list-style-type: none"><li data-bbox="350 1491 667 1522">• Are of general utility<li data-bbox="350 1528 1422 1596">• Are considered standard housing obligations of the participant or homeowner; and<li data-bbox="350 1602 1192 1633">• Are not of direct medical or remedial benefit to the participant<li data-bbox="350 1640 1422 1787">• Examples of exclusions include, but are not limited to: carpeting, roof repairs, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping, and general home repairs or maintenance. <p data-bbox="321 1829 1422 1896">Home modifications exclude costs for improvements exclusively required to meet local building codes.</p>
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<p>The infrastructure of the home involved in the funded modification must comply with all applicable local codes and have the capability to accept and support the proposed changes.</p> <p>Home modifications required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in the home.</p> <p>Home modifications exclude general construction costs in a new home or additions to a home purchased by the participant. If a participant or the participant's family purchases or builds a home while in the process of transitioning, it is the participant's or family's responsibility to assure the home will meet basic needs, such as having a ground floor bath or bedroom when the participant has mobility limitations. However, home modifications may include assistance with the adaptations noted above (e.g. ramps, grab bars, widening doorways, bathroom modifications) for a recently purchased home.</p> <p>If modifications are needed to a home under construction that require special adaptation to the plan (e.g. roll-in shower), the home modification service may be used to fund the difference between the standard fixture and the modification required to accommodate the participant's need.</p>			
✓ Medically needy (<i>specify limits</i>):			
Same as specified for categorically needy.			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Individual	MCL 339.601 (1) MCL 339.601.2401(1) MCL 339.601.2403(3)	Licensed builder or licensed contractor	
Retail Stores	n/a	n/a	Items purchased must meet the home modification service definition.
Agency or business	MCL 339.601 (1) MCL 339.601.2401(1)	Licensed builder or licensed contractor	

	MCL 339.601.2403(3)		
Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>	
Individual	Center for Independent Living, Area Agency on Aging, or other Community Based Organization	Prior to the provision of services and annually thereafter	
Individual	LARA	Annually	
Contractor	Center for Independent Living, Area Agency on Aging, or other Community Based Organization,	Prior to the provision of services and annually thereafter	
Contractor	LARA	Annually	
Retail Store	Center for Independent Living, Area Agency on Aging, or other Community Based Organization,	As needed	
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

5. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	HCBS Personal Care
Service Definition (Scope):	
<p>Personal care services enable individuals with functional limitations, resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive setting preferred by the individual. Personal care includes the provision of assistance with activities of daily living (eating, toileting, bathing, grooming, dressing, transferring, and mobility) and instrumental activities of daily living (taking medication, meal preparation, shopping for food or other necessities, laundry, and housekeeping).</p> <p>HCBS Personal Care Services provided while in the community are limited to individuals who are not eligible for State Plan Personal Care Services (Home Help) or who require personal care services to begin before State Plan Personal Care Services or other HCBS services (PACE, MI Health Link, MI Choice) can be authorized. At no time shall an individual receive both State Plan Personal Care Services and HCBS Personal Care</p>	

Services at the same time. HCBS Personal Care services may also be authorized when an individual's needs change and they are unable to quickly secure other personal care services available through the State Plan or a waiver.			
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
Individuals must be assessed to need hands-on assistance with at least one ADL to receive this service.			
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (<i>Choose each that applies</i>):			
✓	Categorically needy (<i>specify limits</i>):		
	Services cannot duplicate, replace, or supplant other available state plan services. Individuals enrolled in another HCBS program (waiver or state plan) must receive personal care assistance or services through that program.		
✓	Medically needy (<i>specify limits</i>):		
	Services cannot duplicate, replace, or supplant other available state plan services. Individuals enrolled in another HCBS program (waiver or state plan) must receive personal care assistance or services through that program.		
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Individual	n/a	n/a	Must be enrolled in CHAMPS Must not have any excludable convictions based upon a background check. Individuals must be able to meet the needs of the participant as specified in the person-centered service plan
Agency	n/a	n/a	Must be enrolled in CHAMPS Employees and other key staff must not have any excludable convictions based upon a background check. Employees must be able to meet the needs of the participant as specified in the person-centered service plan.
Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification		Frequency of Verification (<i>Specify</i>):

	<i>(Specify):</i>	
Individual	Center for Independent Living, Area Agency on Aging, or other Community Based Organization	Prior to the provision of services and annually thereafter
Agency	Center for Independent Living, Area Agency on Aging, or other Community Based Organization	Prior to the provision of services and annually thereafter
Service Delivery Method. <i>(Check each that applies):</i>		
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/> Provider managed

6. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. *(Select one):*

<input checked="" type="radio"/>	The state does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. <i>(Specify criteria):</i>

2. Description of Participant-Direction. *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

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3. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

<input type="radio"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="radio"/>	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the state affected by this option):</i>

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

5. Financial Management. *(Select one) :*

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):*

Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

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8. **Opportunities for Participant-Direction**

- a. **Participant–Employer Authority** (individual can select, manage, and dismiss State plan HCBS providers). *(Select one):*

<input type="radio"/>	The state does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- b. **Participant–Budget Authority** (individual directs a budget that does not result in payment for medical assistance to the individual). *(Select one):*

<input type="radio"/>	The state does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):</i>
	Expenditure Safeguards. <i>(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.</i>

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c) document choice of services and providers.

<i>Requirement</i>		<i>Service plans address assessed needs of 1915(i) participants</i>
Discovery		
Discovery Evidence <i>(Performance Measure)</i>		<p>Number and percent of individuals with a person-centered service plan that includes services and supports that align with their assessed needs and expressed goals.</p> <p>Numerator: Number of individuals with a person-centered service plan that includes services and supports that align with their assessed needs and expressed goals.</p> <p>Denominator: All person-centered service plans.</p>
Discovery Activity <i>(Source of Data & sample size)</i>		100% MDHHS will review all person-centered service plans to determine whether the plan includes services and supports that align with their assessed needs and expressed goals.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>		MDHHS will review each person-centered service plan developed by a transition navigator and submitted to MDHHS for approval. MDHHS must approve all service plans before services can be delivered. When MDHHS identifies a discrepancy between the assessment and the person-centered service plan, the transition navigator must make corrections to the assessment or plan to the satisfaction of MDHHS and the individual.
Frequency		Continuous and ongoing, compiled annually
Remediation		
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>		<p>MDHHS will collect, analyze, and aggregate remediation activities. This may require an in-person visit with the individual or may be a correction of an error or omission in the documentation submitted to MDHHS. The transition navigator will be required to submit corrected documents to MDHHS within 30 days of being notified of the needed corrections. Service providers will receive reports of the case record reviews and allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS will monitor the implementation of the corrective action plan to assure quality improvements are realized.</p> <p>Any issues found that jeopardize the health or welfare of the individual will require immediate remediation to the satisfaction of the individual and MDHHS.</p>

Frequency <i>(of Analysis and Aggregation)</i>	Annually
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Requirement	<i>Service plans are updated annually</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of person-centered service plans updated at least annually or sooner if indicated.</p> <p>Numerator: Number of person-centered service plans updated at least annually or sooner if indicated.</p> <p>Denominator: All person-centered service plans open and active for at least 365 days.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	MDHHS will monitor 100% of the person-centered service plans that have been approved for at least 365 days.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS reviews each person-centered service plan developed by a transition navigator and submitted to MDHHS for approval that remains open and active for 365 days or more. MDHHS verifies that these plans are updated at least annually, or sooner when indicated. When MDHHS identifies a plan that was not updated when it should have been, the transition navigator is required to make corrections to the plan to the satisfaction of MDHHS and the individual.
Frequency	Continuous and ongoing, compiled annually
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur annually for all person-centered service plans that remain open for at least 365 days. Service providers receive reports of the case record reviews and are allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized.</p> <p>Any issues found that jeopardize the health or welfare of the individual require immediate remediation to the satisfaction of the individual and MDHHS.</p>
Frequency <i>(of Analysis and Aggregation)</i>	Annually

Requirement	<i>Service plans document choice of services and providers.</i>
Discovery	
Discovery Evidence	Number and percent of individuals with service plans that document choice of services and providers.

<i>(Performance Measure)</i>	Numerator: Number of individuals with service plans that document choice of services and choice of providers. Denominator: All service plans reviewed.
Discovery Activity <i>(Source of Data & sample size)</i>	100% MDHHS reviews all person-centered service plans to determine whether the plan includes documentation of choices of services and providers for the individual.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS or a contracted entity will review each person-centered service plan developed by a transition navigator and submitted to MDHHS for approval to assure documentation includes the choices between services and service providers. When MDHHS identifies a discrepancy, the transition navigator will be required to make corrections to the plan to the satisfaction of MDHHS and the beneficiary.
Frequency	Continuous and ongoing, compiled annually
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>MDHHS collects, analyzes, and aggregates remediation activities. This may require an in-person visit with the individual or may just be a correction of an error or omission in the documentation submitted to MDHHS. The transition navigator is required to submit corrected documents to MDHHS within 30 days of being notified of the needed corrections. Service providers will receive reports of the case record reviews and are allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized.</p> <p>Any issues found that jeopardize the health or welfare of the individual require immediate remediation to the satisfaction of the individual and MDHHS.</p>
Frequency <i>(of Analysis and Aggregation)</i>	Annually

2. **Eligibility Requirements:** (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

Requirement	An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.
Discovery	

	Discovery Evidence <i>(Performance Measure)</i>	Number and percent of 1915(i) services evaluations completed. Numerator: Number of 1915(i) services evaluations completed. Denominator: All 1915(i) services referrals received.
	Discovery Activity <i>(Source of Data & sample size)</i>	Transition agencies must track all referrals made to them and document the referral in the nursing facility transition portal. This data is available to MDHHS once it is entered in the nursing facility transition portal. The sample size is 100%.
	Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS use referral and claims data for the number of evaluations completed to calculate this performance measure. When an agency is not completing a timely evaluation for referrals made, MDHHS requires corrective action of the entity.
	Frequency	Continuous & ongoing, compiled annually
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur continuously. Service providers receive data reports and are allowed 30 days to explain discrepancies and develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized quarterly. Any issues found that jeopardize the health or welfare of the individual require immediate remediation to the satisfaction of the individual and MDHHS.
	Frequency <i>(of Analysis and Aggregation)</i>	Annually
Requirement		The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	Number and percent of 1915(i) services evaluations made by a qualified evaluator using an approved instrument. Numerator: Number of 1915(i) services evaluations made by a qualified evaluator using an approved instrument. Denominator: All 1915(i) services records.
	Discovery Activity <i>(Source of Data & sample size)</i>	100% MDHHS reviews all 1915(i) case records to determine whether the evaluations were made by a qualified evaluator using the appropriate instrument.
	Monitoring Responsibilities	MDHHS reviews the evaluations made to assure the appropriate instrument was used and a qualified evaluator completed the determination. When an evaluation is not completed properly, or someone who is not qualified to be a transition navigator completes an evaluation, MDHHS requires corrective action.

	<i>(Agency or entity that conducts discovery activities)</i>	
	Frequency	Continuous and ongoing, compiled annually
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur continuously and ongoing. Evaluators receive reports of the findings and are allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized.</p> <p>Any issues found that jeopardize the health or welfare of the individual including having an evaluation completed by a non-qualified person, require immediate remediation to the satisfaction of the individual and MDHHS.</p>
	Frequency <i>(of Analysis and Aggregation)</i>	Annually

Requirement	<i>The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.</i>	
Discovery		
Discovery Evidence <i>(Performance Measure)</i>	The number and percent of individuals enrolled in 1915(i) services for more than a year who have had an annual reevaluation. Numerator: The number of individuals enrolled in 1915(i) services for more than a year who have had an annual reevaluation. Denominator: The number of individuals enrolled in 1915(i) services for more than a year.	
Discovery Activity <i>(Source of Data & sample size)</i>	MDHHS monitors all beneficiaries who have been enrolled in 1915(i) services for a year or more since the last evaluation. MDHHS assures that beneficiaries enrolled in 1915(i) services for longer than a year have an annual reevaluation. The sample size will be 100%.	
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS reviews the evaluations to assure the appropriate instrument was used and a qualified evaluator completed the determination. When an evaluation is not completed properly, MDHHS requires corrective action. Any issues found that jeopardize the health or welfare of the individual, including having an evaluation completed by a non-qualified person, require immediate remediation to the satisfaction of the individual and MDHHS.	
Frequency	Continuous & ongoing	
Remediation		

Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Evaluators serving individuals who have not had a reevaluation after being enrolled for a year are required to perform a reevaluation or discharge the individual. Case record documentation must assure the individual is making progress toward their goals of transitioning and participating in the community. Once a missed or late evaluations identified, reevaluations need to be conducted within one week.
Frequency <i>(of Analysis and Aggregation)</i>	Continuous & ongoing

3. Providers meet required qualifications.

Requirement	Providers meet required qualifications
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of non-licensed or non-certified 1915(i) services providers that meet provider qualifications. Numerator: Number of non-licensed or non-certified providers that meet provider qualifications. Denominator: All non-licensed or non-certified providers.
Discovery Activity <i>(Source of Data & sample size)</i>	100% of non-licensed or non-certified providers, MDHHS/CHAMPS
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS monitors providers and assures that the proper documentation to verify provider qualifications is submitted to the Department as required. Provider end dates are be used to assure unqualified providers are not paid for services rendered.
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS uses CHAMPS to analyze and aggregate the data. When a non-licensed, non-certified provider is found that does not meet provider qualifications, their provider eligibility is end dated in CHAMPS and they are no longer be able to bill for services provided to individuals. MDHHS recoups payments made to providers who were not qualified at the time of service provision.
Frequency	Continuous and ongoing.

	(of Analysis and Aggregation)	
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Requirement		Providers meet required qualifications
Discovery		
Discovery Evidence (Performance Measure)		<p>Number and percent of licensed or certified 1915(i) services providers that meet provider qualifications.</p> <p>Numerator: Number of licensed or certified providers that meet provider qualifications.</p> <p>Denominator: All licensed or certified providers.</p>
Discovery Activity (Source of Data & sample size)		100% of licensed or certified providers MDHHS/CHAMPS
Monitoring Responsibilities (Agency or entity that conducts discovery activities)		MDHHS monitors providers and assures the proper documentation to verify provider qualifications is submitted to the Department as required. Provider end dates are used to assure unqualified providers are not paid for services rendered.
Frequency		Continuous and ongoing
Remediation		
Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)		MDHHS uses CHAMPS to analyze and aggregate the data. When a licensed or certified provider is found that does not meet provider qualifications, their provider eligibility is end dated in CHAMPS and they are no longer able to bill for services provided to individuals.
Frequency (of Analysis and Aggregation)		Continuous and ongoing.

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

Requirement	Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery	

Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of provider-controlled settings that meet the HCBS settings requirements used by individuals enrolled in 1915(i) services who have transitioned from an institution.</p> <p>Numerator: Number of provider-controlled settings that meet the HCBS settings requirements used by individuals enrolled in 1915(i) services who have transitioned from an institution.</p> <p>Denominator: All provider-controlled settings used by individuals enrolled in 1915(i) services who have transitioned from an institution.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	<p>MDHHS monitors all individuals enrolled in 1915(i) services who have transitioned from an institution and chosen to use a provider-controlled setting in the community. All provider-controlled settings must meet the HCBS settings requirements in 42 CFR 441.710(a)(1) and (2) prior to the individual using that setting.</p> <p>The sample size is 100%.</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS or Transition Navigators work with provider-controlled settings to assure they meet the HCBS settings rule before the individual uses a specific provider.
Frequency	Continuous & ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Transition Navigators have access to an MDHHS database that identifies whether a provider-controlled setting has been evaluated for compliance to the HCBS settings rule, and if so, whether the setting meets the requirements. When individuals choose a setting that has not been deemed compliant, the Transition Navigator will need to inform the individual that 1915(i) services must stop upon transition to this setting and of other available options that are compliant where transition and other HCBS services could continue. Should the individual still choose a non-compliant setting, no Medicaid-funded reimbursement for services after the transition date will be approved.
Frequency <i>(of Analysis and Aggregation)</i>	Continuous & ongoing

5. The SMA retains authority and responsibility for program operations and oversight.

Requirement	<i>The SMA retains authority and responsibility for program operations and oversight.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of service plans for participants that were completed within 90 days from the initial assessment.</p> <p>Numerator: Number of service plans for participants that were completed within 90 days from the initial assessment</p>

		Denominator: Number of beneficiaries with person-centered transition plans
	Discovery Activity <i>(Source of Data & sample size)</i>	100% of all service-plans submitted to MDHHS for approval of 1915(i) services.
	Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS reviews all person-centered service plans to assure they are completed within 90 days of initially assessing the individual for 1915(i) services.
	Frequency	Continuous and ongoing
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS collects, analyzes, and aggregates remediation activities. Reviews are continuous and ongoing for all person-centered service plans approved. Service providers receive reports of the case record reviews and are allowed 30 days to correct any deficiencies noted. MDHHS monitors the implementation of the corrective action to assure quality improvements are realized. Any issues found that jeopardize the health or welfare of the individual will require immediate remediation to the satisfaction of the individual and MDHHS.
	Frequency <i>(of Analysis and Aggregation)</i>	Annually

Requirement		The SMA retains authority and responsibility for program operations and oversight.
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	Number and percent of service plans that were approved by MDHHS. Numerator: Number of service plans that were approved by MDHHS. Denominator: Number of service plans submitted for approval by MDHHS.
	Discovery Activity <i>(Source of Data & sample size)</i>	100% of all person-centered service plans submitted to MDHHS for approval
	Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS reviews all person-centered service plans submitted for approval. MDHHS contacts the transition navigator for any plans submitted that cannot be approved to address the issues identified. The transition navigators have 30 days to remediate all issues.
	Frequency	Continuous and Ongoing

Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur continuously and ongoing for all person-centered service plans submitted for approval. Service providers receive reports of the case record reviews and are allowed 30 days to correct any deficiencies noted. MDHHS monitors the implementation of the corrective action to assure quality improvements are realized.</p> <p>Any issues found that jeopardize the health or welfare of the individual will require immediate remediation to the satisfaction of the individual and MDHHS.</p>
Frequency <i>(of Analysis and Aggregation)</i>	Annually

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement	<i>The SMA maintains financial accountability through payment of claims for the services that are authorized and furnished to 1915(i) participants by qualified providers.</i>	
Discovery		
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of service plans that supported paid services. Numerator: Number of service plans that supported paid services. Denominator: Number of service plans approved by MDHHS.	
Discovery Activity <i>(Source of Data & sample size)</i>	100% of all service plans	
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS assures that all 1915(i) services billed are included on the approved person-centered service plan prior to adjudicating the claims submitted by the provider.	
Frequency	Continuous and Ongoing	
Remediation		
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur continuously and ongoing all person-centered service plans authorized by MDHHS. Service providers are allowed 30 days to correct any deficiencies noted. MDHHS monitors the implementation of the corrective action to assure quality improvements are realized. Claims for services not included on the person-centered service plan will not be authorized for payment.	

	Any issues found that jeopardize the health or welfare of the individual will require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency (of Analysis and Aggregation)	Annually

Requirement	<i>The SMA maintains financial accountability through payment of claims for the services that are authorized and furnished to 1915(i) participants by qualified providers.</i>	
Discovery		
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of 1915(i) services claims payments made to providers for 1915(i) services participants with active Medicaid eligibility. Numerator: Number of 1915(i) services claims payments made to providers for 1915(i) services participants with active Medicaid. Denominator: Total number of 1915(i) services claims payments.	
Discovery Activity <i>(Source of Data & sample size)</i>	MDHHS monitors payments made to providers of 1915(i) services to assure payments subject to FFP are only issued for Medicaid-eligible individuals. This will be a 100% sample size.	
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS has edits in place prior to approving claims to verify that only claims for Medicaid beneficiaries are approved for payment and submitted for FFP.	
Frequency	Continuous and ongoing	
Remediation		
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS assures FFP is only requested for claims made for 1915(i) services provided to Medicaid-eligible beneficiaries. MDHHS periodically evaluates all 1915(i) services claims payments subject to FFP to assure the individuals served had Medicaid eligibility on the date of service. Claims adjustments or recoupments are made for any claims for which FFP was requested, but the individual did not have Medicaid eligibility on the date of service.	
Frequency <i>(of Analysis and Aggregation)</i>	Continuous and ongoing	

<i>Requirement</i>	<i>The SMA maintains financial accountability through payment of claims for the services that are authorized and furnished to 1915(i) participants by qualified providers.</i>
<i>Discovery</i>	

Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of 1915(i) services FFS payments that have been paid at rates approved by MDHHS.</p> <p>Numerator: Number of 1915(i) services FFS payments that have been paid at rates approved by MDHHS.</p> <p>Denominator: All 1915(i) services FFS payments.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	<p>MDHHS monitors payments made to providers of 1915(i) services to assure payments are only issued for Medicaid-eligible individuals at the MDHHS approved rates.</p> <p>The sample size is 100%.</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS uses edits in the MMIS system to assure claims are paid at the rates approved by MDHHS. All claims for services that are above the MDHHS-approved rates are either rejected or adjusted down to the MDHHS approved rate before issuing payment.
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS assures FFP is only claimed for 1915(i) services provided to Medicaid-eligible individuals. MDHHS periodically evaluates all 1915(i) services claims payments made to assure the individuals served had Medicaid eligibility on the date of service and the claims are paid at the rates approved by MDHHS. Recoupments or adjustments are made as necessary for payments for service provided to all non-eligible individuals and for payments made that are not at the MDHHS approved rate.
Frequency <i>(of Analysis and Aggregation)</i>	Continuous and ongoing

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Requirement	<i>The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of case records that indicate a provider took appropriate action when they suspect incidences of abuse, neglect and exploitation have occurred.</p> <p>Numerator: Number of case records that indicate a provider took appropriate action when they suspect incidences of abuse, neglect and exploitation.</p> <p>Denominator: Number of case records reviewed that indicate an incidence of abuse, neglect or exploitation may have occurred.</p>

Discovery Activity <i>(Source of Data & sample size)</i>	A statistically significant randomly drawn sample of case records to review. Confidence interval is +/- 5%.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS reviews a randomly selected statistically significant sample of all case records for individuals approved for 1915(i) services. This review may include interviews with participants to determine if any potential incidents of abuse, neglect, or exploitation may have occurred, and if so whether those incidents were reported as required.
Frequency	Annually
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur annually for a statistically significant sample of case records. Service providers receive reports of the case record reviews and are allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized. Any issues found that jeopardize the health or welfare of the individual require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency <i>(of Analysis and Aggregation)</i>	Annually

Requirement	<i>The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of individuals or legal guardians who received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents. Numerator: Number of individuals or legal guardians who received information and education in the prior year as documented in the case record. Denominator: Number of case records reviewed.
Discovery Activity <i>(Source of Data & sample size)</i>	A statistically significant randomly drawn sample of case records to review. Confidence interval is +/- 5%.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS reviews a randomly selected statistically significant sample of all case records for individuals approved for 1915(i) services. This review may include interviews with participants to determine if any potential incidents of abuse, neglect, or exploitation may have occurred, and if so whether those incidents were reported as required.

	Frequency	Annually
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur annually for a statistically significant sample of case records. Service providers receive reports of the case record reviews and are allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized quarterly.</p> <p>Any issues found that jeopardize the health or welfare of the individual require immediate remediation to the satisfaction of the individual and MDHHS.</p>
	Frequency <i>(of Analysis and Aggregation)</i>	Annually

	Requirement	<i>The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</i>
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of Transition Navigators who have completed required training to identify and report suspected incidents of abuse, neglect, and exploitation, and how to prevent additional incidents.</p> <p>Numerator: Number of Transition Navigators who have completed required training to identify and report suspected incidents of abuse, neglect, and exploitation, and how to prevent additional incidents.</p> <p>Denominator: All Transition Navigators.</p>
	Discovery Activity <i>(Source of Data & sample size)</i>	<p>MDHHS reviews Transition Navigator records to determine whether each Transition Navigator received training on identifying, reporting, and preventing incidents of abuse, neglect, and exploitation.</p> <p>100% sample size.</p>
	Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS reviews agency and individual training records to assure transition navigators are trained on how to identify and report suspected incidents of abuse, neglect or exploitations.
	Frequency	Continuous and ongoing
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS collects, analyzes, and aggregates remediation activities. Reviews of Transition Navigator training will occur annually for all new Transition Navigators. Any Transition Navigator who cannot verify receipt of such training is required to participate in a training and provide verification of participation within 30 days of identifying the issue.

Frequency <i>(of Analysis and Aggregation)</i>	Continuous and ongoing
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System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

MDHHS designed the 1915(i) services quality improvement strategy to assess and improve the quality of services and supports provided through the 1915(i) services option. MDHHS is the Single State Agency responsible for establishing the components of the quality improvement strategy which includes several tools to gather data and measure individual and system performance. Tools utilized include the record review protocol, the participant satisfaction survey, and a Critical Incident Reporting (CIR) system. The system was designed with input from many stakeholders including participants, MI Choice waiver agencies, Centers for Independent Living, PACE organizations, and other interested parties.

An administrative oversight committee remains in place. This committee is comprised of representatives from Area Agencies on Aging, Centers for Independent Living, MDHHS Leadership, PACE, and the Michigan Home and Community Based Services Network. Additionally, the Quality Management Collaborative, which is chaired by HCBS participants, many of whom have transitioned from the nursing facility, is consulted as needed.

Data gathered from the record reviews is used to foster improvements and provide technical assistance at the agency whose records are being reviewed. Annually, this data is compiled to look for systemic trends and areas in need of improvement. The participant satisfaction survey is administered monthly and compiled annually to program participants. This includes those in the process of transitioning, those who have transitioned, and those who closed without transition. Any issues identified through this survey are immediately resolved to the satisfaction of the individual. Data is compiled at the end of each survey cycle and analyzed for trends and areas of improvement.

The administrative oversight committee assist with prioritizing areas of improvement. This group's top priority is to facilitate improvements that will make transitioning easier for the person being served. Everyone on the administrative oversight committee has training in continual quality improvement and this expertise is used to facilitate improvements.

2. Roles and Responsibilities

MDHHS maintains overall responsibility for quality assurance, quality improvements and quality performance.

MDHHS staff perform case record reviews. Contracted entities conduct the participant satisfaction surveys. These entities are responsible for providing technical assistance when identified in the performance of their duties. The entities also retain responsibility to identify areas in need of improvement and make MDHHS aware of any identified trends or areas that need immediate remediation.

Providers are responsible for furnishing services according to MDHHS policies and procedures and for continuously improving their performance and the experiences of the individuals they serve. They retain responsibility for submitting claims to MDHHS for adjudication and for assuring all claims for service are provided according to established policies and procedures.

3. Frequency

Quality improvement is continuous and ongoing. MDHHS continuously monitors claims submitted for 1915(i) services, the qualifications of providers, and the satisfaction of individuals served with 1915(i) services. Case record reviews are conducted continuously and ongoing for all records across all providers. Contractors conduct participant satisfaction surveys each month and compile the data annually.

4. Method for Evaluating Effectiveness of System Changes

MDHHS uses the continual Quality Improvement strategy to facilitate system changes. This focuses on a plan, do, study, act framework for examining the issues, piloting solutions, and studying results before requiring systemic changes. Data is analyzed at least annually to determine whether changes implemented led to improved outcomes for the individuals using 1915(i) services. When issues are identified, a study of the root cause of the issue is conducted. Any barriers to success identified will be removed or overcome to facilitate quality improvements.

1915(i) State Plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. **Services.** (Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):

Community Support Services: Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support & Training, Fiscal Intermediary, Housing Assistance, Respite Care, Skill-Building Assistance, Specialized Medical Equipment & Supplies, Supported/Integrated Employment, and Vehicle Modification.

2. **Concurrent Operation with Other Programs.** (Indicate whether this benefit will operate concurrently with another Medicaid authority): **Select one:**

<input type="radio"/>	Not applicable		
<input checked="" type="radio"/>	Applicable		
Check the applicable authority or authorities:			
<input type="checkbox"/>	Services furnished under the provisions of §1915(a)(1)(a) of the Act. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. <i>Specify:</i> (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the specific 1915(i) State plan HCBS furnished by these plans; (d) how payments are made to the health plans; and (e) whether the 1915(a) contract has been submitted or previously approved.		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):			
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program operated under §1932(a) of the Act. <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</i>		
<input checked="" type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i> On 10/1/2023, the §1915(i) SPA will operate concurrently with the §1115 Behavioral Health Demonstration Waiver.		

3. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** (*Select one*):

<input checked="" type="checkbox"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program <i>(select one)</i> :	
	<input type="radio"/>	The Medical Assistance Unit <i>(name of unit)</i> :
	<input checked="" type="checkbox"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit <i>(name of division/unit)</i> <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>
		Michigan Department of Health and Human Services (MDHHS)/Behavioral Health and Developmental Disabilities Administration (BHDDA).
<input type="radio"/>	The State plan HCBS benefit is operated by <i>(name of agency)</i> a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State plan HCBS Operational and Administrative Functions.

☒ (By checking this box the state assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed *(check each that applies)*:

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2 Eligibility evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

8 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Contracted Entity: MDHHS/BHDDA, as the **Medicaid State Agency**, will maintain accountability, directly perform, and/or otherwise monitor all administrative functions of the state plan HCBS benefit. MDHHS local field offices establish Medicaid eligibility (function 2) as **the other state agency** and MDHHS/BHDDA contracts with regional managed care Pre-paid Inpatient Health Plans (PIHP), as the **other contracted entity**, to assist in monitoring functions of the HCBS benefit (functions 1, 3, 4, 5, 6, 7, and 10). MDHHS/BHDDA, the PIHP, an EQR Vendor, and **local non-state entities**/Community Mental Health Service Programs (CMHSP) will all be actively involved in assuring quality and implementation of identified quality improvement activities (function 10).

(By checking the following boxes the State assures that):

5. ☒ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
- related by blood or marriage to the individual, or any paid caregiver of the individual
 - financially responsible for the individual
 - empowered to make financial or health-related decisions on behalf of the individual
 - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. (If the state chooses this option, specify the conflict of interest protections the state will implement):

MDHHS/BHDDA as the state Medicaid agency will deliver 1915(i) SPA services through contracted arrangements with its managed care PIHPs regions. The PIHPs have responsibility for monitoring person-centered service plans and the network's implementation of the 1915 (i) SPA services, which require additional conflict of interest protections including separation of entity and provider functions within provider entities.

The right of every individual receiving public mental health services in Michigan to the development of an individual plan of services and supports using the person-centered planning process is established by law in Chapter 7 of the Michigan Mental Health Code. Through the MDHHS/PIHP contract, MDHHS delegates the responsibility for the authorization of the service plan to the PIHPs. The PIHPs delegate the responsibilities of plan development to CMHSP supports coordinator or other qualified staff chosen by the individual or family. These individuals responsible for the IPOS are not providers of any HCBS for that individual and are not the same people responsible for the independent HCBS needs assessment. The CMHSPs authorize the implementation of service through a separate service provider entity. The development of the IPOS through the person-centered planning (PCP) process is led by the beneficiary with the involvement of allies chosen by the beneficiary to ensure that the service plan development is conducted in the best interests of the beneficiary. The beneficiary has the option of choosing an independent facilitator (not employed by

or affiliated with the PIHP) to facilitate the planning process. In addition, the PIHP, through its Customer Services Handbook and the one-on-one involvement of a supports coordinator, supports coordinator assistant, or independent supports broker are required to provide full information and disclosure to beneficiaries about the array of services and supports available and the choice of providers. The beneficiary has the option to choose his or her supports coordinator employed by a PIHP subcontractor or can choose an independent supports coordinator (not employed directly by or affiliated with the PIHP except through the provider network) or select a supports coordinator assistant or independent supports broker. This range of flexible options enables the beneficiary to identify who he or she wants to assist with service plan development that meets the beneficiaries' interests and needs. Person-centered planning is one of the areas that QMP Site Review Team addresses during biennial reviews of each PIHP.

The MDHHS/BHDDA has several safeguards in place to assure that the independent assessment, independent eligibility evaluation, development of the Individual Plan of Service (IPOS), and delivery of 1915(i) services by the PIHP provider network are free from conflict of interest through the following:

- 1) The mandated separation required in the MDHHS/PIHP contract that assures the assessor(s) of eligibility will not make final determinations about the amount, scope and duration of 1915i services;
- 2) The MDHHS/PIHP contract assures the provider responsible for the independent HCBS needs assessment are separate from the case manager/supports coordinator providers responsible for the development of the IPOS;
- 3) All Medicaid beneficiaries are supported in exercising their right to free choice of providers and are provided information about the full range of 1915(i) services, not just the services furnished by the entity that is responsible for the person-centered service plan development. All beneficiaries are advised about the Medicaid Fair Hearing process in the Customer Services Handbook that is provided by the PIHP to the individual at the onset of services, at least annually at the person-centered planning meeting and upon request of the individual at any time. The Medicaid Fair Hearings process is available to the individual to appeal decisions made related to 1915(i) services. This may include beneficiaries who believe they were incorrectly determined ineligible for 1915(i) services; beneficiaries who believe the amount, scope, and duration of services determined through the person-centered planning process is inadequate to meet their needs; and if 1915(i) services are reduced, suspended or terminated. Adequate Notice of Medicaid Fair Hearing rights is provided at the time the person-centered plan of service is developed and Advanced Notice of Medicaid Fair Hearing rights is provided prior to any reduction, elimination, suspension or termination of services;
- 4) The results of the individual needs assessment, including any other historical assessment or evaluation results, may be used as part of the information utilized in developing the individual plan of services (IPOS). Oversight/coordination of the IPOS is done by a case manager or supports coordinator or other qualified staff chosen by the individual or family, is not a provider of any other service for that individual, and is not the professional/entity that completes the individual needs assessment/authorization for eligibility or services;
- 5) The PIHP performs the utilization management managed care function to authorize the amount, scope and duration of 1915i services. PIHP utilization management staff are completely separate from the sub-contracted staff and entities performing evaluation, assessment, planning, and delivery of 1915i services;
- 6) As part of its Quality Assessment Performance Improvement Plan (QAPIP), each PIHP "has mechanisms to identify and correct under-utilization as well as over-utilization" of services [MDHHS/PIHP Contract Attachment P.7.9.1]. PIHPs use a number of different mechanisms as part of utilization management to monitor for under- and over-utilization of services. For example, the PIHP may use an independent qualified clinician to review recommended 1915(i) services; UM staff may perform regular reviews to determine if authorizations and service / units utilized are tied to

IPOS goals and whether services authorized / used are medically necessary and the level approved is appropriate to meet the goals in the IPOS; or collect utilization data for trending and analysis.

7) MDHHS also monitors through its site review process and the External Quality Review (EQR) to assure that 1915(i) services will be determined and delivered appropriate and free from conflict of interest. The EQR includes a standard that evaluates the PIHP's utilization management system to assure there are written criteria and procedures for making utilization decisions, mechanisms for identifying under- and over-utilization, and processes for providing Medicaid Fair Hearing notice if a service is denied, suspended, reduced or terminated. As part of the Quality Improvement Strategy, MDHHS will implement changes as needed with CMS approval if required based on the discovery, analysis and remediation of the performance measures to ensure there are no fiduciary conflicts or incentives to either over or under utilize services.

Additional Assurances in MDHHS/PIHP Contract Section 30.0 CONFLICT OF INTEREST:

The PIHP and MDHHS are subject to the federal and state conflict of interest statutes and regulations that apply to the PIHP under this contract, including Section 1902(a)(4)(C) and (D) of the Social Security Act: 41 U.S.C. Chapter 21 (formerly Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. §423): 18 U.S.C. §207): 18 U.S.C. §208: 42 CFR §438.58: 45 CFR Part 92: 45 CFR Part 74: 1978 PA 566: and MCL 330.1222. Self-Determination Policy and Practice Guideline (Attachment P4.7.1) and Medicaid Services Verification – Technical Requirements (Attachment P6.4.1)

6. ☒ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
7. ☒ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.
8. ☒ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	10-1-2023	9-30-2024	50,000
Year 2			
Year 3			
Year 4			
Year 5			

2. ☒ **Annual Reporting.** (By checking this box the state agrees to): annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☒ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State’s Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)
2. **Medically Needy** *(Select one):*

<input type="checkbox"/> The State does not provide State plan HCBS to the medically needy.
<input checked="" type="checkbox"/> The State provides State plan HCBS to the medically needy. <i>(Select one):</i>
<input type="checkbox"/> The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.
<input checked="" type="checkbox"/> The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations/Reevaluations** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed *(Select one):*

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other <i>(specify State agency or entity under contract with the State Medicaid agency):</i> The PIHP provider network will perform the face-to face assessments, compile required documentation, and submit findings to the MDHHS/BHDDA. The MDHHS/BHDDA will make the determination of needs-based criteria through an independent evaluation and re-evaluation.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications)*

MDHHS staff must have a minimum of a bachelor’s degree, preferably in a health or social services field. Staff are trained in the needs-based criteria outlined for these 1915(i) State Plan services and are able to evaluate documentation to determine whether each applicant meets these criteria. Staff will have access to state systems to verify that individuals are Medicaid eligible and currently residing in a HCBS setting.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

For an Evaluation/Reevaluation the MDHHS/BHDDA staff will apply the needs-based criteria described in 5 below to determine whether the individual in the targeted group is eligible for 1915(i) services. The PIHPs network will utilize standardized instruments to assist in identifying

level of need (i.e. LOCUS, SIS, ASAM, Gain-I0), administer other face to face assessments related to the individual's functional abilities (i.e. EFL, AFLS, other adaptive behavior/global functioning scales, etc.), and identify services and supports required to reach the expected outcomes of community inclusion and participation. The PIHPs network will provide evidence to MDHHS/BHDDA for making the needs-based eligibility determination through a Waiver Support Application (WSA) portal.

The MDHHS/BHDDA will conduct evaluations using validated instruments specific to each individual's condition that identifies the individual meets all the eligibility requirements for 1915(i) service(s).

- For children and adolescents, with SED, the Preschool and Early Childhood Functional Assessment Scale (PECFAS) and the Child Adolescent Functional Assessment Scale (CAFAS) is utilized. For children and adolescents with intellectual or developmental disability, standardized tools to identify functional abilities, adaptive behavior/global functioning, and level of support needs (i.e. DD-CGAS, Vineland, SIS-C, etc.) will be utilized.
- For adults with mental health and co-occurring mental health and substance use disorder related needs, the Level of Care Utilization System (LOCUS) is applied. For adults with intellectual or developmental disability related needs the Supports Intensity Scale (SIS) is used. Adults presenting with needs only involving substance use disorders the Global Appraisal of Individual Needs Initial (GAIN-I) Core assessment is utilized as it directly supports the American Society of Addiction Medicine (ASAM) level of care criteria that this service system is based on.

Re-evaluation is done annually. A formal review of the IPOS will occur no less than annually with the individual and any other person chosen to participate by the individual or guardian. MDHHS/BHDDA will make determination of continuing eligibility based on evidence provided by the PIHP and evaluation that the individuals still meet the needs-based criteria described in 5 below.

4. ☒ **Reevaluation Schedule.** *(By checking this box, the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

To be eligible for 1915(i) services an individual must meet all of the following requirements:

1. Have a substantial functional limitation in 1 or more of the following areas of major life activity:
 - (A) Self-care.
 - (B) Communication.
 - (C) Learning.
 - (D) Mobility.
 - (E) Self-direction.
 - (F) Capacity for independent living.
 - (G) Economic self-sufficiency; and

2. Without 1915 (i) services the beneficiary is at risk of not increasing or maintaining sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity or community inclusion and participation.

6. ☒ Needs-based Institutional and Waiver Criteria. *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
1. Have a substantial functional limitation in 1 or more of the following areas of major life activity: (A) Self-care. (B) Communication. (C) Learning. (D) Mobility. (E) Self-direction. (F) Capacity for independent living. (G) Economic self-sufficiency; AND 2. Without 1915 (i) services the beneficiary is at risk of not increasing or maintaining sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity, or community inclusion and participation.	Must meet nursing facility level of care, e.g. demonstrate 1) need for assistance with ADLs of bed mobility, transfers, toilet use, or eating, 2) cognitive performance deficits, a) severely impaired in decision making, b) short-term memory problem and at least moderately impaired in decision making, or c) short-term memory problem and is sometimes or rarely understood 3) physician involvement with unstable medical condition within the last 14 days, 4) have at least one treatment or condition in the last 14 days including: stage 3-4 pressure ulcers, intravenous or parenteral feedings, intravenous medications, end-stage care, daily tracheostomy, respiratory, or suctioning care, pneumonia, daily oxygen therapy, daily insulin with 2 order	Must meet ICF/IID level of care, e.g. current assessments of the beneficiary reflect evidence of a developmental disability and/or serious mental illness. The beneficiary's intellectual or functional limitations indicate that he/she would be eligible for health, habilitative, and active treatment services provided at the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care [U.S. PL 111-256.	Must meet long-term acute care hospital (LTACH) level of care, e.g. 1) have a medically complex condition, 2) demonstrate active comorbidities that require complex medical management and a multidisciplinary treatment plan to promote medical and functional improvement lead by a medical practitioner; and 3) have a reasonable potential to benefit from an intense medical treatment program.

	changes, or peritoneal or hemodialysis, 5) received at least 45 minutes of skilled speech, occupational or physical rehabilitation therapies in the last 7 days 6) have displayed challenging behaviors (wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, resisted care in 4 of the last 7 days or had delusions or hallucinations in the last 7 days. 7) be LTSS participant for a year or more and have service dependency 8) be determined medically frail.		
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*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☒ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (Specify target group(s)):

Individual beneficiaries' with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☒ **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
9. **Reasonable Indication of need for services:** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be

documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	Minimum number of services. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is: <table border="1"><tr><td>(1) One</td></tr></table>	(1) One
(1) One		
ii.	Frequency of services. The state requires (select one):	
<input type="checkbox"/>	The provision of 1915(i) services at least monthly	
<input checked="" type="checkbox"/>	Monthly monitoring of the individual when services are furnished on a less than monthly basis If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: At least one 1915(i) service every three months in addition to monthly monitoring.	

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. *(Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The state assures that this 1915(i) will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings statewide transition plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings statewide transition plan. Approximately 72% of individuals receiving these state plan services have the services delivered in settings that are following the federal HCBS Settings Rule. These settings include their own home where their names are on the leases and if they have roommates, have chosen those people who live with them; or living with family members in the home of their relative (non-provider owned or controlled), or living with a foster family where only one or two individuals with disabilities share a home with their foster family. In each of these settings, individuals have full access to the home, such as meals and snacks available at any time, ability to have visitors, having privacy for conducting personal business, and can come and go in the community. These settings allow the participants to be in control of their life and be fully integrated in the community. More information can be found on the Statewide Transition Plan. https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943-334724--,00.html and https://www.michigan.gov/documents/mdhhs/Michigan_STP_623488_7.pdf

The Medicaid Provider Manual has a Chapter on Home and Community Based Services and within that chapter, it establishes the expectation that any new HCBS provider must be in immediate compliance with the rule and it reads as follows:

3.7 NEW PROVIDERS

Effective October 1, 2017, any new HCBS provider and their provider network must be in immediate compliance with the federal HCBS Final Rule in order to render services to Medicaid beneficiaries. This requirement does not apply to existing providers and their provider networks who rendered HCBS to Medicaid beneficiaries before the effective date of this requirement. The Michigan Department of Health and Human Services (MDHHS) will continue to work with existing providers towards coming into compliance with the federal HCBS Final Rule as specified in the State Transition Plan.

In order to comply with the federal HCBS Final Rule, new providers must:

- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Enhance independence;
- Enhance independence in making life choices;
- Enable choice regarding services and who provides them; and
- Ensure that the setting is integrated in, and supports full access to, the greater community.

New residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the:

- Setting is selected by the individual from among setting options;
- Individual has a lease or other legally enforceable agreement providing similar protection;
- Individual has privacy in his/her unit, including lockable doors;
- Individual has a choice of roommates (if applicable) and freedom to furnish or decorate the unit;
- Individual controls his/her own schedule, including access to food at any time;
- Individual can have visitors at any time; and
- Setting is physically accessible.

New non-residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the setting:

- *Does not isolate the individual from the broader community; and*
- *Is not institutional in nature or has the characteristics of an institution.*

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.
2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).
3. ☒ The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.
4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Must meet one of the following qualifications:

Mental Health Professional:

An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following: a physician, psychologist, registered professional nurse licensed or otherwise authorized to engage in the practice of nursing under part 172 of the public health code (1978 PA 368, MCL 333.17201 to 333.17242), licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code (1978 PA 368, MCL 333.18501 to 333.18518), licensed professional counselor licensed or otherwise authorized to engage in the practice of counseling under part 181 of the public health code (1978 PA 368, MCL 333.18101 to 333.18177), or a marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the public health code (1978 PA 368, MCL 333.16901 to 333.16915). **NOTE:** The approved licensures for disciplines identified as a Mental Health Professional include the full, limited and temporary limited categories.

Qualified Intellectual Disability Professional (QIDP):

Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) or one year experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietitian, therapeutic recreation specialist, a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor's degree or higher in a human services field.

Qualified Mental Health Professional (QMHP):

Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education

from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited licensed marriage and family therapist, a licensed physician's assistant or a human services professional with at least a bachelor's degree or higher in a human services field.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. (*Specify qualifications*):

The Michigan Mental Health Code establishes the right for all individuals to have an Individual Plan of Service (IPOS) developed through a person-centered planning process (Section 712, added 1996). The PIHP shall monitor quality of implementation of person-centered planning by its sub-contracted network of providers in accordance with the MDHHS Person-Centered Planning Practice Guideline (Attachment P 4.4.1.1) and inform the individual/family or authorized representative(s) of their rights to choose among providers for individual case management/supports coordination, or self-direct. If the individual/family or authorized representative(s) prefer an independent facilitator to assist them, the PIHP Customer Services Unit maintains a list of person-centered planning (PCP) independent facilitators [MDHHS/PIHP Contract Attachment P.6.3.1.

The CMHSP or local contracted provider agency chosen by the individual and/or their family, under contract with the PIHP, is responsible for the development and implementation of the Individual Plan of Services (IPOS)

The case manager, supports coordinator or other qualified staff or independent facilitator that assists in developing the IPOS is not a provider of any other service for that individual;

Qualified staff must be able to perform the following functions:

1. Planning and/or facilitating planning using person-centered. This function may be delegated to an independent facilitator chosen by the family or authorized representative(s).
2. Developing an IPOS using the person-centered planning process, including revisions to the IPOS at the request of the beneficiary/guardian or authorized representative(s) or as changing circumstances may warrant.
3. Linking to, coordinating with, follow-up of, and advocacy with all medically necessary supports and services, including the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers.
4. Monitoring of the 1915 i service and other mental health services the individual receives.
5. Brokering of providers of services/supports
6. Assistance with access to entitlements and/or legal representation.

Provider qualifications are as follows:

Supports Coordinator:

1. Chosen by the family or authorized representative(s) of the minor child.
2. Possesses at least a bachelor's degree in human services field and one year of experience with the population the supports coordinator will be serving.

Case Manager:

1. Chosen by the individual/guardian or authorized representative(s) of the minor child.

2. Is a QIDP or QMHP or if the case manager has a bachelor's degree without specialized training or experience, they must be supervised by a QMHP or QIDP.

- 6. Supporting the Participant in Development of Person-Centered Service Plan.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

- A) Each PIHP must have a Customer Services Unit, as required by the MDHHS/PIHP contract in boilerplate language (Section 6.3 and attachment P.6.3.1) to provide the following functions:
- Welcome and orient individuals to services and benefits available, and the provider network.
 - Provide information about how to access mental health, primary health, and other community services.
 - Provide information about how to access the various rights processes.
 - Help individuals with problems and inquiries regarding benefits.
 - Assist people with and oversee local complaint and grievance processes.
 - Track and report patterns of problem areas for the organization.

The Customer Service Handbook is provided to all new beneficiaries initially and at least annually thereafter. The Handbook contains information explaining the PCP process (Template #8 of the MDHHS/PIHP Contract Attachment P.6.3.1). In addition to the assistance and information provided by the PIHP's Customer Services Unit, the PIHP will provide each family or authorized representative(s) of the minor child a choice of working with a case manager, supports coordinator or other qualified staff, or an independent facilitator to assist them in being actively engaged in the IPOS development process.

The strengths, needs, preferences, abilities, interests, goals, and health status of the beneficiary are determined through pre-planning and the PCP process. Results from the independent assessment and any other medically-necessary assessments by qualified providers, including but not limited to behavioral, psychosocial, speech, occupational and/or physical therapy, social/recreational, and physical and mental health care, are information used in the PCP process. The PCP process considers all life domains of the beneficiary, including emotional, psychological and behavioral health; health and welfare; education/ needs; financial and other resources; cultural and spiritual needs; crisis and safety planning; housing and home; meaningful relationships and attachments; legal issues and planning; daily living; family; social, recreational and community inclusion; and other life domains as identified by the family or authorized representative(s), beneficiary, or assessors.

- B) The CMHSP under contract with the PIHP is responsible for the development and implementation of the Individual Plan of Services (IPOS). Each PIHP provider will assist the beneficiary or authorized representative(s) in understanding that they may choose to work with a case manager or supports coordinator or other qualified staff. If the beneficiary, guardian, or authorized representative(s) prefer an independent facilitator to assist them, the PIHP Customer Services Unit maintains a list of person-centered planning (PCP) independent facilitators. The IPOS is developed based on findings of all assessments and input from the beneficiary and the family or authorized representative(s). It includes the identification of outcomes based on the beneficiary's stated goals if applicable based on the beneficiary's age, interests, desires and preferences; establishment of meaningful and measurable goals to achieve identified outcomes; determination of the amount, scope, and duration of all medically-necessary services, for those supports and services provided through the public mental health system; identification of other services and supports the beneficiary, family or authorized representative(s) may require to which the public mental

health system will assist with linking to the necessary resources. The IPOS directs the provision of supports and services to be provided to assist the beneficiary in achieving the identified outcomes.

The Person-Centered Planning (PCP) process to develop the Individual Plan of Services (IPOS) is required by the Michigan Mental Health Code (MCL 330.1712). Additionally, for children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach that encompasses the belief that the family is at the center of the service planning process and the service providers are collaborators. The PCP process is an individualized, needs-driven, strengths-based process for children and their families or authorized representative(s). Consistent with Michigan's strong focus on a family-driven/youth-guided service planning process, all meetings are scheduled at times and locations convenient to the child and family or authorized representative(s). The family or authorized representative(s) of the minor child identify other people to participate in planning, such as extended family members, friends, neighbors and other health and supports professionals.

The IPOS must specify how identified supports and services will be provided as part of an overall, comprehensive set of supports and services that does not duplicate services that are the responsibility of another entity, such as a private insurance or other funding authority. Per the Michigan Medicaid Provider Manual (MPM), "The PIHP must offer direct assistance to explore and secure all applicable first- and third-party reimbursements and assist the beneficiary to make use of other community resources for non- Medicaid services, or Medicaid services administered by other agencies."

The IPOS must address the health and welfare of the beneficiary. This may include coordination and oversight of any identified medical care needs to ensure health and safety, such as medication complications, changes in psychotropic medications, medical observation of unmanageable side effects of psychotropic medications or comorbid medical conditions requiring care.

The MPM requires that all services specified in the IPOS must be "[d]elivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies."

Life domain planning is always a blend of formal and informal resources, such as natural supports. It uses strategies that are based on strengths, focused on need, are individualized and community based. The IPOS identifies each of the interventions/responsibilities to be implemented, and who is responsible to implement or monitor the service. MDHHS encourages the use of natural supports to assist in meeting the beneficiary's needs to the extent that the family or authorized representative(s) or friends who provide the natural supports are willing and able to provide this assistance. The use of natural supports must be documented in the beneficiary's IPOS.

Per the MPM, each beneficiary must be made aware of the amount, duration, and scope of the services to which they are entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service within 7 days of the commencement of services, or if an individual is hospitalized for less than 7 days, before discharge or release. The beneficiary must receive a copy of their individual plan of service within 15 business days of completion of the plan.

The IPOS is a dynamic document that is revised based on changing needs, newly-identified or developed strengths and/or the result of periodic reviews and/or assessments. Per the MPM, “[t]he individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary’s health and welfare needs or changes in the beneficiary’s preferences for support). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person centered planning.”

7. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Each PIHP must maintain a provider network that enables an individual beneficiary, the family or authorized representative(s) of the minor child to choose from among a range of available network providers and change providers within the PIHP in accordance with the Balanced Budget Act of 1997 and the MDHHS/PIHP contract. Each PIHP must have a Customer Services Unit that will provide the beneficiary, family or authorized representative(s) with information about the choice of 1915(i) providers and service array (Attachment P.6.3.1) initially and annually. Or the beneficiary may choose a self-determination arrangement. (MDHHS/PIHP Contract Attachment P4.7.1) Additional information and changes to the choices of services and providers will be provided by the PIHP Individually based on the changing needs of the beneficiary and/or their family.

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The person centered plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. A copy of the IPOS is distributed to the individual and with all the providers responsible for its implementation.

MDHHS will utilize an electronic data platform called the Waiver Support Application (WSA) portal to manage all eligibility determinations for individuals who receive 1915(i) services. PIHP's will upload the independent HCBS assessment information, and service plan information from the person-centered IPOS in the secure portal for MDHHS review and approval. MDHHS staff will compare the person's service plan information to the individual's needs and goals identified in the assessment, assure that all other resources are used before Medicaid and the plan meets State and Federal requirements, before issuing approval.

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

<input type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input checked="" type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other (<i>specify</i>):	The PIHP is responsible for assuring that a written or electronic record of the beneficiaries IPOS is maintained for a minimum of seven years, which exceeds requirements of 45 CFR 92.42. Each PIHP determines the location for storing records and makes these records available for the State to review upon request.			

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	1. Specialized Medical Equipment & Supplies
Service Definition (Scope):	
<p>Specialized Medical Equipment & Supplies include an item or set of items that enable the individual to increase their ability to perform activities of daily living with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which he/she lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All items must be ordered by a physician on a prescription as defined within the Medicaid Provider Manual. An order is valid for one year from the date it was signed.</p> <p>Coverage includes:</p> <ul style="list-style-type: none">• Items necessary for independent living (e.g., Lifeline, sensory integration equipment, electronic devices for emergencies/PERS, etc.)• Communication devices• Special personal care items that accommodate the person's disability (e.g., reachers, full-spectrum lamp)• Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions• Ancillary supplies and equipment necessary for proper functioning of equipment and supply items• Repairs to covered equipment and supplies that are not covered benefits through other insurances <p>Assessments by an appropriate health care professional, specialized training needed in conjunction with the use of the equipment and warranted upkeep will be considered as part of the cost of the services.</p> <p>Coverage excludes:</p> <ul style="list-style-type: none">• Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home.• Items that are considered family recreational choices.• Educational supplies required to be provided by the school as specified in the child's Individualized Education Plan. <p>Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase.</p> <p>In order to cover repairs of items, there must be documentation in the individual plan of services that the specialized equipment and supplies continues to medically necessary. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.</p>	

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy (*specify limits*):

☐ Medically needy (*specify limits*):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Physician	Licensed as a Physician in the State of Michigan under section 333.17001 of the public health code Act 368 of 1978	Not applicable	Prescribed by a Licensed Physician within the scope of his or her practice under Michigan law.
Retail or medical supply stores	N/A	N/A	Items purchased must meet the specialized equipment and supplies service definition

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):	Frequency of Verification (<i>Specify</i>):
Physician	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and minimally every 2 years thereafter.
Retail or medical supply stores	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	As needed

Service Delivery Method. (*Check each that applies*):

☐ Participant-directed ☒ Provider managed

Service Specifications (*Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover*):

Service Title: 2. Vehicle Modification

Service Definition (Scope):

Vehicle modifications include adaptations or alterations to an automobile or van that is the individual's primary means of transportation in order to accommodate the special and medical needs of the individual. These adaptations must be specified in the individual plan of service and enable the individual to integrate more fully into the community and to ensure the health, welfare and safety of the individual. All items must be ordered by a physician on a prescription as defined within the Medicaid Provider Manual. An order is valid for one year from the date it was signed.

Coverage includes:

- Adaptations to vehicles

Assessments by an appropriate health care professional, specialized training needed in conjunction with the use of the adaptations and alterations will be considered as part of the cost of the services.

Coverage excludes:

- The purchase or lease of a vehicle;
- Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the individual;
- Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modification(s).

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. In order to cover repairs of vehicle modifications, there must be documentation in the individual plan of services that the alterations continue to medically necessary. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy (*specify limits*):

☐ Medically needy (*specify limits*):

Provider Qualifications (For each type of provider. Copy rows as needed):

Provider Type (Specify):	License (Specify):	Certification (Specify):	Other Standard (Specify):
Physician	Licensed as a Physician in the State of Michigan under	Not applicable	Prescribed by a Licensed Physician within the scope of his or her practice under Michigan law.

	section 333.17001 of the public health code Act 368 of 1978		
Agency or business	N/A	N/A	Must meet the vehicle modification service definition, may be certified or licensed with MI LARA annually.
Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>		Frequency of Verification <i>(Specify):</i>
Physician	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)		Prior to delivery of services and minimally every 2 years thereafter.
Agency or business	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)		Prior to the provision of services and every two years thereafter
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	3. Enhanced Pharmacy
Service Definition (Scope):	
<p>Enhanced pharmacy items are physician-ordered, nonprescription "medicine chest" items as specified in the individual's plan of service. There must be documented evidence that the item is not available through Medicaid or other insurances and is the most cost-effective alternative to meet the beneficiary's need.</p> <p>The following items are covered only for adult beneficiaries living in independent settings (i.e., own home, apartment where deed or lease is signed by the beneficiary):</p> <ul style="list-style-type: none"> • Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies • First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads) <p>The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:</p> <ul style="list-style-type: none"> • Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, tooth-brushes, anti-plaque rinses, antiseptic mouthwashes) • Vitamins and minerals • Special dietary juices and foods that augment, but do not replace, a regular diet • Thickening agents for safe swallowing when the beneficiary have a diagnosis of dysphagia and either: <ul style="list-style-type: none"> ○ A history of aspiration pneumonia, or ○ Documentation that the beneficiary is at risk of insertion of a feeding tube without the thickening agents for safe swallowing. <p>Coverage excludes:</p>	

<ul style="list-style-type: none"> Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products) 			
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (<i>Choose each that applies</i>):			
<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Physician	Licensed as a Physician in the State of Michigan under section 333.17001 of the public health code Act 368 of 1978	Not applicable	Prescribed by a Licensed Physician within the scope of his or her practice under Michigan law.
Retail or medical supply stores	N/A	N/A	Items purchased must meet the enhanced pharmacy service definition
Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):		Frequency of Verification (<i>Specify</i>):
Physician	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)		Prior to delivery of services and minimally every 2 years thereafter.
Agency or business	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)		Prior to the provision of services and every two years thereafter
Service Delivery Method. (<i>Check each that applies</i>):			
<input type="checkbox"/>	Participant-directed		<input checked="" type="checkbox"/>
		Provider managed	

Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover</i>):	
Service Title:	4. Environmental Modifications

Service Definition (Scope):

Physical adaptations to the beneficiary's own home or apartment and/or workplace. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources (e.g., housing commission grants, MSHDA, and community development block grants), for assistance. It is expected that the case manager/supports coordinator will assist the beneficiary in the pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.

Coverage includes:

- The installation of ramps and grab-bars.
- Widening of doorways.
- Modification of bathroom facilities.
- Special floor, wall or window covering that will enable the beneficiary more independence or control over his environment, and/or ensure health and safety.
- Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary.
- Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications.
- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.
- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.
- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs.

Coverage excludes:

- Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary, or do not support the identified goals of community inclusion and participation, independence or productivity.
- Adaptations or improvements to the home that are of general utility or cosmetic value and are considered to be standard housing obligations of the beneficiary. Examples of exclusions include, but are not limited to, carpeting (see exception above), roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs.
- Cost for construction of a new home or new construction (e.g., additions) in an existing home.
- Environmental modifications costs for improvements exclusively required to meet local building codes.
- Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, or are the responsibilities of Michigan Rehabilitation Services.

The PIHP must assure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PIHP to work with the beneficiary and the builder to ensure that the work is completed as outlined in the contract and that issues are resolved among all parties. In the event that the contract is terminated prior to the completion of the work, Medicaid capitation payments may not be used to pay for any additional costs resulting from the termination of the contract.

The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must follow all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance.

The environmental modification must incorporate reasonable and necessary construction standards and comply with applicable state or local building codes. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves and must indicate that Medicaid is not obligated for any restoration costs.

If a beneficiary purchases an existing home while receiving Medicaid services, it is the beneficiary's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. Medicaid funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways) for a recently purchased existing home.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy (*specify limits*):

☐ Medically needy (*specify limits*):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Physician	Licensed as a Physician in the State of Michigan under section 333.17001 of the public health code Act 368 of 1978		Prescribed by a physician, working within their scope of practice

Agency or business	MCL 339.601 (1) MCL 339.601.2401(1) MCL 339.601.2403(3)	Licensed builder or licensed contractor	Must meet environmental modification service definition
Verification of Provider Qualifications <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>	
Physician	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter	
Agency or business	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1) and LARA	PIHP is responsible prior to the provision of service and LARA is responsible annually thereafter for licensing.	
Service Delivery Method. <i>(Check each that applies):</i>			
<input type="checkbox"/> Participant-directed		<input checked="" type="checkbox"/> Provider managed	

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	5. Family Support and Training
Service Definition (Scope):	
<p>Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his ability to achieve goals of:</p> <ul style="list-style-type: none">• Performing activities of daily living;• Perceiving, controlling, or communicating with the environment in which the individual lives; or• Improving the person's inclusion and participation in the community or productive activity, or opportunities for independent living. <p>The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service.</p> <p>Coverage includes:</p> <ul style="list-style-type: none">• Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the person at home as specified in the individual plan of service.	

<ul style="list-style-type: none"> Counseling and peer support provided by a trained counselor or peer one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities. Family Psycho-Education (SAMHSA model -- specific information is found in the GUIDE TO FAMILY PSYCHOEDUCATION, Requirements for Certification, Sustainability, and Fidelity) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining. Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or developmental disabilities as part of the treatment process to be empowered, confident and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner, who has or had a child with special mental health needs, provides education, training, and support and augments the assessment and mental health treatment process. The parent support partner provides these services to the parents and their family. These activities are provided in the home and in the community. The parent support partner is to be provided regular supervision and team consultation by the treating professionals 			
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
<p>Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.</p> <p>(Choose each that applies):</p>			
<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (For each type of provider. Copy rows as needed):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following: a physician, psychologist, registered professional nurse licensed or otherwise authorized to engage in the practice of nursing under part 172 of the public health code (1978 PA 368, MCL 333.17201 to 333.17242), licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code (1978 PA 368, MCL 333.18501 to 333.18518), licensed professional counselor licensed or otherwise authorized to engage in the

			practice of counseling under part 181 of the public health code (1978 PA 368, MCL 333.18101 to 333.18177), or a marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the public health code (1978 PA 368, MCL 333.16901 to 333.16915). NOTE: The approved licensures for disciplines identified as a Mental Health Professional include the full, limited and temporary limited categories.
Child Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; or an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.
Qualified Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited licensed marriage and family therapist, a licensed

			physician's assistant or a human services professional with at least a bachelor's degree or higher in a human services field.
Qualified Intellectual Disability Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) or one year experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietitian, therapeutic recreation specialist, a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor's degree or higher in a human services field.
Parent Support Partner	None	None	Individual who: <ul style="list-style-type: none"> • has lived experience as a parent/caregiver of a child with Serious Emotional Disturbance and Intellectual/Developmental Disability, and • is employed by the PIHP/CMHSP or its contract providers, and is trained in the Michigan Department of Health and Human Services approved curriculum and ongoing training model.

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Mental Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Child Mental Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Qualified Mental Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Qualified Intellectual Disability Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Qualified Behavioral Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Parent Support Partner	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Service Delivery Method. <i>(Check each that applies):</i>		
<input checked="" type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/> Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: 6. Fiscal Intermediary

Service Definition (Scope):

Fiscal Intermediary services are defined as services that assist the adult beneficiary, or a representative identified in the beneficiary's individual plan of services, to meet the beneficiary's goals of community participation and integration, independence or productivity while controlling his individual budget and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The fiscal intermediary helps the beneficiary manage and distribute funds contained in the individual budget. Fiscal intermediary services include, but are not limited to:

- Facilitation of the employment of service workers by the beneficiary, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures;
- Assuring adherence to federal and state laws and regulations; and
- Ensuring compliance with documentation requirements related to management of public funds.

The fiscal intermediary may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification of provider qualifications (including reference and background checks), and assisting the beneficiary to understand billing and documentation requirements.

Fiscal intermediary services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained in the beneficiary's plan of service so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.

Fiscal intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Neither providers of other covered services to the beneficiary, family members, or guardians of the beneficiary may provide fiscal intermediary services to the beneficiary.

Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):			
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):			
<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Entity/Organization or Fiscal Agent	None	None	Must meet fiscal intermediary service requirements. Entity or individual fiscal agent may not be the provider of other covered services for the individual for whom it is providing fiscal intermediary services.
Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):		Frequency of Verification (<i>Specify</i>):
Entity/Organization or Fiscal Agent	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)		Prior to delivery of services and every two years thereafter
Service Delivery Method. (<i>Check each that applies</i>):			
<input type="checkbox"/>	Participant-directed		<input checked="" type="checkbox"/> Provider managed

Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover</i>):	
Service Title:	7. Housing Assistance
Service Definition (Scope):	
Housing Assistance enables beneficiaries to secure and/or maintain their own housing as set forth in the beneficiaries' individual plan of service. Services must be provided in the home or a community setting and includes the following components: <ul style="list-style-type: none">Conducting a community integration assessment identifying the beneficiaries preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual, assistance in budgeting for housing/living expenses, assistance in	

obtaining/accessing sources of income necessary for community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).

- Assisting beneficiary with finding and securing housing as needed. This may include arranging for or providing transportation.
- Assisting beneficiary in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.
- Developing an individualized community integration plan based upon the assessment as part of the overall Person-Centered Plan. Identify and establish short and long-term measurable goal(s) and establish how goals will be achieved and how concerns will be addressed.
- Participating in Person-Centered planning meetings at re-determination and/or revision plan meetings as needed.
- Providing supports and interventions per the Person-Centered Plan (individualized community integration portion).
- Supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager. This includes providing support/intervention for dispute resolution with landlord/property manager.
- Housing assistance will provide supports to preserve the most independent living arrangement and/or assist the individual in locating the most integrated option appropriate to the individual.

Coverage excludes:

- Costs for room and board (i.e. rent, mortgage, motel/hotel stays, security deposit etc.)
- Funding for on-going housing costs (i.e. repairs, utility bills, insurance, taxes, appliances, etc.)

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy (*specify limits*):

☐ Medically needy (*specify limits*):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following: a physician, psychologist, registered professional nurse licensed or otherwise authorized

			to engage in the practice of nursing under part 172 of the public health code (1978 PA 368, MCL 333.17201 to 333.17242), licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code (1978 PA 368, MCL 333.18501 to 333.18518), licensed professional counselor licensed or otherwise authorized to engage in the practice of counseling under part 181 of the public health code (1978 PA 368, MCL 333.18101 to 333.18177), or a marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the public health code (1978 PA 368, MCL 333.16901 to 333.16915). NOTE: The approved licensures for disciplines identified as a Mental Health Professional include the full, limited and temporary limited categories.
Qualified Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited licensed marriage and family therapist, a licensed physician's assistant or a human services professional with at least a bachelor's degree or higher in a human services field.
Qualified Intellectual Disability Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) or one year experience in

			treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietitian, therapeutic recreation specialist, a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor's degree or higher in a human services field.
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Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Mental Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Qualified Mental Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Qualified Intellectual Disability Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Service Delivery Method. *(Check each that applies):*

<input checked="" type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: 8. Respite Services

Service Definition (Scope):

Respite services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used.

Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).

- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).
- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence
- Licensed family foster care home
- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family
- Licensed family child-care home

Respite care may not be provided in:

- Day program settings, ICF/IIDs, nursing homes, or hospitals

Respite care may not be provided by:

- Parent of a minor beneficiary receiving the service
- Spouse of the beneficiary served
- Beneficiary's guardian
- Unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2020, or January 1, 2021 if Michigan receives approval of a good faith effort exemption request, and for home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any

individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed):*

Provider Type <i>(Specify):</i>	License <i>(Specify):</i>	Certification <i>(Specify):</i>	Other Standard <i>(Specify):</i>
Direct Support Specialist	None	None	Individual with specialized training, is able to perform basic first aid procedures; trained in the beneficiary's plan of service, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law.

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Direct Support Specialist	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Service Delivery Method. *(Check each that applies):*

☒ Participant-directed ☒ Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: 9. Skill Building Assistance

Service Definition (Scope):

Skill-building assistance consists of activities identified in the individual plan of service that assist a beneficiary to increase their economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services occur in community-based integrated settings with individuals without disabilities, provide knowledge and specialized skill development and/or supports to achieve specific outcomes consistent with the individual's identified goals with the purpose of furthering habilitation goals that will lead to greater opportunities of community independence, inclusion, participation, and productivity.

Services includes:

- Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills
- Work preparatory (time-limited work pathway) services to attain individual competitive integrated employment in the community in which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
 - Services are intended to develop and teach skills that lead to individual competitive integrated employment including, but not limited to; ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training
 - Provide learning and work experiences, including volunteering, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in competitive integrated employment
 - Are expected to occur over a defined period of time with specific employment-related goals and outcomes to be achieved, as determined by the individual's person-centered service plan
 - Enable an individual to attain individual competitive integrated employment and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities.
 - Participation in skill-building is not a required pre-requisite for individual competitive integrated employment or receiving supported employment services

Skill-building service component(s) needed for each individual are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

If an individual has a need for transportation to participate, maintain, or access the skill-building services, the same provider may be reimbursed for providing this transportation, only after it is determined that it is not otherwise available (e.g. volunteer, family member) and is the least expensive available means suitable to the beneficiary's need, in accordance with the Medicaid Provider Manual non-emergency medical transportation policy.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (*Choose each that applies*):

<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):		
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):		
Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Direct Support Professional	None	None	Individual with specialized training, is able to perform basic first aid procedures; trained in the beneficiary's plan of service, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law.
Verification of Provider Qualifications (<i>For each provider type listed above. Copy rows as needed</i>):			
Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):		Frequency of Verification (<i>Specify</i>):
Direct Support Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)		Prior to delivery of services and every two years thereafter
Service Delivery Method. (<i>Check each that applies</i>):			
<input checked="" type="checkbox"/>	Participant-directed		<input checked="" type="checkbox"/> Provider managed

Service Specifications (<i>Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover</i>):	
Service Title:	10. Community Living Supports
Service Definition (Scope):	
Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.). Coverage includes: Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities: <ul style="list-style-type: none">• Meal preparation• Laundry• Routine, seasonal, and heavy household care and maintenance	

- Activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
- Shopping for food and other necessities of daily living

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

Staff assistance, support and/or training with activities such as:

- Money management
- Non-medical care (not requiring nurse or physician intervention)
- Socialization and relationship building
- Transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
- Participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
- Attendance at medical appointments
- Acquiring or procuring goods, other than those listed under shopping, and non-medical services
- Reminding, observing and/or monitoring of medication administration
- Observing and/or monitoring with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through MDHHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports. CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports

must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings

The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2020, or January 1, 2021 if Michigan receives approval of a good faith effort exemption request, and for home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (*Choose each that applies*):

☐ Categorically needy (*specify limits*):

☐ Medically needy (*specify limits*):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Direct Support Professional	None	None	Individual is able to perform basic first aid procedures and is trained in the beneficiary's plan of service, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):	Frequency of Verification (<i>Specify</i>):
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Direct Support Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
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Service Delivery Method. <i>(Check each that applies):</i>			
<input checked="" type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>			
Service Title:	11. Supported/Integrated Employment		
Service Definition (Scope):			
<p>Supported/Integrated Employment services are services that are provided in a variety of community settings for the purposes of supporting individuals in obtaining and sustaining individual competitive integrated employment. Individual competitive integrated employment refers to full or part-time work at minimum wage or higher, with wages and benefits similar to workers without disabilities performing the same work, and fully integrated with co-workers without disabilities. Supported employment services promote self-direction, are customized, and aimed to meet an individual's personal and career goals and outcomes identified in the individualized person-centered service plan. Services may be provided continuously, intermittently, on behalf of, or on a diminishing basis as needed to promote community inclusion and competitive integrated employment.</p> <p>Coverage includes:</p> <ul style="list-style-type: none"> Job-related discovery, person-centered employment/career planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, asset development and career advancement services career planning that supports an individual to make informed choices about individual competitive integrated employment or self-employment. The outcome of this service is sustained individual competitive integrated employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals as outlined in the individual's person-centered service plan. <p>Supported employment services include the following categories:</p> <ul style="list-style-type: none"> Individual supported employment supports sustained paid employment at or above the minimum wage and career development in an integrated, competitive setting in the general workforce, in a job that meets personal and career goals Self-employment refers to an individual-run business that nets the equivalent of a competitive wage, after reasonable period for start-up, and is either home-based or takes place in regular integrated business, industry or community-based settings Small group supported employment support are services and training activities provided in typical business, industry and community settings for groups of two to six workers with disabilities paying at least minimum wage. The purpose of funding for this service is to support sustained paid employment and work experience that leads to individual competitive integrated employment. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities, Supported employment small group employment support must promote integration into the workplace and interaction between workers with disabilities and people without disabilities in those workplaces. 			

Supported/integrated employment service component(s) needed for each individual are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

If an individual has a need for transportation to participate, maintain, or access the skill-building services, the same provider may be reimbursed for providing this transportation, only after it is determined that it is not otherwise available (e.g. volunteer, family member) and is the least expensive available means suitable to the beneficiary's need, in accordance with the Medicaid Provider Manual non-emergency medical transportation policy

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (*Choose each that applies*):

☐ Categorically needy (*specify limits*):

☐ Medically needy (*specify limits*):

Provider Qualifications (*For each type of provider. Copy rows as needed*):

Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
Employment Specialist/Job Coach	None	None	Individual has completed specialized training; is able to perform basic first aid procedures, is trained in the beneficiary's plan of service, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and to report on employment related activities performed; and in good standing with the law.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type (<i>Specify</i>):	Entity Responsible for Verification (<i>Specify</i>):	Frequency of Verification (<i>Specify</i>):
Employment Specialist/Job Coach	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Service Delivery Method. (*Check each that applies*):

<input checked="" type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed
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8. ☒ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

The HCBS services that are impacted by the above assurance are Community Living Supports (CLS), Skill Building, Respite, and Supported/Integrated Employment. These services do not allow for payment to relatives or legally responsible individuals/legal guardians as outlined in the descriptions found in the Medicaid provider manual.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (Select one):

<input type="radio"/>	The state does not offer opportunity for participant-direction of State plan HCBS.
<input checked="" type="checkbox"/>	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. <i>(Specify criteria):</i>

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):

Attachment P.4.7.1 of the MDHHS/PIHP contract contains the Self-Determination Policy and Practice Guideline. The guideline sets the standards and expectations for self-directed care. Every beneficiary accessing iSPA services will be informed of self-directed opportunities through their local CMHSP/PIHP on an ongoing basis. Each PIHP entity are involved in supporting participant direction through allocation of resources and education to individuals pursuing self-directed options as outlined in the MDHHS/PIHP contract.

Self-determination is the value that people served by the public mental health system must be supported to have a meaningful life in the community. The components of a meaningful life include work or volunteer activities that are chosen by and meaningful to person, reciprocal relationships with other people in the community, and daily activities that are chosen by the individual and support the individual to connect with others and contribute to his or her community. With arrangements that support self-determination, individuals have control over an individual budget for their mental health services and supports to live the lives they want in the community. The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported.

Person-centered planning (PCP) is a central element of self-determination. PCP is the crucial medium for expressing and transmitting personal needs, wishes, goals and aspirations. As the PCP process unfolds, the appropriate mix of paid/non-paid services and supports to assist the individual in realizing/achieving these personally defined goals and aspirations are identified.

The principles of self-determination recognize the rights of people supported by the mental health system to have a life with freedom, and to access and direct needed supports that assist in the pursuit of their life, with responsible citizenship. These supports function best when they build upon natural community experiences and opportunities. The person determines and manages needed supports in close association with chosen friends, family, neighbors, and co-workers as a part of an ordinary community life.

Person-centered planning and self-determination underscore a commitment in Michigan to move away from traditional service approaches for people receiving services from the public mental health system. In Michigan, the flexibility provided through the contractual guidance of MDHHS and the Mental Health Code requirements of PCP, have reoriented organizations to respond in new and more meaningful ways. Recognition has increased among providers and professionals that many individuals may not need, want, or benefit from a clinical regimen, especially when imposed without clear choice. Many provider agencies are learning ways to better support the individual to choose, participate in, and accomplish a life with personal meaning. This has meant, for example, reconstitution of segregated programs into non-segregated options that connect better with community life.

Self-determination builds upon the choice already available within the public mental health system. In Michigan, all Medicaid beneficiaries who receive services through the public mental health system have a right under the Balanced Budget Act (BBA) to choose the providers of the services and supports that are identified in their individual plan of service “to the extent possible and appropriate.” Qualified providers chosen by the beneficiary, but who are not currently in the network or on the provider panel, should be placed on the provider panel. Within the PIHP, choice of providers must be maintained at the provider level. The individual must be able to choose from at least two providers of each covered support and service and must be able to choose an out-of-network provider under certain circumstances. Provider choice, while critically important, must be distinguished from arrangements that support self-determination. The latter arrangements extend individual choice to his/her control and management over providers (i.e., directly employs or contracts with providers), service delivery, and budget development and implementation.

In addition, to choice of provider, individuals using mental health services and supports have access to a full-range of approaches for receiving those services and supports. Agencies and providers have obligations and underlying values that affirm the principles of choice and control. Yet, they also have long-standing investments in existing programs and services, including their investments in capital and personnel resources. Some program approaches are not amenable to the use of arrangements that support self-determination because the funding and hiring of staff are controlled by the provider (for example, day programs and group homes) and thus, preclude individual employer or budget authority.

It is not anticipated that every person will choose arrangements that support self-determination. Traditional approaches are offered by the system and used very successfully by many people. An arrangement that supports self-determination is one method for moving away from predefined programmatic approaches and professionally managed models. The goals of arrangements that support self-determination, on an individual basis, are to dissolve the isolation of people with disabilities, reduce segregation, promote participation in community life and realize full citizenship rights.

3. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideeness requirements. Select one):*

<input checked="" type="checkbox"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="checkbox"/>	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the state affected by this option):</i>

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
1. Specialized Medical Equipment & Supplies	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Vehicle Modification	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Community Living Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Enhanced Pharmacy	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Environmental Modifications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Family Support and Training	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Fiscal Intermediary	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Housing Assistance	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9. Respite Care Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10. Skill Building Assistance	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
11. Supported/Integrated Employment Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

5. Financial Management. *(Select one) :*

<input checked="" type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☒ Participant-Directed Person-Centered Service Plan. *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

Attachment P.4.7.1 of the MDHHS/PIHP contract contains the Self-Determination Policy and Practice Guideline. The guideline sets the standards and expectations for self-directed care. Termination of participation is addressed as part of that policy.

The most effective method for making changes is through the person-centered/family-driven/youth-guided planning process in order to identify and address problems that may be interfering with the success of the arrangement.

Either party—the PIHP or the person—may terminate a self-determination agreement, and therefore, the self-determination arrangement. Common reasons that a PIHP may terminate an agreement after providing support and other interventions described in this guideline include: failure to comply with Medicaid documentation requirements; failure to stay within the authorized funding in the individual budget; inability to hire and retain qualified providers; substantiated fraud or abuse of Medicaid funding by the individual and/or family; and conflict between the individual and providers that results in an inability to implement IPOS. Prior to the PIHP terminating an agreement, and unless it is not feasible, the PIHP shall inform the individual of the issues that have led to consideration of a discontinuation or alteration decision, in writing, and provide an opportunity for problem resolution. Typically, resolution will be conducted using the person-centered planning process, with termination being the option of choice if other mutually-agreeable solutions cannot be found. In any instance of PIHP discontinuation or alteration of a self-determination arrangement, the local processes for dispute resolution may be used to address and resolve the issues.

- Termination of a Self-Determination Agreement by a PIHP is not a Medicaid Fair Hearings Issue. Only a change, reduction, or termination of Medicaid services can be appealed through the Medicaid Fair Hearings Process, not the use of arrangements that support self-determination to obtain those services.
- Discontinuation of a self-determination agreement, by itself, shall neither change the individual's IPOS, nor eliminate the obligation of the PIHP to assure specialty mental health services and supports required in the IPOS are provided.
- In any instance of PIHP discontinuation or alteration, the person must be provided an explanation of applicable appeal, grievance and dispute resolution processes and (when required) appropriate notice.
- All self-directed services and supports are continuity ensured during the appeal, grievance, and dispute resolution process, and individuals health and welfare is assured during the transition process for voluntary and involuntary termination of participant direction in accordance with the MDHHS/PIHP contract.

8. Opportunities for Participant-Direction

- a. **Participant–Employer Authority** (individual can select, manage, and dismiss State plan HCBS providers). *(Select one):*

<input type="radio"/>	The state does not offer opportunity for participant-employer authority.
<input checked="" type="checkbox"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input checked="" type="checkbox"/>	Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input checked="" type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- b. **Participant–Budget Authority** (individual directs a budget that does not result in payment for medical assistance to the individual). *(Select one):*

<input type="radio"/>	The state does not offer opportunity for participants to direct a budget.
<input checked="" type="checkbox"/>	<p>Participants may elect Participant–Budget Authority.</p> <p>Participant-Directed Budget. <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):</i></p> <p>An individual budget includes the expected or estimated costs of a concrete approach of obtaining the mental health services and supports included in the plan of service. Both the individual plan of service (IPOS) and the individual budget are developed in conjunction with one another through the person-centered planning process (PCP). Both the participant and the PIHP must agree to the amounts in the individual budget before it is authorized for use by the participant. This agreement is based not only on the amount, scope and duration of the services and supports in the IPOS, but also on the type of arrangements that the participant is using to obtain the services and supports. Those arrangements are also determined primarily through the PCP process.</p> <p>Michigan uses a retrospective zero-based method for developing an individual budget. The amount of the individual budget is determined by costing out the services and supports in the IPOS, after an IPOS that meets the participant's needs and goals has been developed. In the IPOS, each service or support is identified in amount, scope and duration (such as hours per week or month). The individual budget should be developed for a reasonable period of time that allows the participant to exercise flexibility (usually one year).</p> <p>Once the IPOS is developed, the amount of funding needed to obtain the identified services and supports is determined collectively by the participant, the mental health agency (PIHP or designee), and others participating in the PCP process.</p> <p>This process involves costing out the services and supports using the rates for providers chosen by the participant and the number of hours authorized in the IPOS. The rate for directly employed workers must include Medicare and Social Security Taxes (FICA), Unemployment Insurance, and Worker's Compensation Insurance. The individual budget is authorized in the amount of that total cost of all services and supports in the IPOS. The individual budget must include the fiscal intermediary fee if a fiscal intermediary is utilized.</p> <p>Participants must use a fiscal intermediary if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. If a participant chooses to contract only with providers that are already under contract with the PIHP, there is no requirements that a fiscal intermediary be used.</p> <p>Fiscal intermediary is available to any participant using a self-determination arrangement. Each PIHP develops a contract with the fiscal intermediary to provide financial management services (FMS) and sets the rate and costs for the services. The average monthly fee has ranged from \$75.00 to \$125.00. Actual costs for the FMS will vary depending on the individual's needs and usage of FMS, as well as the negotiated rate between the PIHP and fiscal intermediary.</p> <p>Expenditure Safeguards. <i>(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.</i></p>

Participants must use a fiscal intermediary if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. Most participants use FMS through a fiscal intermediary even if they only contract with providers already under contract with the PIHP; however, there is no requirement that they do so.

The funds in an individual budget are transferred to the fiscal intermediary, which handles payment for services and supports in the IPOS upon receipt of invoices and timesheets authorized by the participant. The fiscal intermediary provides both the participant and the mental health agency (PIHP or designee) a monthly report of expenditures and flags expenditures that are over or under the expected amount by ten percent or more. This report is the central mechanism for monitoring implementation of the budget. Over- or underutilization identified in the report can be addressed by the supports coordinator (or another chosen qualified provider) and participant informally or through the PCP process.

The supports coordinator, supports coordinator assistant, or independent supports broker (or other chosen qualified provider) is responsible for assisting the participant in implementing the individual budget and arrangements, including understanding the budget report. A participant can use an independent supports broker to assist him or her in implementing and monitoring the IPOS and budget. When a participant uses an independent supports broker, the supports coordinator (other qualified provider selected by the participant) has a more limited role in planning and implementation of arrangements so that the assistance provided is not duplicated. However, the authorization and monitoring the IPOS and individual budget cannot be delegated to an Independent Supports Broker by the PIHP or designee.

If using FMS through a fiscal intermediary, the supports coordinator, supports coordinator assistant, or independent supports broker (or other chosen qualified provider) receives a copy of the budget and a copy of the monthly budget report. In the required monitoring and face-to-face contact, they have with the participant, the supports coordinator, supports coordinator assistant or independent supports broker (or other qualified provider) must address any over- or under-utilization of the budget that they identify in the monthly budget report. If the participant does not use a fiscal intermediary because he or she only contracts with providers already under contract with the PIHP, the PIHP must provide a monthly budget report to the participant and supports coordinator, supports coordinator assistant or independent supports broker (or other qualified provider) so the participant can effectively manage his or her budget and thereby, exercise budget authority.

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c) document choice of services and providers.**
2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**
3. **Providers meet required qualifications.**
4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
5. **The SMA retains authority and responsibility for program operations and oversight.**
6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement		<i>Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers.</i>
Discovery		
Discovery Evidence <i>(Performance Measure)</i>	A) Number and percent of enrolled participants whose IPOS had adequate strategies to address their assessed health and safety risks. N: Number of enrolled cases reviewed whose IPOS had adequate strategies to address their identified health and safety risks assessed D: Number of all enrolled participants sampled	
Discovery Activity <i>(Source of Data & sample size)</i>	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan.	
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA	

Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
Frequency <i>(of Analysis and Aggregation)</i>	Annually
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	A) Number and percent of Individual Plans Of Services (IPOS) reviewed that address the assessed needs of a beneficiary N: Number of records reviewed with evidence that the IPOS addresses the assessed needs of the beneficiary D: Number of IPOS records reviewed in the sample
Discovery Activity <i>(Source of Data & sample size)</i>	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation)</i>	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.

<i>activities; required timeframes for remediation)</i>	
Frequency <i>(of Analysis and Aggregation)</i>	Annually

Requirement	<i>Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	B) Number and percent of reviewed IPOS that were updated within 365 days of their last plan of service N: Number of records reviewed that the IPOS was updated within 365 days D: Number of IPOS records reviewed in the sample
Discovery Activity <i>(Source of Data & sample size)</i>	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.

Frequency (of Analysis and Aggregation)	Annually
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Requirement	<i>Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers.</i>	
Discovery		
Discovery Evidence <i>(Performance Measure)</i>	C) Number and percent of records reviewed with documented evidence that beneficiaries were informed of their right to choose among providers. N: Number of beneficiaries reviewed who are informed of their right to choose among providers. D: Number of records reviewed in the sample	
Discovery Activity <i>(Source of Data & sample size)</i>	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan	
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA	
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.	
Remediation		
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.	
Frequency <i>(of Analysis and Aggregation)</i>	Annually	

Requirement	<i>Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and c) document choice of services and providers.</i>	
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Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	C) Number and percent of records reviewed with documented evidence that beneficiaries were informed of their right to choose among services. N: Number of beneficiaries reviewed who are informed of their right to choose among services. D: Number of records reviewed in the sample
	Discovery Activity <i>(Source of Data & sample size)</i>	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan
	Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
	Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
	Frequency <i>(of Analysis and Aggregation)</i>	Annually

Requirement	Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
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Discovery	
Discovery Evidence <i>(Performance Measure)</i>	A) Number and percent of evaluations completed where applicants meet the eligibility criteria for 1915(i) State plan HCBS benefit. N: Number of evaluations completed where applicants meet the eligibility criteria for the 1915(i) state plan benefit D: Number of evaluations completed for all applicants
Discovery Activity <i>(Source of Data & sample size)</i>	Source: WSA Sample Size: 100%
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	Ongoing for data collection
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS/BHDDA. The WSA is used to communicate electronically with the PIHPs regarding questions or issues on individual eligibility evaluation that arise as the result of review. The PIHP must respond within 15 days by providing the required additional information. Their response is reviewed to determine that appropriate action was taken and if any additional follow-up is necessary. A less formal, but documented, method of communication is through email exchange. This method is used when MDHHS staff is requesting clarification of a minor point. Responses to emails are expected within 1-2 business days
Frequency <i>(of Analysis and Aggregation)</i>	Annually
Requirement	Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	

Discovery Evidence <i>(Performance Measure)</i>	B) The number and percent of records reviewed with evidence the instruments and tools were appropriately applied to determine eligibility of 1915(i) services N: Number of cases with evidence that instruments were applied appropriately as part of the eligibility process D: All records reviewed in the sample
Discovery Activity <i>(Source of Data & sample size)</i>	Source: WSA Sample Size: 100%
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	Ongoing for data collection
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS/BHDDA The WSA is used to communicate electronically with the PIHPs regarding questions or issues on individual eligibility evaluation that arise as the result of review. The PIHP must respond within 15 days by providing the required additional information. Their response is reviewed to determine that appropriate action was taken and if any additional follow-up is necessary. A less formal, but documented, method of communication is through email exchange. This method is used when MDHHS staff is requesting clarification of a minor point. Responses to emails are expected within 1-2 business days
Frequency <i>(of Analysis and Aggregation)</i>	Annually

Requirement	Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence	C) Number and percent of re-evaluations for eligibility were within 365 days of the last eligibility determination

<i>(Performance Measure)</i>	N: Number of enrolled beneficiaries that were re-evaluated for eligibility within 365 days of their last eligibility determination D: All re-evaluations provided for enrolled beneficiaries for 1915(i) state plan services
Discovery Activity <i>(Source of Data & sample size)</i>	Source: WSA Sample Size: 100%
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	Ongoing for data collection
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS/BHDDA The WSA is used to communicate electronically with the PIHPs regarding questions or issues on individual eligibility re-evaluation that arise as the result of review. The PIHP must respond within 15 days by providing the required additional information. Their response is reviewed to determine that appropriate action was taken and if any additional follow-up is necessary. A less formal, but documented, method of communication is through email exchange. This method is used when MDHHS staff is requesting clarification of a minor point. Responses to emails are expected within 1-2 business days.
Frequency <i>(of Analysis and Aggregation)</i>	Annually

Requirement	Providers meet required qualifications.
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number of licensed providers of state plan services for beneficiaries meet credentialing standards N: Number of providers of state plan services that meet credentialing standards D: All providers reviewed in the sample
Discovery Activity	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years

<i>(Source of Data & sample size)</i>	Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
Frequency <i>(of Analysis and Aggregation)</i>	Annually
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of non-licensed, non-certified service providers that meet credentialing standards as stated in the Michigan Medicaid Provider Manual. N: Number of non-licensed, non-certified providers that meet credentialing standards D: All non-licensed, non-certified providers reviewed in the sample
Discovery Activity <i>(Source of Data & sample size)</i>	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915 (I)SPA
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	

Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.</p> <p>PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.</p>
Frequency <i>(of Analysis and Aggregation)</i>	Annually
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of case records with providers that meet staff training requirements.</p> <p>N: Number of case records with service providers that meet staff training requirements.</p> <p>D: Number of all cases reviewed in the sample.</p>
Discovery Activity <i>(Source of Data & sample size)</i>	<p>Source: Site Review</p> <p>Aggregate data from the sample by MDHHS across 2 fiscal years</p> <p>Sample Size: stratified random sample for statistically significant number based on total number served by the 1915 (I)SPA</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	<p>Ongoing for data collection</p> <p>Each PIHP receives a comprehensive on-site review biennially.</p>
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.</p> <p>PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.</p>
Frequency <i>(of Analysis and Aggregation)</i>	Annually

Requirement		Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery		
Discovery Evidence (Performance Measure)	Number and percent of service settings that meet the home and community based setting requirements N: Number of service settings that meet the home and community based setting requirement D: All service settings in surveys	
Discovery Activity (Source of Data & sample size)	Source: WSA HCBS Survey Data Sample Size: 100%	
Monitoring Responsibilities (Agency or entity that conducts discovery activities)	MDHHS/BHDDA	
Frequency	Continuous and ongoing data collection	
Remediation		
Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	PIHPs Providers are required to submit a corrective action plan to the PIHPs within 30 days. Providers are responsible for remediating any identified issues within 90 days after the Plan of Correction has been approved by the PIHP.	
Frequency (of Analysis and Aggregation)	Ongoing	

Requirement		The SMA retains authority and responsibility for program operations and oversight.
Discovery		
Discovery Evidence	Number and percent of administrative hearing timeframes that were met related to 1915(i) N: Number of administrative hearing timeframes met D: All hearings.	

<i>(Performance Measure)</i>	
Discovery Activity <i>(Source of Data & sample size)</i>	Source: Appeals database Sample Size: 100% Method: Report compilation and analysis of all beneficiary completed Administrative Law Judge hearings
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	PIHPs are responsible for remediating any identified issues required by the Decision and Order of the Administrative Law Judge within the timeframe ordered.
Frequency <i>(of Analysis and Aggregation)</i>	Annually
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of case records with services that require prior authorization are implemented by the PIHP according to established policy. N: Number of case records that have prior authorization implemented by the PIHP's according to policy D: Number of all case records with services that require prior authorization reviewed in the sample.
Discovery Activity <i>(Source of Data & sample size)</i>	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) SPA.
Monitoring Responsibilities <i>(Agency or entity that)</i>	MDHHS/BHDDA

	<i>conducts discovery activities)</i>	
	Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Providers are required to submit a corrective action plan to the PIHPs within 30 days. Providers are responsible for remediating any identified issues within 90 days after the Plan of Correction has been approved by the PIHPs. PIHPs are responsible for remediating any identified issues required by the Decision and Order of the Administrative Law Judge within the timeframe ordered.
	Frequency <i>(of Analysis and Aggregation)</i>	Annually
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	Number and percent of IPOS compliance issues that were remediated within 90 days. N: Number cases reviewed with IPOS compliance issues remediated within 90 days. D: All cases reviewed that require remediation of IPOS compliance issues
	Discovery Activity <i>(Source of Data & sample size)</i>	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: All cases reviewed that require remediation of IPOS compliance issues
	Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
	Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation		
	Remediation Responsibilities	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.

<i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
Frequency <i>(of Analysis and Aggregation)</i>	Annually

Requirement	<i>The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of capitation payments to PIHPs are made in accordance with CMS approved actuarially sound rate methodology. N: Number of capitation payments made to PIHPs at the approved rate through the CMS certified MMIS. D: All capitation payments made to PIHPs through the CMS certified MMIS for participants sampled.
Discovery Activity <i>(Source of Data & sample size)</i>	Source: CHAMPS Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915 (i)SPA
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required</i>	PIHPs are responsible for remediating any identified payments issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. MDHHS/BHDDA will recoup any inappropriate payments made to PIHPs in accordance with managed care requirements for financial accountability.

<i>timeframes for remediation)</i>	
Frequency <i>(of Analysis and Aggregation)</i>	Ongoing

Requirement	<i>The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Number and percent of substantiated reports of abuse, neglect, and exploitation that has been remediated. N: Number and percent of substantiated reports of abuse, neglect, and exploitation that has been remediated. D: Number and percent of substantiated reports of abuse, neglect, and exploitation.
Discovery Activity <i>(Source of Data & sample size)</i>	Source: Office of Recipient Rights Sample Size: 100%
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	On a semi-annual basis, local CMHSP ORRs report to MDHHS the summaries of all allegations received and investigated, whether there was an intervention, and the numbers of allegations substantiated. The summaries are reported by category of rights violations. Information from these reports is entered into a database to produce a State report by waiver programs. Follow-up actions by MDHHS include data confirmation, consultation, and on-site follow-up. If there are issues involving potential or substantiated Rights violations, or serious problems with the local Rights office, the state Office of Recipient Rights, which has authority under Section 330.1754(6)(e), may intervene as necessary. The CMHSP level data is aggregated to the PIHP level where affiliations exist. Each CMHSP rights office must include in its semi- annual and annual complaint data reports to the MDHHS Office of Recipient Rights, allegations of all recipient rights complaints investigated or intervened upon on behalf of recipients based upon specific population. An annual report is produced by the State ORR and submitted to stakeholders and the Legislature. Aggregate data are shared with MDHHS-BHDDA, the Quality Improvement Council (QIC) and waiver staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

	Frequency <i>(of Analysis and Aggregation)</i>	Annually
Discovery		
	Discovery Evidence <i>(Performance Measure)</i>	Number and percent of enrollees requiring emergency medical treatment due to medication error. N: Number of enrollees requiring emergency medical treatment due to medication error. D: All enrollees with reported incidents of emergency medical treatment for injuries or medication errors
	Discovery Activity <i>(Source of Data & sample size)</i>	Source: The Critical Incident Reporting System (CIRS) provides individual level data on medication errors that resulted in emergency medical treatment or hospitalization. The CIRS is the source for information related to medication errors that are critical incidents. PIHPs will still be required to identify those incidents and carry out actions to prevent or reduce the likelihood that this type of critical incident would re-occur. Sample Size: 100%
	Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	MDHHS will monitor the critical incidents related to medication errors through the CIRS to monitor for trends and outliers. MDHHS may require the PIHP to receive additional technical assistance or training as a result of CIRS data. On-site follow-up on reported critical incidents regarding medication errors takes place at a maximum during QMP biennial site reviews. During these site reviews, MDHHS-BHDDA staff verifies the PIHP's process for Critical Incident Reporting is being implemented per MDHHS policy. Any noted shortcomings in the PIHP's processes or outcomes would be reflected in a written site review report which would in turn require submission of a corrective action plan by the PIHP and additional follow-up by MDHHS 90 days after the corrective action plan has been approved.
	Frequency <i>(of Analysis and Aggregation)</i>	Annually
Discovery		
	Discovery Evidence	Number and percent of records being reviewed where the Behavior Treatment Plan Review Committees (BTPRC) policy was followed. N: Number of records being reviewed where the BTPRC policy was followed.

<i>(Performance Measure)</i>	D: Number of records reviewed with Behavioral Treatment Plan in the sample.
Discovery Activity <i>(Source of Data & sample size)</i>	Source: Site Review Sample Size: Stratified random sample for statistically significant number based on total number served by the 1915 (I)SPA.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.</p> <p>PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.</p> <p>MDHHS requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict an individual's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700[j]). In addition, the use of restraint and seclusion is addressed in the MDHHS Standards for Behavior Treatment Plan Review Committees, Attachment P.1.4.1 to the Medicaid Specialty Supports and Services Program contract between MDHHS-BHDDA and the PIHPs; the Agreement Between MDHHS-BHDDA and CMHSPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1.d. Each rights office established by the Mental Health Code, including those of the CMHSPs, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually. The Department of Licensing and Regulatory Affairs (LARA) is responsible for investigation of reports of unlawful restraint and/or seclusion in a licensed foster care facility. Unlawful use of restraint or seclusion may also</p>

	<p>come to the attention of LARA during announced or unannounced inspections and at the time of the biennial licensure process. Mechanical or chemical restraint and seclusion are prohibited in licensed adult foster care homes per DHS Administrative Rule 400.14308 as follows: R 400.14308 Resident behavior interventions prohibitions. (2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (a) Use any form of punishment. (b) Use any form of physical force other than physical restraint as defined in these rules. Physical restraint is defined as bodily holding of a resident with no more force than is necessary to limit the resident's movement. (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident. (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner. Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDHHS-BHDDA Site Review Team, which reviews agency policy for consistency with State law during biennial visits. The Site Review Team would also watch for any unauthorized use of restraints or seclusion during its review of incident reports and interviews with participants or staff.</p>
Frequency <i>(of Analysis and Aggregation)</i>	Annually
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Number and percent of beneficiaries who have received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.</p> <p>N: Number of beneficiaries who received information and education in the prior year.</p> <p>D: Number of beneficiaries case records sampled</p>
Discovery Activity <i>(Source of Data & sample size)</i>	<p>Source: Site Review</p> <p>Aggregate data from the sample by MDHHS across 2 fiscal years</p> <p>Sample Size: stratified random sample for statistically significant number based on total number served by the 1915 (I)SPA.</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	MDHHS/BHDDA
Frequency	<p>Ongoing for data collection</p> <p>Each PIHP receives a comprehensive on-site review biennially.</p>
Remediation	

Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	<p>PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.</p> <p>PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.</p>
Frequency (of Analysis and Aggregation)	Annually
Discovery	
Discovery Evidence (Performance Measure)	<p>Number and percent of beneficiaries requiring hospitalization due to injury related to the use of physical management (PM) where remediation was complete to avoid future incidents of this type.</p> <p>N: Number of beneficiaries requiring hospitalization due to injury related to the use of PM where remediation was complete to avoid future incidents of this type</p> <p>D: All beneficiaries requiring hospitalization due to injury related to the use of physical management.</p>
Discovery Activity (Source of Data & sample size)	<p>Source: The Critical Incident Reporting System (CIRS) provides individual level data on medication errors that resulted in emergency medical treatment or hospitalization. The CIRS is the source for information related to medication errors that are critical incidents. PIHPs will still be required to identify those incidents and carry out actions to prevent or reduce the likelihood that this type of critical incident would re-occur.</p> <p>Sample Size: 100%</p>
Monitoring Responsibilities (Agency or entity that conducts discovery activities)	MDHHS/BHDDA
Frequency	Ongoing
Remediation	
Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation)	Any critical incident for a participant has a short-term response to assure the immediate health and welfare of the participant for whom the incident was reported and a longer- term response to address a plan of action or intervention to prevent further occurrence if applicable. If the incident involves potential criminal activity, the incident would also be reported to law enforcement. If the incident involves an action that may be under the authority of Child Protective Services or Adult Protective Services, the appropriate agency would be notified.

<i>activities; required timeframes for remediation)</i>	Second, the CMHSP would begin the process of determining whether the incident meets the criteria and definition for sentinel events and if they are related to practice of care. If the incident was also reported to the CMHSP ORR, that office begins the process of determining whether there may have been a violation of the participant's rights. If the CMHSP determines the incident is a sentinel event, a thorough and credible root cause analysis is completed, improvements are implemented to reduce risk, and the effectiveness of those improvements must be monitored. Following completion of a root cause analysis or investigation, a CMHSP must develop and implement either a) a plan of action (JCAHO) or intervention (per CMS approval and MDHHS contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. The CMHSP ORR also follows its process to investigate and recommend remedial action to the CMHSP Director for follow-up. If an egregious event is reported through the Event Notification or through other sources, MDHHS may follow-up through a number of different approaches, including sending a site reviewer or other clinical professional as appropriate to follow-up immediately, telephone contact, requiring follow-up action by the PIHP, requiring additional training for PIHP providers, or other strategies as appropriate. During a QMP on-site visit, if the site review team member identifies an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.
Frequency <i>(of Analysis and Aggregation)</i>	Annually

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. **Methods for Analyzing Data and Prioritizing Need for System Improvement**

The MDHHS system improvement strategy encompasses 1915(i) SPA with the following three 1915(c)'s waivers: MI Children's Waiver Program, MI Habilitation Supports Waiver, and MI Waiver for Children with Serious Emotional Disturbances.

MDHHS designed the consolidated quality improvement strategy to assess and improve the quality of services and supports provided through the available the 1915(i) services waiver options and the 1915(i) state plan. This is evident in the following components;

- participant services-all waivers and the 1915(i) offer similar services to participants to remain in the community with the focus on the provision of services and supports to maintain or increase a level of functioning in order to achieve an individual's goals of community inclusion and participation, independence, recovery, or productivity.
- participant safeguards-all waivers and the 1915(i) follow the same participant safeguards outlined throughout the individual waiver and (i) SPA applications.
- quality management: the information below outlines the approach which is the same or similar across waivers and the 1915(i).

The quality management approach is the same or similar across waivers and the 1915(i):

- methodology for discovering information: the state draws from several tools to gather data and measure individual and system performance. Tools utilized include the record review

protocol, the CHAMPS, WSA, HCBS survey, and a Critical Incident Reporting system (CIRS) across all waivers and 1915(i) participants.

- b) manner in which individual issues are remedied: MDHHS is the Single State Agency responsible for establishing the components of the quality improvement strategy which includes the remediation of all waiver and 1915 (i) issues at an individual level and all actions and timelines are recorded and tracked through annual monitoring activities.
- c) process for identifying and analyzing trends/patterns: Data gathered from the record reviews will be used initially to foster improvements and provide technical assistance at the agency whose records are being reviewed. Annually, this data will be compiled to look for systemic trends and areas in need of improvement and published in the state's annual report. Using encounter data, measure penetration rates of beneficiaries who access services at the PIHP level to determine a baseline, median, and negative statistical outliers. The state will track and trend critical incidents that involve beneficiaries at the PIHP level: baseline, then identify negative statistical outliers. And track and trend requests for Medicaid Fair Hearing by beneficiaries, and track and trend by PIHP the Fair Hearing decisions that are found in favor of the beneficiary.
- d) majority of the performance indicators are the same: the majority of the performance measures associated with CMS assurances are the same.

The provider network is the same across the 1915(i) and waiver programs. All provider types (i.e. licensed/non-licensed, certified/non-certified) within the 1915(i) and the waivers are required to meet the same training and background check requirements according to policy in order to furnish HCBS. Provider oversight is the same across the 1915(i) and waivers and all services are included in the consolidated reporting.

2. Roles and Responsibilities

MDHHS maintains overall responsibility for quality assurance, quality improvements and quality performance.

The Quality Improvement Council (QIC) has primary responsibility for identifying and prioritizing needs related to the Quality Improvement Strategy (QIS), which would include changes to 1915(i) system processes as applicable. The Quality Improvement Council meets every other month basis to review data and information from numerous sources, such as site review findings, 372 reports, state-level workgroups for practice improvement, EQR standard and special project reports, legislative reports, and performance improvement plan activities. The QIC determines where there are needs for system improvement and makes recommendations to MDHHS to incorporate into system improvement activities. The timeframe for incorporating changes is dependent on whether it is an issue requiring immediate enactment which would be addressed through policy changes or an amendment to the MDHHS/CMHSP and MDHHS/PIHP contracts. Otherwise, changes to the QIS are generally implemented in conjunction with the annual contracts between MDHHS and the PIHPs and CMHSPs. The Quality Management Program (QMP) incorporates all of the programs operated in the public mental health system, including the §1115 Behavioral Health Demonstration, Habilitation Support Waiver (HSW), Children's Waiver Program (CWP), the Waiver for Children with Serious Emotional Disturbance (SEDW) and the 1915(i) State plan. The PIHPs/CMHSPs adhere to the same standards of care for each beneficiary served and the same data is collected for all beneficiaries regardless of funding source. The MDHHS QMP Site Review team conducts comprehensive biennial reviews at each PIHP (and affiliate CMHSPs). During the alternate years, QMP staff visit PIHP/CMHSPs to follow-up on implementation of plans of correction resulting from the previous year's comprehensive review. This site visit strategy includes rigorous standards for assuring the needs, including health and welfare, of 1915(i) participants are addressed. The comprehensive reviews include clinical record reviews, administrative reviews, consumer/stakeholder meetings and consumer interviews. In addition to identifying individual issues that are addressed in remediation, the QMP findings are also used for identifying trends to

implement systems improvements. This site visit strategy covers all consumers served by 1915(i) services with rigorous standards for assuring the health and welfare of the enrolled beneficiaries.

The comprehensive reviews include the clinical record reviews; review of personnel records to ensure the all providers meet provider qualifications and have completed training prior as required by policy as published in the Michigan Medicaid Provider Manual; review of service claims to ensure that the services billed were identified in the IPOS as appropriate to identified needs; review of the Critical Incident Reporting System and verification that the process is being implemented per MDHHS policy; review and verification that Behavior Treatment Plan Review Committees are operated per MDHHS policy; follow up on reported critical incidents regarding medication errors and monitoring to assure the PIHPs/CMHSPs are not using restraints or seclusion as defined in Michigan's Mental Health Code. As identified throughout this application, the biennial site review is the data source for discovery and remediation for a number of Performance Measures. MDHHS staff complete a proportionate random stratified sample at the 95% confidence level for the biennial review for each PIHP. At the on-site review, clinical record reviews are completed to determine that the IPOS: Includes services and supports that align with and address all assessed needs, addresses health and safety risks, is developed in accordance with MDHHS policy and procedures, including utilizing person centered/family-driven youth guided planning, and is updated at least annually.

Clinical record reviews are also completed to determine that participants are afforded choice between 1915(i) services and between/among service providers and that services are provided as identified in the IPOS.

QMP staff conduct consumer interviews with a random sample of those individuals whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews are conducted with beneficiaries who reside in group homes or are living independently with intense and continuous in-home staff or in the homes of families served by the 1915(i) services.

Contracted entities will conduct record reviews and participant satisfaction surveys. These entities will be responsible for providing technical assistance when identified in the performance of their duties. The contracted entities also retain responsibility to identify areas in need of improvement and make MDHHS aware of any identified trends or areas that need immediate remediation.

Providers are responsible for furnishing services according to MDHHS policies and procedures and for continuously improving their performance and the experiences of the individuals they serve. They retain responsibility for submitting claims to MDHHS for adjudication and for assuring all claims for service are provided according to established policies and procedures.

3. Frequency

MDHHS will monitor plans of service, claims submitted for 1915(i) services and the qualifications of providers biennially through the PIHP site review process.

Case record reviews will be conducted biennially on a statistically significant number of records across all 1915(i) enrollees.

4. Method for Evaluating Effectiveness of System Changes

MDHHS will utilize a number of sources to analyze effectiveness of system changes, including but not limited to site reviews, performance indicators, encounter data, critical incident data and Medicaid Fair Hearing data. Data will be analyzed at least to determine whether changes implemented led to improved outcomes for the individuals using 1915(i) services.

When issues are identified, a study of the root cause of the issue will be conducted. Any barriers to success identified will be removed or overcome to facilitate quality improvements.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE MICHIGAN

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

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 of MICHIGANSTATE 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 of MICHIGANSTATE 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

State of MICHIGANSTATE STANDARDS FOR INSTITUTIONS

- 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 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

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

CONTRACT BETWEEN THE
MICHIGAN DEPARTMENT OF SOCIAL SERVICES
AND THE
MICHIGAN DEPARTMENT OF PUBLIC 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 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 statutes, 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.

- Section A - Budget Review and Comment
- Section B - Certification of Medical Assistance Providers
- Section C - Medical Review and Independent Professional Review (MP/IPR)
- Section D - Early and Periodic Screening, Diagnosis & Treatment (EPSDT)
- Section E - Medical Assistance and the Crippled Children Program
- Section F - Medical Assistance and Title V Projects
- Section G - Trust Fund Procedures

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.

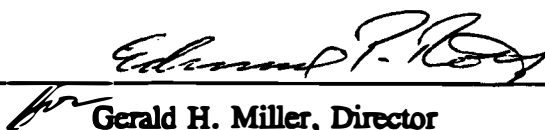
1. Hospitals, including public and private psychiatric hospitals and psychiatric units of general hospitals.
2. Nursing homes.
3. County medical care facilities.
4. Hospital long-term care units.
5. Nursing care units in state MI/MR institutions.
6. Home health agencies.
7. Laboratories.
8. Ambulance services.
9. Freestanding surgical outpatient facilities.
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

Supersedes

TN No. N/A

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

Rev. 1/01/81

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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

Rev. 1/01/81

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

Rev. 1/01/81

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

Rev. 1/01/81

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 upon 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

Rev. 1/01/81

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 re-schedule 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.

Rev. 1/01/81

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.

Rev. 1/01/81

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

Rev. 1/01/81

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

Rev. 1/01/81

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-

Rev. 1/01/81

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:

1. Determine facility compliance with Act 368 of the Public Acts of 1978, as amended.
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.

Rev. 1/01/81

ST.PLAN-4.16-A/Sec.A; Kuerbitz; 9/27/88

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

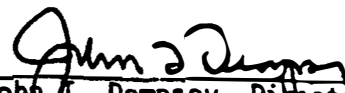
Term, Extension, and Termination: This contract supersedes any prior agreement between the parties and shall continue in effect for a period of one year from the date hereof. It shall remain effective for successive periods of one year each thereafter unless during any such period, this contract shall 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.


Maurice S. Reizen, M.D., Director
Michigan Department of Public
Health

12-16-80
Date


John T. Dempsey, Director
Michigan Department of Social
Services

12/26/80
Date

^H
ADDENDUM TO THE CONTRACT BETWEEN
THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES
AND
THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH

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:

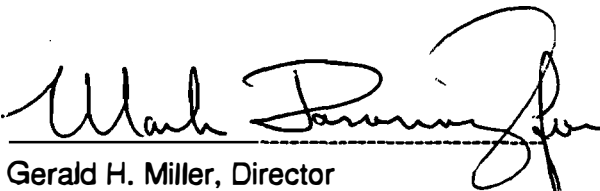
1. Add a specialty code to the provider's enrollment file when notified by public health of certification. If the provider is not currently enrolled with Medicaid, the enrollment application will be sent for completion.
2. Process provider claims.

TN No. 96-02 Approval Date 2-23-96 Effective Date 10-01-95

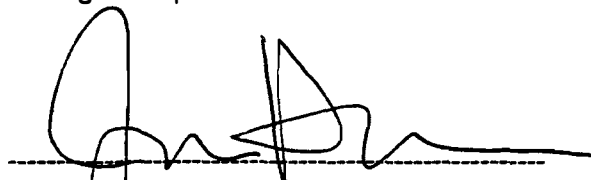
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TN No. 93-18

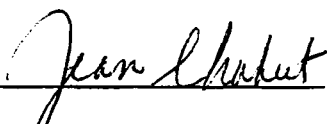
3. Fund provider reimbursement effective October 1, 1995.
4. Respond to inquiries regarding billing and reimbursement.
5. Audit participating providers as indicated in the State Plan.
6. Create and generate reports on expenditures and utilization as requested by Public Health.
7. Approve and adopt program 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, Chief
Center for Health Promotion
and Chronic Disease Prevention

DATE: 10/6/95

TN No. 96-02 Approval Date 2-23-96 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.

TN No. 93-25 Approval Date 10-27-93 Effective Date 10-1-92

Supersedes

TN No. 91-39

Addendum K for FY 92-94
Page 2

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 MDPH 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 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.

TN No. 93-25 Approval Date 10-27-93 Effective Date 10-7-92

Supersedes

TN No. 91-39

Addendum K for FY 92-94
Page 3

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.

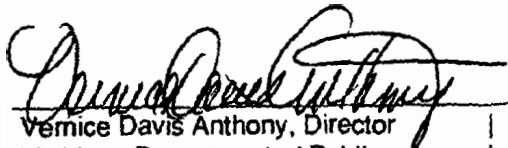
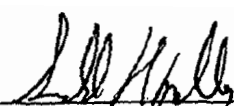
TN No. 93-25 Approval Date 10-27-93 Effective Date 10-1-92

Supersedes

TN No. 91-39

Addendum K for FY 92-94
Page 4

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.

	
Vernice Davis Anthony, Director Michigan Department of Public Public Health	Gerald Miller, Director Michigan Department of Social Services
Date: SEP 15 1993	Date: 9-20-93

TN No. 93-25 Approval Date 10-27-93 Effective Date 10-1-92
Supersedes
TN No. 91-39

**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 July 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. 99-26 Approval Date 10-22-93 Effective Date 10-1-92

Supersedes

TN No. 91-38

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.

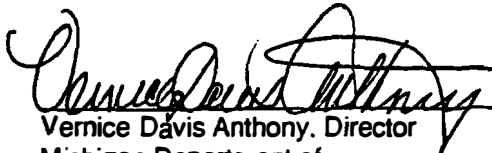
SOCIAL SERVICES WILL:

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.

TN No. 23-26 Approval Date 10-22-93 Effective Date 10-1-92
Supersedes
TN No. 91-38

Addendum L for FY 92-94
Page 3

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 15 1993

Date: 9-20-93

TN No. 93-26 Approval Date 10-23-93 Effective Date 10-1-92
Supersedes
TN No. 91-38

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.

TN No. 95/14 Approval Date 10-27-95 Effective Date 7-1-95
Supersedes
TN No. N/A

Responsibilities:

PUBLIC HEALTH WILL:

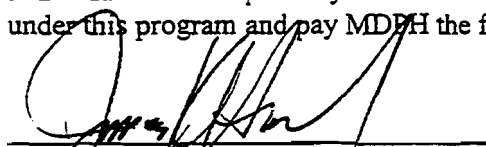
1. Draft and forward to MDSS, for approval, the qualifying standards that agencies must meet in order to provide ombudsman services. The standards must include the requirement that contracted agencies and staff will keep recipients' Medicaid related information confidential.
2. Select and forward to 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.

TN No. 95-14 Approval Date 10-27-95 Effective Date 7-1-95
Supersedes
TN No. N/A

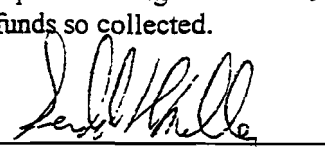
11. Maintain relevant program and fiscal records.

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.


James K. Haveman, Jr., Acting Director
Michigan Department of
Public Health

Date:


Gerald H. Miller, Director
Michigan Department of
Social Services

Date:

TN 95-14 Approval Date 10-25-95 Effective Date 7-1-95

Supersedes

TN No. N/A

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 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.

Supersedes

n.

Effective Date

10-1-91

Approval Date

1-18-93

TIN No.

70-338

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.

TN No. 90-28 Approval Date 11-8-93 Effective Date 10-15-90

Supersedes N/A

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.

TN No. 90-28 Approval Date 11-8-93 Effective Date 10-15-90

Supersedes

TN No. N/A

January 1, 2025 Version. . . . This plan is provided for informational use

version.

only and does not

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.

FIN No. 90-28 Approval Date 11-8-93 Effective Date 12-15-90

Supersedes

FIN No. N/A

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

TN No. 90-28 Approval Date 11-8-93 Effective Date 10-15-90 Supersedes N/A

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.

TN No. 90-28 Approval Date 11-8-93 Effective Date 10-15-93

Supersedes


TN No. N/A

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

by 
for Vernice Davis Anthony
Director

Witness: _____

Dated at Lansing _____, Michigan

MICHIGAN DEPARTMENT OF
SOCIAL SERVICES

This _____ day of _____, 1992

by 
Gerald H. Miller,
Director

Witness: _____

TN No. 90-28 Approval Date 11-8-93 Effective Date 10-15-90

Supersedes

TN No. N/A

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

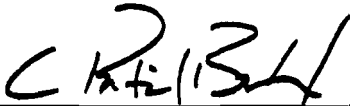
This agreement supersedes any prior agreement between the parties and shall continue in effect until or unless the two parties mutually agree to amend or terminate it. Any change in the agreement requires at least thirty (30) days prior written notice by either party.

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

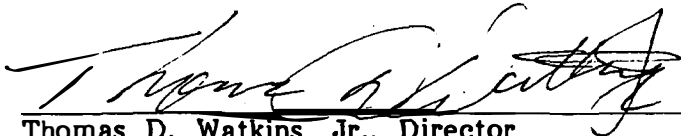
Responsibility for responding to inquiries and coordination of this agreement shall rest with the Entitlements Division, Bureau of Program Development, Quality Assurance for the Department of Mental Health and the Bureau of Program Policy, Medical Services Administration for the Department of Social Services.



C. Patrick Babcock, Director
Michigan Department of Social Services



Date



Thomas D. Watkins, Jr., Director
Michigan Department of Mental Health



Date

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.

TN No. 93-03 Approval Date 3-19-93 Effective Date 01-01-93

Supersedes

TN No. 90-18

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.

TN No. 93-03 Approval Date 2-19-93 Effective Date 01-01-93

Supersedes

TN No. 90-18

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.

TN No. 23-03 Approval Date 2-19-93 Effective Date 01-01-93
Supersedes
TN No. 90-18

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.

TN No. 93-02 Approval Date 2-19-93 Effective Date 01-01-93

Supersedes

TN No. 90-18

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 agreements 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.

TN No. 93-03 Approval Date 2-19-93 Effective Date 01-01-93

Supersedes

TN No. 90-18

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 July 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 Services 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.

TN No. 93-03 Approval Date 2-19-93 Effective Date 01-01-93

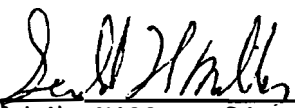
Supersedes

TN No. N/A

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.

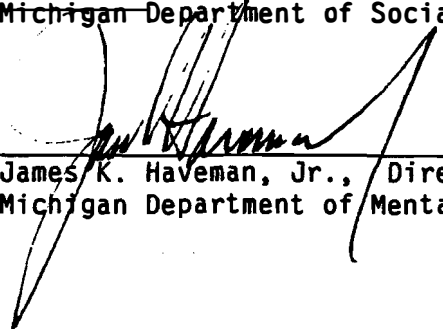
This schedule becomes effective October 1, 1991, and remains in effect as long as Mental Health administers the CSLA amendment or unless modified or cancelled by mutual consent of both parties.



Gerald H. Miller, Director
Michigan Department of Social Services

12-17-92

Date



James K. Haveman, Jr., Director
Michigan Department of Mental Health

Oct 15, 1992

Date

TRV No. 93-03 Approval Date 2-19-93 Effective Date 01-01-93

Supersedes

TRV No. N/A

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

Attachment 4.16-A
Page C-3

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.

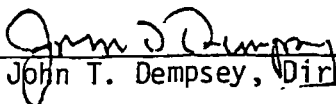
DSS Responsibilities

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

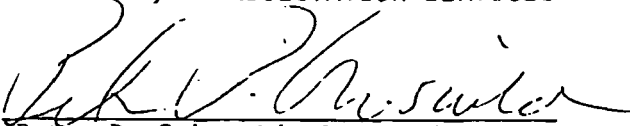


Dr. John T. Dempsey, Director

Date

6/10/80

STATE OF MICHIGAN - DEPARTMENT OF
EDUCATION, REHABILITATION SERVICES



Peter P. Griswold, State Director
of Rehabilitation

Date

6/10/80

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.

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

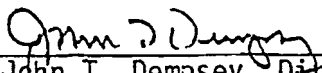
The Operational Oversight Committee will establish an annual statement of objectives for service based on each agency's priorities for service and funding. At least semi-annually, the Operational Oversight Committee will review and evaluate each agency's progress toward these objectives and report its 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.

STATE OF MICHIGAN
DEPARTMENT OF SOCIAL SERVICES

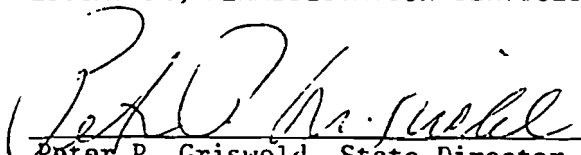


Dr. John T. Dempsey, Director

6/10/80

Date

STATE OF MICHIGAN - DEPARTMENT OF
EDUCATION, REHABILITATION SERVICES



Peter P. Griswold, State Director
of Rehabilitation

6/10/80

Date

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.

Rev. 10/01/80

ST.PLAN-4.16-A/Sec.C; Kuerbitz; 9/28/88

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:

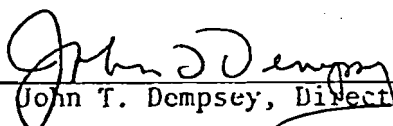
RS and MSA will seek methods for reducing paper processing and overlapping services, records, and other medical information for those recipients referred from one program to the other. Full consideration will be given to current laws and regulations regarding confidentiality.

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:

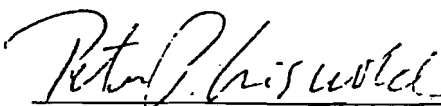
The specific activities outlined in this section shall be monitored by the Operational Oversight Committee described in Part II, as scheduled by that committee. The liaison persons from each agency shall sit on that committee.

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

**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:

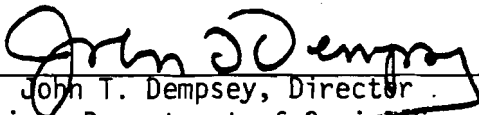
1. Utilize the Michigan Department of Public Health's certification, including the fire safety evaluation, as one of the determinants for provider enrollment and payment purposes.
2. Exercise ultimate authority to enroll provider facilities in the Medicaid Program.
3. By inter-departmental billing between 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 liason 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.



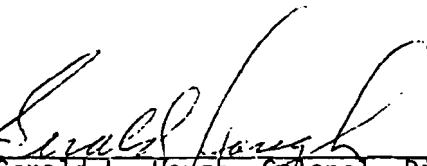
John T. Dempsey, Director
Michigan Department of Social Services

10/20/80
Date



Maurice S. Reizen, M.D., Director
Michigan Department of Public Health

10-1-80
Date



Gerald L. Hough, Colonel, Director
Michigan Department of State Police

9-15-80
Date

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:

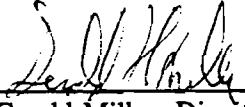
- to promote quality targeted case management (TCM) services for high risk elderly clients on the verge of entering a nursing home;
- to promote quality home and community based waiver services for elderly and disabled (HCBS/ED) clients who are nursing home eligible;
- to assure the proper expenditure 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

8-29-94

Date

MICHIGAN OFFICE OF SERVICES TO THE AGING



Diane K. Braunstein, Director

8/2/94

Date

TN No. 93-05 Approval Date 10-18-94 Effective Date 1-1-93

Supersedes

TN No. 89-22

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.
9. FFP - Federal Financial Participation. The federal share of reimbursement for 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.).

TN No. 93-05

Approval Date 10-18-94 Effective Date 1-1-93

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TN No. 89-22

Schedule A

DEFINITIONS

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; re-assessment/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.

TN No. 93-05 Approval Date 10-18-94 Effective Date 1-1-93
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TN No. 89-22

Schedule B
TARGETED CASE MANAGEMENT

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.

TN No. 93-05
Supersedes
TN No. N/A

Approval Date 10-18-94 Effective Date 1-1-93

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.

TN No. 93-05
Supersedes
TN No. N/A

Approval Date 10-18-94 Effective Date 1-1-93

Schedule C
HOME AND COMMUNITY BASED SERVICES
ELDERLY AND DISABLED WAIVER
(AND PERSONAL CARE)

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.
4. Conduct hearings of client appeals on waiver eligibility and service denials.
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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Approval Date 10-18-94 Effective Date 1-1-93

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.

TN No. 93-05
Supersedes
TN No. N/A

Approval Date 10-18-94 Effective Date 1-1-95

Schedule C
HOME AND COMMUNITY BASED SERVICES
ELDERLY AND DISABLED WAIVER
(AND PERSONAL CARE)

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.

TN No. 93-05
Supersedes
TN No. N/A

Approval Date 10-18-94 Effective Date 1-1-93

Schedule C
HOME AND COMMUNITY BASED SERVICES
ELDERLY AND DISABLED WAIVER
(AND PERSONAL CARE)

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.

TN No. 93-05
Supersedes
TN No. N/A

Approval Date 10-18-94 Effective Date 1-1-93

Schedule C
HOME AND COMMUNITY BASED SERVICES
ELDERLY AND DISABLED WAIVER
(AND PERSONAL CARE)

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;

TN No. 93-05
Supersedes
TN No. N/A

Approval Date 10-18-94 Effective Date 1-1-93

Schedule C
HOME AND COMMUNITY BASED SERVICES
ELDERLY AND DISABLED WAIVER
(AND PERSONAL CARE)

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.

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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 § 16.103), was created by Governor Jennifer M. Granholm in E.O. 2005-1 and amended in E.O. 2005-26; and

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TN No.: N/A new page

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:

TN NO.: 06-07

Approval Date: FEB 08 2008

Effective Date: 05/15/2006

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

TN NO.: 06-07 Approval Date: FEB 08 2008 Effective Date: 05/15/2006

Supersedes
TN No.: N/A new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperative Agreements

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 & O's 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 II(1) or II(2)(b) .

(b) **Three (3) business days from the date of receipt of a D & O for appeals involving:** Breast and Cervical Cancer Prevention

~~FEB 08 2008~~

TN NO.: 06-07

Approval Date: _____

Effective Date: 05/15/2006

Supersedes

TN No.: N/A new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperative Agreements

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.

TN NO.: 06-07

Approval Date: FEB 08 2008

Effective Date: 05/15/2006

Supersedes

TN No.: N/A new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperative Agreements

- (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

TN NO.: 06-07

Approval Date: FEB 08 2008

Effective Date: 05/15/2006

Supersedes

TN No.: N/A new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperative Agreements

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 &

TN NO.: 06-07

Approval Date: FEB 08 2008 Effective Date: 05/15/2006

Supersedes

TN No.: N/A new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperative Agreements

Os 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.

TN NO.: 06-07 Approval Date: FEB 08 2008 Effective Date: 05/15/2006

Supersedes
TN No.: N/A new page


STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperative Agreements

VI. PRIOR AGREEMENTS

Upon execution by both parties, revised Joint Operating Agreement replaces and supercedes the Joint Operating Agreements executed by the parties on May 5, 2006 and October 28, 2006.

 11/14/07
A. Edwin Dore Date
Chief Deputy Director
MDCH

 11/15/07
Peter L. Plummer Date
Executive Director
SOAHR

TN NO.: 06-07 Approval Date: FEB 08 2008 Effective Date: 05/15/2006
Supersedes
TN No.: N/A new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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.
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TN NO.: 16-0005

Approval Date: MAY 24, 2016

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Supersedes

TN No.: 12-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Liens and Adjustments or Recoveries

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).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Liens and Adjustments or Recoveries

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.

TN NO.: 16-0005

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TN No.: 12-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MICHIGAN

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.

TN No. 92-05
Supersedes Approval Date 04-14-92 Effective Date 10-01-91
TN No. N/A
HCFA ID: 7986E

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

ATTACHMENT 4.18-D
Page 2
OMB No.: 0938-

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

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.

TN No.	<u>92-05</u>	Approval Date	<u>04-14-92</u>	Effective Date	<u>10-01-91</u>
Supersedes	<u>N/A</u>				
TN No.	<u>N/A</u>				

HCFA ID: 7986E

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

ATTACHMENT 4.18-E
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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.

TN No. 92-05
Supersedes 90-23 Approval Date 04-14-92 Effective Date 10-01-91

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AUGUST 1991

ATTACHMENT 4.18-E
Page 2
OMB No.:0938-

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.

TN No. 92-05
Supersedes 90-23 Approval Date 04-14-92 Effective Date 10-01-91
HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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.

TN No. 24-0001

Approval Date: MAR 19, 2024

Effective Date: 1/01/2024

Supersedes

TN No. 15-0015

CMS-101090 (09/06)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

C. For groups of individuals with family income above 150 percent of the FPL:

1. Premiums

- a. ☒ No premiums are imposed.
- b. ☐ Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

D. Period of determining aggregate 5 percent cap

Specify the period for which the 5 percent maximum would be applied.

☐ / Quarterly

☐ / Monthly

TN No. 24-0001

Approval Date: MAR 19, 2024

Effective Date: 1/01/2024

Supersedes

TN No. 15-0015

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.

RECEIVED

MAY 14 2001

DMCH - MI/MN/WI

Approval Date 6-6-01
Effective Date 10-7-97

Plan # 97-20
Supersedes Plan # 98-04

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)***

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.

TN NO.: 11-08

Approval Date: MAY 25 2012

Effective Date: 07/01/2011

Supersedes

TN No.: 98-08

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.

TN NO.: 14-0019

Approval Date: AUG 25, 2015

Effective Date: 10/01/2014

Supersedes

TN No.: 11-08

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. 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.

TN NO.: 14-0019

Approval Date: AUG 25, 2015

Effective Date: 10-01-2014

Supersedes
TN No.: 98-08

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Rates
Inpatient Hospital Services***

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**TN NO.: 17-0003Approval Date MAY 8, 2017Effective Date: 01/01/2017

Supersedes

TN No.: 15-0014

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Rates
Inpatient Hospital*****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.

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TN No.: 13-08

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates Inpatient Hospital

2. Statewide DRG Rates

Two statewide medical/surgical hospital DRG rates are developed by the state using the Episode File. For hospital DRG rate setting purposes, the medical/surgical Episode File is limited to those hospitals enrolled with the state as of October 1 of the applicable rate year. Two separate statewide rates are developed: one rate is developed for prospective payment system (PPS) hospitals and another rate is developed for hospitals designated as critical access by CMS as of October 1 of the applicable rate year. In the event a hospital status changes from PPS to critical access hospital (CAH), the state recognizes the hospital under CAH status as of the CMS effective date. The reverse is also true. If a hospital status changes from CAH to PPS, the state recognizes the hospital under PPS status as of the CMS effective date. Statewide rates are updated annually on October 1.

A budget neutrality factor is included in the hospital price calculation. Hospital prices are reduced by the percentage necessary so that total aggregate hospital payments using the new hospital prices and DRG relative weights do not exceed the total aggregate hospital payments made using the prior hospital base period data and DRG Grouper relative weights. The estimate is based on one year's paid claims, including MHP encounter data with FFS rates applied. The calculated DRG prices are deflated by the percentage necessary for the total payments to equate to the amount paid prior to the change. Budget neutrality for CAHs is determined as a group, independent of PPS.

Hospitals' final DRG rates are calculated as follows:

- The case mix is calculated using the sum of all relative weights assigned to each hospital's claims during the base period, divided by the total number of episodes for the hospital during the same period.
- The case mix index adjusted cost for each hospital is summed.
- A hospital-specific standardized cost per discharge is computed.
 - Divide total adjusted costs by the total number of episodes.
 - Divide average costs by the case mix.
 - Multiply the result by the applicable inflation factor to bring costs to a common point in time. Costs are inflated through the rate period. For example, for FY 2015 rates, costs are inflated through September 30, 2016. Inflation factors are obtained from IHS Global Insight.
- The statewide rate per discharge is the weighted mean of all hospital-specific standardized cost.
- A rate adjustment is applied to designated level I and II trauma facilities.
- The statewide rate is adjusted by an Area Wage Index and Budget Neutrality Factor to determine the hospital's final DRG rate.

In developing the statewide DRG rate, the following data and calculations are used for each hospital:

- 1) Hospital's adjusted charges;
- 2) Inpatient cost-to-charge ratio;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates – Inpatient Hospital

- 3) Hospital's adjusted costs (line 1 x line 2);
- 4) Hospital's episodes;
- 5) Cost per discharge (line 3/line 4);
- 6) Hospital's case mix;
- 7) Standardized cost per discharge (line 5/line 6);
- 8) Establish statewide rate as weighted standardized cost per discharge $((\sum \text{line 7} \times \text{line 4}) / \sum \text{line 4})$;
- 9) Apply rate adjustment to designated level I and II trauma facilities;
- 10) Hospital's Area Wage Index;
- 11) Apply budget neutrality factor; and
- 12) Hospital's final DRG rate (line 8 x line 9 x line 10). The DRG rate is rounded to the nearest whole dollar amount.

The statewide rates are listed on the state Inpatient Hospital website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Inpatient Hospitals.

3. Relative Weights

Michigan-specific relative weights are developed utilizing the adjusted costs from the Episode File. The average cost for episodes within each DRG is calculated by dividing the sum of the costs for the episodes by the number of episodes within the DRG. The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes. A table showing the relative weights, average lengths of stay, and low day outlier threshold for each DRG is available on the state Inpatient Hospital website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Inpatient Hospitals. Relative weights are updated annually on October 1.

The state establishes alternate weights for neonatal services from episodes that are assigned to one of the DRGs in the following range: 580x-640x. These weights are utilized for services rendered in a neonatal intensive care unit (NICU). The remaining claims assigned to these DRGs are used for the base weights (non alternate weights). No other alternate weights are assigned.

To ensure each relative weight adequately reflects resource utilization for a particular DRG in the state, the state requires that each DRG have a minimum of 10 episodes. If a DRG does not have at least 10 episodes, an alternative solution is applied as follows:

State-Specific Relative Weight Methodology:

- If the episode count for a DRG is 10 or more, use the relative weight setting methodology outlined. Otherwise:
 - For severity levels 1 through 3 where the targeted severity level is equal to n :
 - If the episode count for the next greater severity level is 10 or more, the following calculation is completed: $(\text{MI DRG Severity}_{n+1} \text{ Relative Weight}) \times (\text{National DRG Severity}_n \text{ Relative Weight}) / (\text{National DRG Severity}_{n+1} \text{ Relative Weight}) = (\text{MI Relative Weight Factor}_n)$
 - Otherwise, $(\text{National DRG Severity}_n \text{ Relative Weight}) \times (\text{MI Case Mix Factor}_n)$

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Payment Rates
Inpatient Hospital***

- For severity level 4:
 - If the episode count for the prior 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, $(\text{National DRG Severity}_n \text{ Relative Weight}) \times (\text{MI Case Mix Factor}_n)$
- Where:
 - $(\text{MI Case Mix Factor}_n) = \text{sum of Michigan specific relative weights multiplied by the number of episodes if the number of episodes is 10 or more divided by the sum of National relative weights multiplied by the number of episodes if the number of episodes is 10 or more.}$
 - $(\text{MI Alternate Weight Case Mix Factor}) = \text{Average of } (\text{MI Alternate Weight DRG Severity}) / (\text{MI DRG Severity Relative Weight}) \text{ for DRGs with an episode count of 10 or more.}$
- 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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

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:
 - (a) 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.
 - (b) 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:

$$\text{Medical/Surgical Area Wage Index Adjusted Rate} = 0.70 \times \text{Area Wage Index} + 0.30$$

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State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates Inpatient Hospital

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:

- 2 x Hospital DRG Rate x Relative Weight (twice the regular payment for a transfer paid on a per day basis for episodes getting less than a full DRG); or
- \$35,000.

Cost outliers are reimbursed according to the following formula:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

$$(\text{Hospital DRG Rate} \times \text{Relative Weight}) + [(\text{Charges} \times \text{Operating Cost-to-Charge Ratio}) - (\text{Cost Threshold})] \times 85 \text{ percent} = \text{Reimbursement for Cost Outlier Claim}$$

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Rates
Inpatient Hospital***

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:

DRG	Description
001x	Liver Transplant &/or Intestinal Transplant
002x	Heart &/or Lung Transplant
006x	Pancreas Transplant
440x	Kidney Transplant

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.

H. Long Acting Reversible Contraceptives (LARCs)

Long Acting Reversible Contraceptives (LARCs) provided in the inpatient hospital setting immediately postpartum are excluded from the DRG payment. An additional payment for the LARC device will be made to a hospital when a LARC is provided immediately postpartum. Practitioners will receive payment for their professional services related to the immediate postpartum LARC insertion procedure when billed separately from the professional global obstetric procedure codes and the hospital facility. Costs associated with LARC device are to be billed separately from the inpatient visit using the Medicaid fee schedule (insertion and device).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Rates
Inpatient Hospital***

I. Hospital Rapid Whole Genome Sequencing (rWGS) Testing Reimbursement

Rapid whole genome sequencing testing provided in the inpatient hospital setting is excluded from the DRG payment. An additional payment for medically necessary rWGS will be made to a hospital when established clinical criteria is met. Costs associated with rWGS are to be billed separately from the inpatient episode. Hospital reimbursement will be made according to the Medicaid laboratory fee schedule.

J. Spinraza

Spinraza provided in the inpatient hospital setting is excluded from the DRG payment. An additional payment for medically necessary Spinraza will be made to a hospital when established clinical criteria is met. Costs associated with Spinraza are to be billed separately from the inpatient episode. Hospital reimbursement will be made according to the Medicaid fee schedule.

K. Outcomes-Based Contract Arrangements

Drugs provided under outcomes-based contract arrangements with drug manufacturers for drugs provided to Medicaid beneficiaries in the inpatient hospital setting are excluded from the DRG payment. An additional payment for drugs under an outcomes-base contract arrangement will be made to a hospital when established clinical criteria is met. Costs associated with these drugs are to be billed separately from the inpatient episode. Hospital reimbursement will be made according to the Medicaid fee schedule.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates Inpatient Hospital

B. Reimbursement for Long Term Acute Care Hospitals (LTACHs) and Freestanding Rehabilitation Hospitals/Distinct Part Rehab 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Rates
Inpatient Hospital***

- 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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State of MICHIGAN

Policy and Methods for Establishing Rates - Inpatient Hospital

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State of MICHIGAN

Policy and Methods for Establishing Rates – Inpatient Hospital

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***Policy and Methods for Establishing Rates
Inpatient Hospital***

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State of MICHIGAN

***Policy and Methods for Establishing Rates
Inpatient Hospital***

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Policy and Methods for Establishing Rates – Inpatient Hospital

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Rates
Inpatient Hospital***

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Rates
Inpatient Hospital***

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Policy and Methods for Establishing Rates Inpatient Hospital

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:

$$\frac{\text{Medicaid Inpatient Days (Whole Hospital including Subproviders)}}{\text{Total Hospital Days (Whole Hospital including Subproviders)}}$$

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Rates
Inpatient Hospital***

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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State of MICHIGAN

Methods of Payment of Reasonable Costs - Inpatient Hospital Services

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

Effective state plan rate year 2024, the disproportionate share hospital pools and methodology described in the inpatient hospitals section are discontinued. 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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State: MICHIGANMETHODS OF PAYMENT OF REASONABLE COSTS -
INPATIENT HOSPITAL SERVICES

$$\frac{\text{Hospital's DSH Share}}{\sum \text{DSH Shares for the Group}} \times \text{Allocated DSH Pool}$$

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:

$$\text{Title XIX Charges} \times \text{Operating Ratio} \times (\text{IV} - 0.2)$$

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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

c. Distinct Part Rehab Units

Distinct part rehab units are allocated approximately \$500,000 for DSH payments. The share of the DSH payment paid to hospitals with IV of at least 20 percent is based on a DSH share of the following:

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:

Note: Subsection “a.” has been deleted. The next subsection is “b.” Effective state plan rate year 2024, the regular disproportionate share hospital pools and methodology described in the inpatient hospitals section are discontinued.

- b. Effective state plan rate year 2024, the special disproportionate share hospital pool and methodology described in this section is discontinued. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care***

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care***

Note: Subsection "d." has been deleted. The next subsection is "e."

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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

e. Institute for Mental Disease

A special DSH pool will be established to take into account the situation of State psychiatric hospitals that serve indigent persons with serious mental illness requiring inpatient treatment. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care***

f. Government Provider DSH Pool

Effective state plan rate year 2024, the special disproportionate share hospital pool and methodology described in this section is discontinued. 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 through fiscal year 2018, \$94,649,000 for fiscal year 2019 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care***

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

Effective state plan rate year 2024, the special disproportionate share hospital pool and methodology described in this section is discontinued. 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 \$185,000,000 in fiscal year 2018 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:

Component	FY 2018 and Subsequent Fiscal Years
Small and Rural components	\$60,000,000
Large-Urban components	\$125,000,000
TOTALS	\$185,000,000

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care***

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. $(\text{Hospital Title XIX Outpatient FFS Payments}) / (\text{Hospital Title XIX Outpatient FFS Charges}) = (\text{Hospital Title XIX Outpatient Payment to Charge Ratio})$
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. $(\text{Net Hospital Outpatient Uncompensated Title XIX Equivalent Payments}) / (\sum \text{of all Net Hospital Outpatient Uncompensated Title XIX Equivalent Payments}) = (\text{Outpatient Uncompensated DSH Hospital Pool Factor})$
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.

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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

4. DSH Process

Effective state plan rate year 2024, DSH payments will be limited to the institute for mental disease (IMD) pool. All other regular and special DSH pools will be discontinued effective state plan rate year 2024.

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, non-IMD 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: Final DSH Settlement calculations. No hospital will receive a DSH payment in excess of its initial DSH limit.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates Inpatient Hospital Care

Effective state plan rate year 2024, DSH payments will be limited to the institute for mental disease pool. All other regular and special DSH pools will be discontinued effective state plan rate year 2024.

DSH payments will be applied against a hospital's DSH limit in the following order:

1. Institute for Mental Disease Pool
2. \$45 Million Pool
3. Outpatient Uncompensated Care DSH Pool
4. University with Both a College of Allopathic Medicine and a College of Osteopathic Medicine Pool (University Pool)
5. Government Provider DSH Pool (GP Pool)

Step 2: Final DSH Settlement Step

Effective state plan rate year 2024, DSH payments will be limited to the institute for mental disease pool. All other regular and special DSH pools will be discontinued effective state plan rate year 2024.

DSH limits, DSH payments and Medicaid utilization rates are recalculated during the final DSH settlement step. DSH funds will be reallocated in the following manner:

1. Institute for Mental Disease Pool
2. \$45 Million Pool
3. Outpatient Uncompensated Care DSH pool
4. University with Both a College of Allopathic Medicine and a College of Osteopathic Medicine Pool (University Pool)
5. Government Provider DSH pool (GP Pool)
6. Unspent funds not applicable to Step 1

The State will recalculate hospital-specific DSH limits, DSH payment allocations and Medicaid utilization rates upon completion of the DSH audit for the applicable DSH year. Inpatient and outpatient cost and payment data utilized from Step 1 will be refreshed to account for any cost report changes that occurred between steps during the cost report acceptance process. DSH limits and Medicaid utilization rates will be calculated using the final DSH audit.

No hospital will receive a DSH payment in excess of its audited DSH Settlement limit.

- A. Upon completion of the calculations for the first five pools outlined in the order above, any remaining unspent federal DSH allotment will be distributed through a new pool. The remaining allotment will be distributed 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 University and GP DSH pools. No hospital will receive an allocation in excess of its remaining audited hospital-specific DSH limit capacity or other federal limits. The formulas to distribute these funds are as follows:

1.
$$\frac{(\text{Eligible hospital's remaining audited DSH limit capacity} + \text{University DSH payment amount} + \text{GP DSH payment amount})}{(\sum \text{of all eligible hospitals' audited remaining DSH limit capacity} + \text{University DSH payment amount} + \text{GP DSH payment amount})} = (\text{Hospital Pool Factor})$$
2.
$$(\text{Hospital Pool Factor}) \times (\text{Pool Amount}) = \text{Pool Payment}$$

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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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TN No.: 13-07

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

METHODS OF PAYMENT OF REASONABLE COSTS -
INPATIENT HOSPITAL SERVICES

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:

$$\frac{\text{Occupancy}}{0.6} \times \text{Medicaid Share of Capital}$$

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:

$$\frac{\text{Occupancy}}{0.75} \times \text{Medicaid Share of Capital}$$

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

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. Over payments 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:

$$FTEs \times Casemix \times (Hospital's Title V \& Title XIX Days / Hospital's Total Days) = Adjusted FTEs$$

$$GME Funds Pool Size \times (Adjusted FTEs / \sum Adjusted FTEs) = Hospital's Distribution$$

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 through FY 2020, the GME Funds Pool size will be \$52,565,600. For FY 2021 and each subsequent year, the GME funds pool size will be \$26,054,100.

Primary Care Pool

To calculate each hospital's share of the Primary Care Pool, the following formula will be used:

$$FTEs \times (Hospital's Title V \& Title XIX Outpatient Charges / Hospital's Total Charges) = Adjusted FTEs$$

$$Primary Care Pool Size \times (Adjusted FTEs / \sum Adjusted FTEs) = Hospital's Distribution$$

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

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 through FY 2020, the primary care pool size will be \$10,322,700. For FY 2021 and each subsequent year, the primary care pool size will be \$5,116,400.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care

GME Innovations MIDOCs Program

The GME MIDOCs Program supports the expansion of residencies and subsequent retention efforts for approved high need specialties in underserved areas of the state, where current and future physician shortages undermine the health and well-being of Medicaid beneficiaries. The MIDOCs program offers physician training in integrated and patient-centered care for underserved populations that will further the state's Medicaid quality goals. To be eligible for MIDOCs GME funding, the MIDOCs participating medical school must enter into an agreement with the state agency specifying the number of MIDOCs residents to be supported, the total annual cost of such residencies, any post-residency expenditures to retain physicians in underserved areas of Michigan and the amount of other sources of funding available for the program, if any. Sponsoring institutions may receive funding from other sources but Medicaid will act as a payer of last resort to only cover costs not reimbursed through other sources. The state agency will pay the MIDOCs participating medical school an amount equal to the amount of otherwise unreimbursed costs.

The single state agency will approve four (4) agreements with MIDOCs participating medical schools statewide each state fiscal year (SFY), covering residencies for the academic year (July-June (AY)) beginning within the SFY. The agreements will total \$1.52 million in Fiscal Year 2019, \$10.73 million in Fiscal Year 2020, \$19.98 million in Fiscal Year 2021, \$27.75 million in Fiscal Year 2022, \$28.5 million in Fiscal Year 2023, and \$22.8 million in Fiscal Year 2024.

In addition, the following requirements must be met:

- The MIDOCs participating medical school must have submitted to the state agency its MIDOCs program proposal for new or expanded residency program(s) to promote access in underserved areas of the state
- The new or expanded program(s) must possess appropriate accreditation credentials
- The new or expanded program(s) must meet the MIDOCs curriculum standards, including those related to didactic education on patient centered medical homes, interprofessional education, behavioral and physical health integration, and continuous quality improvement
- The MIDOCs participating medical school must be the sponsoring institution of the residency program(s) or have an approved agreement with the sponsoring institution
- The MIDOCs participating medical school or the sponsoring institution (if not the medical school) must have agreements with all training sites for the MIDOCs residents
- If GME distributions exceed the expenses incurred by the MIDOCs participating medical school, their affiliated sponsoring institution and/or the clinical training sites related to the MIDOCs residencies, the size of the payment will be reduced to bring these elements into alignment.

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Supersedes

TN No.: 19-0002

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates – Inpatient Hospital

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
6. Non-program related issues.

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

METHODS OF PAYMENT OF REASONABLE COSTS -
INPATIENT HOSPITAL SERVICES

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.

TN No. 00-05 Approval 6-6-01 Effective Date 4/1/00
Supersedes 98-08
TN No. _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

METHODS OF PAYMENT OF REASONABLE COSTS -
INPATIENT HOSPITAL SERVICES

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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TN No. _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

**METHODS OF PAYMENT OF REASONABLE COSTS -
INPATIENT HOSPITAL SERVICES**

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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Supersedes
TN No. 02-20

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care***

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. 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Methods and Standards for Establishing Payment Rates
Inpatient Hospital Care***

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 MACI pools.

Allocation of Pool

MACI 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 MACI distribution causes the hospital's Medicaid payments to exceed charges, its MACI 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 MACI 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 MACI payments are final.

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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

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 30th 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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TN No.: 06-04

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

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.

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State of MICHIGAN

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

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."

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Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

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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. Effective State FY 2021, eligibility for the rural access pool is limited to non-critical access hospitals. 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 reported 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Methods and Standards for Establishing Payment Rates
For Services Provided by Psychiatric Residential Treatment Facilities as Described in
Item 16 of Supplement to Attachment 3.1-A***

Psychiatric Residential Treatment Facility (PRTF)

PRTFs are paid a per diem rate, tiered to reflect the severity of the treatment services and staffing ratios. The per diem rates were set as of December 1, 2023, and are effective for services provided on or after that date. All rates are published at www.michigan.gov/medicaidproviders. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of PRTF services.

The per diem is inclusive of:

- 1) Personal care and community living supports
- 2) Psychiatry
- 3) Group and individual behavioral health therapy
- 4) Case management
- 5) Behavior treatment plan development, implementation, and monitoring
- 6) Room and board
- 7) All transportation services. This includes transportation to accomplish PRTF treatment goals, education, and non-emergency non-ambulance medical transportation.

PRTF services must be reimbursed at the lower of the following:

- 1) Submitted charges, or
- 2) Fee schedule for PRTF services as determined by MDHHS

Payment is made for leave days when a reserved bed is held for a recipient on therapeutic or hospital leave. Therapeutic leave days are paid at 75% of the established fee schedule rate for up to consecutive therapeutic leave days. Hospital leave days are paid at 50% of the established fee schedule rate for up to seven consecutive days for each separate and distinct episode of medically necessary hospitalization. Additional leave days may be reimbursed upon authorization by the state.

Coverage for out-of-state PRTFs may only be provided upon authorization by the State. PRTF services must be reimbursed at the lower of the following:

- 1) Submitted charges, or
- 2) Fee schedule for PRTF services as determined by MDHHS

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.

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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)***

1. Physician Services

Payment rates are established by the Medical Services Administration and are 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 payment rates for individual services.

Providers are reimbursed the lesser of the Medicaid payment rate or the provider's usual and customary charge minus any third-party payment. The provider's usual and customary charge is the fee most frequently charged to patients. The payment rate is uniform for private and governmental providers.

Except as otherwise specified in the State Plan, payment rates are established utilizing the following methodology:

- Annual January RBRVS values multiplied by the statewide conversion factor of \$21.30.
- Annual January Anesthesia Base Units (ABUs) plus time units multiplied by the statewide anesthesia conversion factor of \$10.60.

This payment rate methodology is effective for dates of service on or after 10/01/2023.

The rates calculated using the above methodology are published in the practitioner fee schedule on the State's website 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)***

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 July 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
- Clinical Nurse Specialists
- 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.

TN NO.: 18-0011

Approval Date: MAR 19,2019

Effective Date: 12/01/2018

Supersedes TN No.: 12-14

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 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 July 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.

TN NO.: 13-10

Approval Date: MAR 10, 2014

Effective Date: 04/01/2013

Supersedes

TN No.: 10 - 21

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)

Payment Adjustments for Children with Special Health Care Needs Approved Specialty Physicians.

Effective July 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.

TN NO.: 09-09

Approval Date: MAR 15 2010

Effective Date: 04/01/2009

Supersedes
TN No.: 09-09
Supersedes
TN No.: 09-09
Supersedes
TN No.: N/A new page

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***

Physician Services, 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 in collaboration with 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
- 99421-99423 online digital E/M services
- 99441-99443 non-face-to-face telephone E/M 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, pediatric medicine, and general practice, on and after October 1, 2022. The Michigan Medicaid Fee Schedule for the qualified procedure codes is published at www.michigan.gov/medicaidproviders.

TN NO.: 22-0012

Approval Date: Nov 4, 2022

Effective Date: 10/01/2022

Supersedes

TN No.: 17-0015

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***

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 .

TN NO.: 16-0001

Approval Date: JUL 5, 2016

Effective Date: 01/01/2016

Supersedes

TN No.: N/A – New Page

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***

Physician Services, Neonatal Critical Care and Intensive Care Services

Neonatal Services Reimbursement Methodology

Reimbursement for neonatal critical care and intensive care services is 100% 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 1, 2022. All rates are published at www.michigan.gov/medicaidproviders.

TN NO.: 22-0015

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Effective Date: 10/01/2022

Supersedes

TN No.: 20-0003

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***

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.

TN NO.: 17-0011

Approval Date: JAN 23, 2018

Effective Date: 10/24/2017

Supersedes

TN No.: New Page

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***

Physician Services, Pediatric Psychiatric Services

Pediatric Psychiatric Diagnostic Evaluation Services Reimbursement Methodology

Reimbursement for psychiatric diagnostic evaluation services for beneficiaries under 21 years of age is 100% 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 Diagnostic Evaluation Services Payment

This reimbursement methodology applies to services rendered on and after February 1, 2020. All rates are published at www.michigan.gov/medicaidproviders.

Pediatric Psychiatric Services and Procedures Reimbursement Methodology

Reimbursement for psychiatric services or procedures is 67.73% 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 Psychiatric Services Payment

This reimbursement methodology applies to services rendered on and after October 1, 2023. 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***

Preventive Services - Doula Services

Doula Services Reimbursement Methodology

Reimbursement for doula services will be the lesser of the provider's charge or Program fee screens 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 doula services.

Effective Date of Payment

Rates are calculated using the methodology utilized for physician services located in Attachment 4.19-B Page 1. This reimbursement methodology applies to services rendered on and after October 1, 2022. 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***

**Physician Services, Interprofessional Telephone/Internet/Electronic Health Record Consultations
(including eConsults)**

Interprofessional Telephone/Internet/Electronic Health Record Consultations Reimbursement Methodology

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of Interprofessional Telephone/Internet/Electronic Health Record Consultations. Rates are established utilizing the same methodology described for physician services located in Attachment 4.19-B Page 1.

Effective Date of Payment

This reimbursement methodology applies to services rendered on and after December 1, 2023. All rates are published at www.michigan.gov/medicaidproviders.

TN NO.: 23-0021

Approval Date: OCT 18, 2023

Effective Date: 12/01/2023

Supersedes

TN No.: NEW

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.: 17-0005Approval Date: SEPT 20, 2017Effective Date: 04/01/2017

Supersedes

TN No.: 15-0011

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)***

- 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) and Rural Health Clinics (RHCs). Pharmacy claims from FQHCs and RHCs 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.
- i) Prescriptions dispensed by a Tribal 638 Facility Pharmacy are reimbursed at the Indian Health Services outpatient rate in accordance with the annual Federal Register Notice. There is no limit on the number of encounters that may be reimbursed in a single day. The encounter rate includes dispensing services and drug costs. All Tribal 638 Facility Pharmacies are paid the encounter rate by MI Medicaid regardless of their method of purchasing.

TN NO.: 21-0009Approval Date: SEP 13, 2021Effective Date: 10/01/2021

Supersedes

TN No.: 17-0005

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, rural emergency hospitals, 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. Effective FY 2020, the State will reimburse critical access hospitals using an enhanced OPPS reduction factor. Effective FY 2023, the State will reimburse dental services provided in outpatient hospitals according to the Medicaid fee schedule. The current Michigan Medicaid fee schedule and OPPS reduction factors are 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.
- f) To maintain budget neutrality, critical access hospitals that convert to rural emergency hospitals will retain the enhanced OPPS reduction factor for reimbursement.

When service coverage/reimbursement methodology differences exist between Medicare and Medicaid, Medicaid fee schedules are utilized. 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 October 1, 2022.

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.

TN NO.: 14-013

Approval Date: OCT 6, 2014

Effective Date: 07/01/2014

Supersedes
TN No.: 10-04

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)

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.

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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)***

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.”

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State of MICHIGAN

***Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)***

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State of MICHIGAN

***Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)***

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State of MICHIGAN

***Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)***

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State of MICHIGAN

***Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)***

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State of MICHIGAN

***Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)***

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State of MICHIGAN

***Policy and Methods for Establishing Payment Rates
(Other than Inpatient Hospital and Long Term Care Facilities)***

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

POLICY AND METHOD FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)

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:

<u>Fiscal Year Ending</u>	<u>Inflation Factor</u>
12/31/98	1.083
3/31/99	1.077
6/30/99	1.070

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

POLICY AND METHOD FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)

9/30/99

1.064

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

$$\text{Hospital's Distribution} = \frac{\text{Hospital's Costs}}{\Sigma \text{Hospital's Costs}} \times \$4,700,000$$

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

**POLICY AND METHOD FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)**

$$\text{Hospital's Distribution} = \frac{\text{Hospital's Costs}}{\Sigma \text{Hospital's Costs}} \times \$9,300,000$$

Title XIX = Medicaid

CC Ratio = 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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

**POLICY AND METHOD FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)**

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:

<u>Fiscal Year Ending</u>	<u>Inflation Factor</u>
12/31/99	1.042
3/31/00	1.030
6/30/00	1.016
9/30/00	1.000

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

$$\text{Hospital's Distribution} = \frac{\text{Hospital's Costs}}{\sum \text{Hospitals' Costs}} \times \$5,604,400$$

Title XIX FFS = Medicaid fee-for-service

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 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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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)***

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

Hospital's Distribution = $\frac{\text{Hospital's Costs}}{\sum \text{Hospitals' Costs}}$ X \$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

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)***

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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Methods and Standards for Establishing Payment Rates (Other than Hospital and Long Term Care Facilities)

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

**POLICY AND METHOD FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)**

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.

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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)***

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 October 1, 2023, may be found at www.michigan.gov/medicaidproviders .

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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)***

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.

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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)

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 October 1, 2024. 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.

Non-Sterile Gloves

The state Medicaid non-sterile gloves rate was set October 1, 2024. 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. The Michigan Medicaid fee schedule, effective for services rendered on or after October 1, 2024, is available 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.

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)***

5. Rural Health Clinic Services

RHCs will be reimbursed using the methodologies described below:

- (a) An RHC that is not reimbursed under (b) below will be reimbursed based on the Medicaid prospective payment system (PPS) as described in Section 1902(bb) of the Social Security Act. 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 PPS per visit amount will be adjusted each year using the Medicare Economic Index.

The PPS 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 PPS 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. The cost settlement process will commence five months after the RHC's fiscal year end.

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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)***

5. Rural Health Clinic Services (continued)

- (b) Effective August 1, 2017, an RHC may agree in writing, through a memorandum of understanding, to be reimbursed under an alternate payment methodology (APM) for the following services:

- Endometrial ablation (all methods)
- Hysteroscopy and colposcopy procedures
- Post-partum care
- Insertion and removal of non-biodegradable drug delivery implant

RHCs will be reimbursed according to the payment methodology described under individual practitioner services, Attachment 4.19-B, for the services above.

Reimbursement under the above methodology will be greater than or equal to the RHC's PPS rate to ensure compliance with Section 1902(bb)(6)(B) of the act.

NEWLY CREATED RHCS

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. In subsequent fiscal years, the newly established RHC shall be reimbursed using (a) or (b), described above.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

**POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)**

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:

<u>FYE</u>	<u>Inflation Factor</u>
12/31/97	1.081
3/31/98	1.074
6/30/98	1.065
9/30/98	1.056

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)*

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Supersedes TN No. <u>NEW PAGE</u>			
Supersedes TN No. <u>NEW PAGE</u>			

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

**POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)**

CC Ratio = Hospital's outpatient operating cost-to-charge ratio
Hospital Costs = Hospital Charges x CC Ratio x Inflation Factor
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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TN No. new page

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)***

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

Hearing Aid Device Reimbursement Methodology

Reimbursement rates for hearing aid devices covered via a multi-state Medicaid volume purchasing agreement are established directly with hearing aid manufacturers. 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). Providers are reimbursed and not allowed to discount or bill more than the contract established prices. Rates were set September 1, 2019.

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.

Except as otherwise noted in the 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, minus any third party payment. The provider's usual and customary charge should be the fee most frequently charged to patients.

Effective Date of Payment

The agency's fee schedule rates were set as of November 1, 2019 and are effective for hearing aid devices dispensed on and after that date. All rates are published on the Agency's website at www.michigan.gov/medicaidproviders.

Hearing Aid Service Reimbursement Methodology

Reimbursement for hearing aid related services including dispensing fees is made in accordance with Medicaid fee screens. Other State Medicaid fee screens and providers' charges were used as guidelines or reference in determining the maximum fee screen for individual services.

Except as otherwise noted in the plan, state-developed payment rates are uniform for both private and governmental providers. Reimbursement is made in accordance with Medicaid's fee screens or the provider's usual and customary charge for these services, whichever amount is less, minus any third party payment. The provider's usual and customary charge should be the fee most frequently charged to patients.

Effective Date of Payment

The agency's fee schedule was set as of February 1, 2023 and is effective for hearing aid services rendered on and after that date. All rates are published on the Agency's website at www.michigan.gov/medicaidproviders.

2.) Cochlear Implant Services

Payment rates for services related to cochlear implants are established utilizing the methodology described under physician services on Attachment 4.19-B Page 1. The agency's fee schedule rate was set as of 10/1/2023 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.

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.) Prosthetic Limbs, Orthotic Braces and Shoes

Prosthetic Limbs, orthotic braces and shoes reimbursement methodology is 74% of the annual Medicare rates. Except as otherwise noted in the state plan, Michigan's Medicaid payment rates are uniform for both private and governmental providers. Providers are reimbursed the lesser of the Medicaid payment rate or the provider's usual and customary charge minus any third-party payment. The provider's usual and customary charge is the fee most frequently charged to patients. This reimbursement methodology applies to services rendered on and after October 1, 2024. All rates are published at www.michigan.gov/medicaidproviders.

A. 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.

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)***

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. The case manager is permitted to authorize services up to a specified level. For cases exceeding the specified level, decisions are referred to the single state agency to consider the documented need.

Unless otherwise noted, state-developed fee schedule rates are uniform for private and governmental providers of personal care services provided in a beneficiary's own home or his/her place of employment. A rate increase for all providers is effective October 1, 2024. The Michigan Medicaid fee schedule effective for dates of service on or after November 1, 2024, may be found at www.michigan.gov/medicaidproviders.

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 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 specialized waiver 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.

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)

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.
- F.** Reimbursement for Targeted Group G case management services will be on a fee-for-service basis. The case management services are reimbursed separate from the prospective payment system for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics and separate from the all-inclusive rate reimbursement methodology for Tribal FQHCs and Tribal Health Centers. 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 1, 2023, may be found at www.michigan.gov/medicaidproviders.
- G.** Reimbursement for Targeted Group H 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 October 1, 2024, may be found 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)***

9. Case Management Services Continued

- H. Reimbursement for Targeted Group I 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 October 1, 2024, may be found 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)***

9. Case Management Services Continued

- I. Reimbursement for Targeted Group J 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 September 1, 2024, may be found 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****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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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**

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.

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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***

11. Maternal Infant Health Program

Reimbursement for Maternal Infant Health Program Services will be the lesser of the provider's charge or Program fee screens 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 October 1, 2019 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 .

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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***

12. Medical care furnished by licensed practitioners within the scope of their practice as defined by state law.

Providers are reimbursed the lesser of the Medicaid payment rate or the provider's usual and customary charge minus any third-party payment. The provider's usual and customary charge is the fee most frequently charged to patients. The payment rate is uniform for private and governmental providers.

A. Certified Registered Nurse Anesthetists (CRNAs)

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of CRNA services. Payment rates are established utilizing the methodology described for physician services. 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 payment rates are the same for both governmental and private providers of chiropractor services. Payment rates are established utilizing the methodology described for physician services. 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 payment rates are the same for both governmental and private providers of podiatrist services. Payment rates are established utilizing the methodology described for physician services. All rates are published on the Agency's website at www.michigan.gov/medicaidproviders.

D. Optometrists

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of optometrist services. Payment rates are established utilizing the methodology described for physician services. 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 payment rates are the same for both governmental and private providers of pharmacy services. Payment rates were set as of 4/1/2017 and are 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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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

F. Registered/Licensed Dental Hygienists (RDHs)

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of dental hygiene services. The payment rate methodology is effective for dates of service on or after October 1, 2010. All rates are published on the agency's website at www.michigan.gov/medicaidproviders.

G. Psychologists

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of behavioral health services. Payment rates are 90% of the rate established utilizing the methodology described for physician services on Attachment 4.19-B Page 1. This reimbursement methodology applies to services rendered on and after the day after October 1, 2024. All rates are published on the Agency's website at www.michigan.gov/medicaidproviders.

H. Social Workers

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of behavioral health services. Payment rates are 90% of the rate established utilizing the methodology described for physician services on Attachment 4.19-B Page 1. This reimbursement methodology applies to services rendered on and after the day after October 1, 2024. All rates are published on the Agency's website at www.michigan.gov/medicaidproviders.

I. Professional Counselors

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of behavioral health services. Payment rates are 90% of the rate established utilizing the methodology described for physician services on Attachment 4.19-B Page 1. This reimbursement methodology applies to services rendered on and after the day after October 1, 2024. All rates are published on the Agency's website at www.michigan.gov/medicaidproviders.

J. Marriage and Family Therapists

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of behavioral health services. Payment rates are 90% of the rate established utilizing the methodology described for physician services on Attachment 4.19-B Page 1. This reimbursement methodology applies to services rendered on and after the day after October 1, 2024. All rates are published on the Agency's website 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***

K. Certified Nurse Practitioners (CNP)

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of np services. Payment rates are established utilizing the methodology described for physician services. All rates are published on the Agency's website at www.michigan.gov/medicaidproviders.

L. Certified Clinical Nurse Specialists (CNS)

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of CNS services. Payment rates are established utilizing the methodology described for physician services. All rates are published on the Agency's website at www.michigan.gov/medicaidproviders.

M. Certified Nurse Midwives (CMN)

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of CNM services. Payment rates are established utilizing the methodology described for physician services. All rates are published on the Agency's website at www.michigan.gov/medicaidproviders.

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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***

N. Genetic Counseling Services

Except as otherwise noted in the plan, state-developed payment rates are the same for both governmental and private providers of genetic counseling services. Rates are established utilizing the same methodology described for physician services located in Attachment 4.19-B Page 1. The agency's fee schedule rate was set as of 11/1/2021 and are 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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TN No.: NEW

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***

12.1 Physical Therapy and Related Services

A. Physical therapists

Except as otherwise specified in the State Plan, payment rates are established utilizing the following methodology:

- Cognitive therapy: Medicare's January National Physician Fee Schedule Relative Value File values multiplied by the statewide conversion factor of \$26.20.
- All other services and procedures: Methodology described for physician services located in Attachment 4.19-B Page 1.

State-developed payment rates are uniform for both private and governmental providers. Reimbursement is made in accordance with Medicaid's fee screens or the provider's usual and customary charge for these services, whichever amount is less, minus any third-party payment. The provider's usual and customary charge is the fee most frequently charged to patients.

This reimbursement methodology applies to services rendered on or after 10/1/2024. All Medicaid fee schedule rates are published at www.michigan.gov/medicaidproviders

B. Occupational therapists

Except as otherwise specified in the State Plan, payment rates are established utilizing the following methodology:

- Cognitive therapy: Medicare's January National Physician Fee Schedule Relative Value File values multiplied by the statewide conversion factor of \$26.20.
- All other services and procedures: Methodology described for physician services located in Attachment 4.19-B Page 1.

State-developed payment rates are uniform for both private and governmental providers. Reimbursement is made in accordance with Medicaid's fee screens or the provider's usual and customary charge for these services, whichever amount is less, minus any third-party payment. The provider's usual and customary charge is the fee most frequently charged to patients.

This reimbursement methodology applies to services rendered on or after 10/1/2024. All Medicaid fee schedule 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***

C. Speech-language pathologists

Except as otherwise specified in the State Plan, payment rates are established utilizing the following methodology:

- Cognitive therapy: Medicare's January National Physician Fee Schedule Relative Value File values multiplied by the statewide conversion factor of \$26.20.
- All other services and procedures: Methodology described for physician services located in Attachment 4.19-B Page 1.

State-developed payment rates are uniform for both private and governmental providers. Reimbursement is made in accordance with Medicaid's fee screens or the provider's usual and customary charge for these services, whichever amount is less, minus any third-party payment. The provider's usual and customary charge is the fee most frequently charged to patients.

This reimbursement methodology applies to services rendered on or after 10/1/2024. All Medicaid fee schedule rates are published 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. Payment rates are established utilizing the methodology described under physician services. If there is no applicable rate established by this methodology, the state utilizes the rate specified in a fee schedule. The agency's fee schedule rate was set as of 1/1/2020 and is effective for dates of service on or after that date. All rates are published on the agency's website at www.michigan.gov/medicaidproviders.

STATE PLAN UNDER TITEL XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(OTHER THAN INPATIENT HOSPITAL AND LONG TERM CARE FACILITIES)

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 or 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 or the established fee screen. Preliminary fee screens are adjusted to final once each year.

Supersedes
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Supersedes
TN No. 93-22

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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***

13. Rehabilitation Services**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.

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.

g. Peer-Delivered or -Operated Support Services

Peer-Delivered or -Operated Support Services, furnished by enrolled providers or provider agencies, shall be reimbursed on a direct service by service basis and billed in 15 minute units. 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 is effective for dates of service on or after October 1, 2019 and may be found at www.michigan.gov/medicaidproviders.

Note: Page 6b has been deleted. The next page is 6c.

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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)

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.

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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)***

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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TN No.: 01-04

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)***

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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Supersedes ~~TN No. 11-04~~
Supersedes ~~TN No. 11-04~~
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

**POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
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.

Superseded
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Superseded
TN No. 91-02

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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)***

16. Other Services (continued)

Vaccinations –

Effective for services provided on or after October 1, 2022, 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 October 1, 2022, may be found at www.michigan.gov/medicaidproviders.

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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)***

16. Other Services (continued)

COVID-19 Vaccines Administration Services

The reimbursement for COVID-19 vaccine administration services is 100% of Medicare rates for equivalent services. These services will be reimbursed at the lesser of the Medicaid fee screens or the provider's usual and customary charge minus any third-party payment. Except as otherwise noted in the state plan, Michigan Medicaid's payment rates are uniform for both private and governmental providers.

Effective Date of Payment

This reimbursement methodology applies to services rendered on and after the day after the PHE ends. All Medicaid fee schedule 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)***

16. Other Services (continued)

Michigan Medicaid Diabetes Prevention Program (MiDPP)

The reimbursement for MiDPP services is 100% of Medicare rates for equivalent services. These services will be reimbursed at the lesser of the Medicaid fee screens or the provider's usual and customary charge minus any third-party payment. Except as otherwise noted in the state plan, Michigan Medicaid's payment rates are uniform for both private and governmental providers. All rates are published on the Agency's website 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)***

16. Other Services (continued)

Preventive Services - Community Health Worker Services

Community health worker services will be on a fee-for- service basis. Community health worker services are reimbursed separate from the prospective payment system for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics and separate from the all-inclusive rate reimbursement methodology for Tribal FQHCs and Tribal Health Centers. 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 January 1, 2024, may be found at www.michigan.gov/medicaidproviders.

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

STATE MICHIGAN

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item 14 . Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient co-payment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual		Medicare-Medicaid/QMB Individual		Medicare-QMB Individual	
Part A Deductible	<u>X</u>	limited to State plan rates*	<u>X</u>	limited to State plan rates*	<u>X</u>	limited to State plan rates*
	<u> </u>	full amount	<u> </u>	full amount	<u> </u>	full amount
Part A Coinsurance	<u>X</u>	limited to State plan rates*	<u>X</u>	limited to State plan rates*	<u>X</u>	limited to State plan rates*
	<u> </u>	full amount	<u> </u>	full amount	<u> </u>	full amount
Part B Deductible	<u>X</u>	limited to State plan rates*	<u>X</u>	limited to State plan rates*	<u>X</u>	limited to State plan rates*
	<u> </u>	full amount	<u> </u>	full amount	<u> </u>	full amount
Part B Coinsurance	<u>X</u>	limited to State plan rates*	<u>X</u>	limited to State plan rates*	<u>X</u>	limited to State plan rates*
	<u> </u>	full amount	<u> </u>	full amount	<u> </u>	full amount

*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 4.19-B, Exhibit 3.2-A, page 1a.

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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)

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 October 1, 2024 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.

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)***

17 (Continued).

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, 2023, 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.

The Behavioral Health Treatment-Applied Behavior Analysis service reimbursement rate for CPT procedure code 97153 is a state directed payment of not less than \$16.50/unit (\$66.00/hour). This reimbursement methodology applies to services rendered on and after November 1, 2024. All rates are published at www.michigan.gov/medicaidproviders.

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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)***

17 (EPSDT Continued).

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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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)***

17 (EPSDT Continued).

Parent Support Partner Services

Parent Support Partner Services furnished by certified providers or provider agencies, shall be reimbursed on a direct service by service basis and billed by encounter. 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 is effective for dates of service on or after October 1, 2024, and may be found at www.michigan.gov/medicaidproviders.

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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 Hospital and Long Term Care Facilities)

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 four options. In addition, a Tribal 638 Facility Pharmacy would be reimbursed under Option 5.

Option 1: Fee-For-Service

If the Tribal 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 for FQHC services as established in State Plan Attachment 4.19-B, Item 14. Payments must comply with all requirements set forth within State Plan Attachment 4.19-B, Item 14.

Option 3: All-Inclusive Rate Payment Methodology

The Indian Health Service (IHS) per visit outpatient rate will be reimbursed in accordance with the rate published annually in the federal register. As a Tribal 638 facility, the IHC may, in accordance with the Federal Regulations, receive the IHS per visit outpatient rate when FQHC services are provided to Medicaid beneficiaries by IHC providers during a visit.

A visit is a 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 medical visit, one dental visit, and one behavioral health visit with a given beneficiary per day, except when the beneficiary, after the first visit, suffers illness or injury requiring additional diagnosis or treatment.

Option 4: Tribal FQHC Alternative Payment Methodology

A Tribal 638 facility that operates as a Tribal FQHC will be reimbursed for outpatient visits within the FQHC scope of services provided to Medicaid beneficiaries using an alternative payment methodology (APM). The agency allows reimbursement for the same outpatient services and the same number of encounters per day that Tribal 638 facilities provide under this State Plan. The APM is the IHS per visit outpatient rate published annually in the federal register as described in Option 3 above.

A visit is a contact between a Medicaid beneficiary and the tribal FQHC 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 medical visit, one dental visit, and one behavioral health visit with a given beneficiary per day, except when the beneficiary, after the first visit, suffers illness or injury requiring additional diagnosis or treatment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

The APM results in payment of at least the FQHC PPS. The health centers receiving payment under the APM individually agree to receive it.

Option 5: Tribal 638 Facility Pharmacy Methodology

Prescriptions dispensed by a Tribal 638 Facility Pharmacy constitute a separate encounter per prescription and are reimbursed as described in Attachment 4.19-B, Page 1d - Drug Product Reimbursement.

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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***

19. Dental Services

Program fee screens are set at the average commercial rate for Medicaid Dental Services. The average commercial rate is determined by MDHHS staff through information supplied by commercial dental insurers. If this information is not available from commercial carriers, MDHHS will utilize other sources to determine the rate such as a comparison to similar codes, cost analyses of the particular service, or Medicare information if available. Dental Services fee schedule rates were set as of January 1, 2023 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.

Providers are reimbursed the lesser of the Medicaid payment rate or the provider's usual and customary charge minus any third party payment. The provider's usual and customary charge is the fee most frequently charged to patients. The payment rate is uniform for private and governmental providers.

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)***

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.

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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)

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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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)***

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 monthly to the ISDs.

Services include: Occupational Therapy, Physical Therapy, Speech Language and Hearing, Psychological, Physician, Nursing, Personal Care, Targeted Case Management, Rehabilitative and Transportation and the Services of Licensed Practitioners within their scope of practice. Descriptions of each service and licensed practitioners are included on the corresponding Supplement to Attachment 3.1-A section of this State Plan.

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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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. Medicaid allowable costs are reported on the annual Local Education Agency (LEA) cost report. 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 Medicaid 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 methodologies:

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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)**Special Education Medicaid Eligibility Rate**

- 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 Health and Human Services (MDHHS).
- MDHHS 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.

General Education Medicaid Eligibility Rate

- Using the fall general collection student count data, a file containing the names and birthdates of general education students within the ISD is transmitted to the Michigan Department of Health and Human Services (MDHHS).
- MDHHS uses this list to run an eligibility match process against the Medicaid eligibility system. The ratio of the total number of Medicaid eligible students to the total number of students 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. The costs from step 4 are then divided by the total number of Special Education one-way trips to get a Special Education per trip rate.
6. The special education per trip rate is then multiplied by the number OF Medicaid eligible one-way trips to get the total cost for Medicaid eligible specialized transportation. Medicaid eligible transportation is defined as transportation provided to a beneficiary with an IEP/IFSP requiring specialized transportation and receiving a medical service on that date.

C. Annual Reconciliation and Cost Settlement Process Health-related services cost reconciliation and settlement:
 Within six months after the end of the school fiscal year, the ISDs submit the annual LEA cost report to the Michigan Department of Health and Human Services (MDHHS) This filed cost report is used by

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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)***

MDHHS to calculate an interim payment for the following year. Within nine months after the end of the school fiscal year, the filed cost reports are reviewed by MDHHS and an initial settlement is issued. The initial settlement is calculated within three months of the receipt of the finalized cost reports and may result in either an additional payment or recovery of funds.

MDHHS completes the Medicaid Cost Settlement Summary data sheet and Cost Certification form and forwards to the ISDs for approval and signature within 15 months after the end of the school fiscal year. The final cost settlement is processed two months 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 MDHHS within the first one month after receipt of the Cost Settlement Summary. Any discrepancies must be resolved within the three months 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 6) by the number of "allowable" one-way trips 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. Personal care services provided on the bus are not qualifying services for the purpose of trip count.

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:

Two months 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 MDHHS prior to the final settlement.

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Supersedes

TN No.: 07-03

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)

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.

TN NO.: 16-0006

Approval Date: **NOV 9, 2016**

Effective Date: 01/01/2016

Supersedes

TN No.: 15-0003

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)***

24a.1. Non-Emergency Medical Transportation (NEMT)

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of NEMT services. The Agency's fee schedule rates were originally set August 1, 2018. The current fee schedule is located at www.michigan.gov/medicaidproviders and is effective for services provided on or after October 1, 2018.

TN NO.: 18-0008

Approval Date: DEC 19, 2018

Effective Date: 10/01/2018

Supersedes

TN No.: 16-0006

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)***

RESERVED

TN NO.: 21-0005

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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)***

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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)***

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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***

29. Medication-Assisted Treatment (MAT)

A. Unbundled Drug Reimbursement

1. The State will cover all forms of drugs and biologicals that the Food and Drug Administration has approved or licensed for MAT to treat opioid use disorder (OUD).
2. The reimbursement for unbundled prescribed drugs and biologicals used to treat opioid use disorder will be reimbursed using the same methodology as described for drug product reimbursement on Attachment 4.19-B (2), Pages 1c and 1d, for drugs that are dispensed or administered.
3. Payment for unbundled office-based opioid treatment services provided by practitioners not associated with a PIHP or MCO will be reimbursed per the methodology in Attachment 4.19-B, Page 1.

B. Bundled Methadone Administration and Service Rate

Payment for bundled Methadone administration and service rate will be made at a set per unit amount as determined by a minimum fee schedule. The Michigan Medicaid fee schedule is effective for dates of service on or after October 1, 2024, and may be found at www.michigan.gov/medicaidproviders.

C. Opioid Treatment Program (OTP)

- a. The State will cover all forms of drugs and biologicals that the FDA has approved or licensed for MAT to treat OUD.
- b. Payment for unbundled OTP Provider services are reimbursed on a direct service by service basis and billed in 15 minute units. 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 is effective for dates of service on or after October 1, 2020 and may be found 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)

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. Effective State FY 2021, eligibility for the rural access pool is limited to non-critical access hospitals. 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.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input type="checkbox"/>	HCBS Case Management	
<input type="checkbox"/>	HCBS Homemaker	
<input type="checkbox"/>	HCBS Home Health Aide	
<input checked="" type="checkbox"/>	HCBS Personal Care	Effective 10/1/2018, the state uses the same reimbursement rates for HCBS Personal Care as is used for the State Plan Personal Care Option on Item #7 Person Care Services option of Attachment 4.19-B. This service is prior authorized based upon a review of the person-centered service plan and the individual's assessed needs. Michigan uses HCPCS code T1019, Personal care services per 15 minutes for this service. The reimbursement rate depends on whether the provider is an individual or an agency and the participant's county of residence. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of HCBS Personal Care services.
<input type="checkbox"/>	HCBS Adult Day Health	
<input type="checkbox"/>	HCBS Habilitation	
<input type="checkbox"/>	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
	<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
	<input type="checkbox"/>	HCBS Psychosocial Rehabilitation
	<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)
<input checked="" type="checkbox"/>	Other Services (specify below)	

✓	Transition Navigator Case Management Services Michigan has been providing nursing facility transition services officially since January 1, 2005. Historically, these services have been State funded, or a service available through a HCBS waiver. MDHHS developed rates based upon the historical use and payment for these services, while considering factors such as overhead, non-labor costs, and inflation. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Community Transition services. The Agency's fee schedule rate was set as of 2/1/2024 and is effective for services provided on or after that date. All rates are published on the Agency's website at http://www.michigan.gov/medicaidproviders
✓	Community Transition services Michigan has been providing Community Transition services officially since January 1, 2005. Historically, these services have been State funded, or a service available through a HCBS waiver. MDHHS developed rates based upon the historical use and payment for these services, while considering factors such as overhead, non-labor costs, and inflation. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of NFT services. The Agency's fee schedule rate was set as of 10/1/2018, and list revised on 10/1/22, and is effective for services provided on or after that date. All rates are published on the Agency's website at http://www.michigan.gov/medicaidproviders
✓	Non-Medical (Non-Emergency) Transportation (NENMT) Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of NENMT services. The Agency's fee schedule rate was set as of 10/1/2018, is revised to correspond with the agency's NEMT fee schedule and is effective for services provided on or after the effective date of any changes. All rates are published on the Agency's website at http://www.michigan.gov/medicaidproviders
✓	Home Modifications Michigan has not established a reimbursement structure for this service as the cost of this service is subject to wide variation based upon the type of modification needed. MDHHS requires prior authorization of all home modifications and approves reimbursement on a case-by-case basis. For this service to be approved, the transition navigator must submit at least one bid from a qualified provider that describes the modification, how that modification meets the service definition, the cost of building and other materials needed, and the expected labor costs. Smaller items (such as environmental controls) are reimbursed at cost for the item purchased plus the cost of installation. The transition navigator must provide proof of the cost of the item and labor/installation costs prior to approval.

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input type="checkbox"/>	HCBS Case Management
<input type="checkbox"/>	HCBS Homemaker
<input type="checkbox"/>	HCBS Home Health Aide
<input type="checkbox"/>	HCBS Personal Care
<input type="checkbox"/>	HCBS Adult Day Health
<input checked="" type="checkbox"/>	HCBS Habilitation Community Living Supports Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
<input checked="" type="checkbox"/>	HCBS Respite Care Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
For Individuals with Chronic Mental Illness, the following services:	
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)
<input checked="" type="checkbox"/>	Other Services (specify below)
	The 1915(i) is being implemented concurrent with an 1115 authority for managed care. Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for all the 1915 (i) HCBS's. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).

<input checked="" type="checkbox"/>	Environmental Modifications Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c). Michigan has not established a reimbursement structure for this service as the cost of this service is subject to wide variation based upon the type of modification needed. MDHHS will require PIHP prior authorization of all home modifications in accordance with established policy.
<input checked="" type="checkbox"/>	Enhanced Pharmacy Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
<input checked="" type="checkbox"/>	Family Support & Training Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
<input checked="" type="checkbox"/>	Fiscal Intermediary Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
<input checked="" type="checkbox"/>	Housing Assistance Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
<input checked="" type="checkbox"/>	Skill-Building Assistance Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
<input checked="" type="checkbox"/>	Specialized Medical Equipment & Supplies Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c). Michigan has not established a reimbursement structure for this service as the cost of this service is subject to wide variation based upon the type of equipment and supplies needed. MDHHS will require PIHP prior authorization of all equipment and supplies.
<input checked="" type="checkbox"/>	Supported/Integrated Employment Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
<input checked="" type="checkbox"/>	Vehicle Modification Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c). Michigan has not established a reimbursement structure for this service as the cost of this service is subject to wide variation based upon the type of modification needed. MDHHS will require PIHP prior authorization of all vehicle modification according to established policy.

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)***

RESERVED

TN NO.: 21-0005

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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).

QMBs:	Part A <u>SP</u> Deductibles	<u>SP</u> Coinsurance
	Part B <u>SP</u> Deductibles	<u>SP</u> Coinsurance

Other Medicaid Recipients:	Part A <u>SP</u> Deductibles	<u>SP</u> Coinsurance
	Part B <u>SP</u> Deductibles	<u>SP</u> Coinsurance

Dual Eligibles (QMB) Plus):	Part A <u>SP</u> Deductibles	<u>SP</u> Coinsurance
	Part B <u>SP</u> Deductibles	<u>SP</u> Coinsurance

TN NO. <u>97-024</u>	Approval Date <u>2/26/98</u>	Effective Date <u>10-01-97</u>
Supersedes TN No. <u>96-17</u>		

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)

Supplement 1 to ATTACHMENT 4.19-B
Page 3
OMB No.: 0938-

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

TN No. 92-05
Supersedes N/A Approval Date 04-14-92 Effective Date 10-01-91
TN No. N/A

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

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**

A.B. HOSPITAL LEAVE DAYS - payment is subject to the following condition:

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.

TN NO.: 05-11

Approval Date: **MAR 15 2006**Effective Date: 04-01-05

Supersedes

TN No.: 05-07

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

The State has in place a public process which complies with the requirement of Section 1902(a)(13)(A) of the Social Security Act.

TN NO. 97-22 Approval Date 5-7-99 Effective Date 10-01-97

Supersedes

TN No. ~~NA~~ 98-04 BAH

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(LONG TERM CARE FACILITIES)***

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 if the cost report is not submitted within the timeframes established by MDHHS, 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.) Beginning October 1, 2024, if an annual cost report is not received within the timeframes established by MDHHS, a late-file penalty will be assessed beginning on the 15th day of the following month and will continue until a complete and acceptable cost report is received. This includes providers with low or no Medicaid utilization that are required to provide a less than complete cost report or census data. This penalty does not apply to Class VII facilities.
- 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.

TN NO.: 17-0009

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Effective Date: 10/01/2017

Supersedes
TN No.: 05-11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(LONG TERM CARE FACILITIES)***

II. Auditing and Availability of Records

- A. Each cost report submitted is verified for completeness, accuracy, reasonableness, and consistency through a desk audit, an on site audit, or a computer check. The state agency shall ensure an audit of a cost report is completed no later than 21 months after final acceptance of a cost report, a cost report that is not audited within 21 months shall be accepted as filed.

For desk audits or on site audits, the audit sampling methodology will employ either a statistical sampling methodology, a non-statistical sampling methodology or a combination of methodologies.

- B. Each provider must allow access, during audits or reviews by the state agency auditors or their designees and representatives of the United State Department of Health and Human Services, to requisite records and statistical data specified in Section I of this plan. This access will include, but is not limited to:

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).
3. Any records required by the Medicare Principles of Reimbursement, federal laws or regulations, state law, or the state agency's policies.
4. Census records and numbers and types of leave days for each Medicaid beneficiary/resident (i.e. hospital, therapeutic).

During an audit or review, providers must submit records within the time frames determined by the state agency.

- 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 if necessary will retroactively change a previously applied rate. If a statistical sampling methodology was used for an audit, then the audit adjustments may be determined using extrapolation methods. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

III. Allowable Cost Identification

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 multipatient 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

TN NO.: 05-11

Approval Date: MAR 15 2006

Effective Date: 4-1-2005

Supersedes

TN No.: 93-04

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.

TN NO.: 11-12

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Effective Date: 01/01/2012

Supersedes
TN No.: 08-04

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 1. Subsequent to sales, the depreciation basis will be held subject to the limitation on the revaluation of assets mandated by section 1861(v)(1)(O) 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 1, 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 1. 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 either principle 1 or 2 in concurrence with principle 3 below:
1. For Class I and Class II facilities, reimbursement 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 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.

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. 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.
 3. For loans issued on or after October 1, 2019, interest on loans, to be allowable, must reflect a principal balance payment on at least an annual basis if the loan is greater than four years old. For loans issued prior to October 1, 2019, interest on loans, to be allowable, must reflect a principal balance payment on at least an annual basis starting on October 1, 2023. As of October 1, 2024 the minimum payment amount on the principal balance or a payment amount totaling at least 0.1 percent of the total outstanding loan balance, whichever is greater, must be made at least annually for any loan that has a loan period of greater than four years and was issued on or after October 1, 2019 in order for the interest to be an allowable expense. Refinancing of a loan or refinancing of multiple loans is not considered a principal balance payment, nor is a refinanced loan considered a new loan for purposes of this section.
- 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.
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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)***

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- 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).

TN NO.: 05-11

Approval Date: MAR 15 2006

Effective Date: 04-01-2005

Supersedes
TN No.: 90-34

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Michigan

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(LONG TERM CARE FACILITIES)

- 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.

TN No. 93-15 Approval Date 5-20-94 Effective Date 06/10/93

Supersedes

TN No. 90-34

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.

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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)

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 July 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.

TN No. 90-34 Approval Date 03-27-92 Effective Date 10-01-90

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 Medicaid certification under the current ownership 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.
 - b. The current asset value is determined by a formula using historical costs of capital assets times the difference between and inflationary index and an obsolescence factor. Assets purchased prior to 1960 will be treated as if they were brought into service in 1960.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Michigan

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(LONG-TERM-CARE FACILITIES)

- 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.

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Supersedes

TN No. 88-12

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 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 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 on the rolling 15-year history of new construction. The current asset value limit is the sum of the updated historical costs for the facilities included in this calculation divided by the total number of beds in those facilities. The current asset value limit is recalculated annually to include construction costs of new facilities reported on the most recent calendar year filed cost report and the construction index update. The increase in the current asset value bed limit shall not exceed 4% of the limit for the fiscal year beginning October 1, 2019. The per bed upper limit is effective for the period corresponding to the State Fiscal year.
- d. The current asset value floor is determined as 30 percent of the current asset value upper limit.

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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)***

5. Special Provisions: The plan 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 plan cost basis upon which to determine rates or rates are determined by different methods.

- a. Plant Cost Certifications: Such providers are required to certify and submit to the single State agency their expected allowable costs (in accordance with Medicare Principles of Reimbursement as modified by Section III) for interest expense, property taxes, leases, and historical asset acquisition costs prior to the cost reporting period filing deadline and meet the qualifications in order to receive an interim reimbursement rate. 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

- 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

- c. 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.
- 8. Special Note for October 1, 2021 through September 30, 2022: Due to the COVID-19 Public Health Emergency, the Plant Cost Component for Class I facilities will be calculated by applying an average cost increase to the facility's Plant Cost Component from the most recent fiscal year that was non-affected by the COVID-19 Public Health Emergency. The cost increase will be calculated using the average class-wide increase over the previous 5 fiscal years that were non-affected by the COVID-19 Public Health Emergency.
- 9. Special Note for October 1, 2022 through December 31, 2022: Due to the COVID-19 Public Health Emergency, the Plant Cost Component for Class I facilities will be calculated by applying an average cost increase to the facility's Plant Cost Component from the most recent fiscal year that was non-affected by the COVID-19 Public Health Emergency. The cost increase will be calculated using the average class-wide increase over the previous 5 fiscal years that were non-affected by the COVID-19 Public Health Emergency.

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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)***

10. Special Note for January 1, 2023 to September 30, 2023, MDHHS will temporarily increase the Nursing Facility interim Plant Cost Component by 4.55%. This component is calculated by taking the Nursing Facility's previously calculated FY 2022 interim Plant Cost Component and increasing it by 4.55%.

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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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 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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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. 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 required to certify and submit to the state agency their expected plant costs prior to the cost reporting period filing deadline and meet the qualifications in order to receive an interim reimbursement rate. The State agency will use the certified expected dollar value or plant costs, when approved, in calculating the prospective rate, pending audit. 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 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 regulation 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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.

5. Special Note for October 1, 2021 through September 30, 2022: Due to the COVID-19 Public Health Emergency, the Plant Cost Component for Class III facilities will be calculated by applying an average cost increase to the facility's Plant Cost Component from the most recent fiscal year that was non-affected by the COVID-19 Public Health Emergency. The cost increase will be calculated using the average class-wide increase over the previous 5 fiscal years that were non-affected by the COVID-19 Public Health Emergency.

6. Special Note for October 1, 2022 through December 31, 2022: Due to the COVID-19 Public Health Emergency, the Plant Cost Component for Class III facilities will be calculated by applying an average cost increase to the facility's Plant Cost Component from the most recent fiscal year that was non-affected by the COVID-19 Public Health Emergency. The cost increase will be calculated using the average class-wide increase over the previous 5 fiscal years that were non-affected by the COVID-19 Public Health Emergency.

7. Special Note for January 1, 2023 to September 30, 2023, MDHHS will temporarily increase the Nursing Facility interim Plant Cost Component by 4.55%. This component is calculated by taking the Nursing Facility's previously calculated FY 2022 interim Plant Cost Component and increasing it by 4.55%.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

C. Variable Cost Component

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 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

C. Variable Cost Component

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 item: 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.

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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)***

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.

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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)***

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

- c. 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.

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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)***

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State of MICHIGAN

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

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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)***

C. Variable Cost Component

4. RESERVED

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

- a. New Facility: A "new facility" which is defined as a long term care provider in a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

C. Variable Cost Component

5. Special Provisions:

a. New Facility (continued):

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

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

c. Payment Determination:

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

6. Effective 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%.

7. Special Note for October 1, 2021 through September 30, 2022: Due to the COVID-19 Public Health Emergency, the Variable Cost Component for Class I and Class III facilities will be calculated by applying an average cost increase to the facility's Variable Cost Component from the most recent fiscal year that was non-affected by the COVID-19 Public Health Emergency. The cost increase will be calculated using the average class-wide increase over the previous 5 fiscal years that were non-affected by the COVID-19 Public Health Emergency.

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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)***

8. Special Note for October 1, 2022 through December 31, 2022: Due to the COVID-19 Public Health Emergency, the Variable Cost Component for Class I and Class III facilities will be calculated by applying an average cost increase to the facility's Variable Cost Component from the most recent fiscal year that was non-affected by the COVID-19 Public Health Emergency. The cost increase will be calculated using the average class-wide increase over the previous 5 fiscal years that were non-affected by the COVID-19 Public Health Emergency.
9. Special Note for January 1, 2023 to September 30, 2023, MDHHS will temporarily increase the Nursing Facility interim Variable Cost Component by 4.55%. This component is calculated by taking the Nursing Facility's previously calculated FY 2022 interim Variable Cost Component and increasing it by 4.55%.

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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)***

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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

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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)***

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

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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)***

- inpatient hospital rate for currently placed acute care Medicaid patients who are ventilator dependent. The prospective rate shall be periodically re-evaluated (no more than annually) to ensure the reasonableness of the rate and the appropriate balance of supply and demand for special care is met.
3. The cost basis shall be determined in accordance with Section 1 through III of this plan, excluding Sections III.B., III.C. and III.D. Providers are required to maintain distinct part accounting records for all costs associated with the beds to ensure those costs are not included as a reimbursement basis in the other distinct parts of the facility.
 4. 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%.
 5. Special Note for October 1, 2021 through September 30, 2022: Due to the COVID-19 Public Health Emergency, the Variable Cost Component for non-publicly owned ventilator-dependent care units licensed as nursing facilities will be calculated by applying an average cost increase to the facility's Variable Cost Component from the most recent fiscal year that was non-affected by the COVID-19 Public Health Emergency. The cost increase will be calculated using the average class-wide increase for Class V facilities over the previous 5 fiscal years that were non-affected by the COVID-19 Public Health Emergency.
 6. Special Note for October 1, 2022 through December 31, 2022: Due to the COVID-19 Public Health Emergency, the Variable Cost Component for non-publicly owned ventilator-dependent care units licensed as nursing facilities will be calculated by applying an average cost increase to the facility's Variable Cost Component from the most recent fiscal year that was non-affected by the COVID-19 Public Health Emergency. The cost increase will be calculated using the average class-wide increase for Class V facilities over the previous 5 fiscal years that were non-affected by the COVID-19 Public Health Emergency.

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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)***

7. Special Note for January 1, 2023 to September 30, 2023, MDHHS will temporarily increase the Nursing Facility interim Variable Cost Component by 4.55%. This component is calculated by taking the Nursing Facility's previously calculated FY 2022 interim Variable Cost Component and increasing it by 4.55%.

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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.

TN NO.: 09-06

Approval Date: JAN 23 2012

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Supersedes

TN No.: N/A – new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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.

1. Final Audited Rate for October 1, 2021 through September 30, 2022

MDHHS will use the providers audited 2020 cost report to determine the plant cost and long-term asset review information that will flow forward into 2021.

MDHHS will use the providers audited 2021 cost report to determine the plant cost and long-term asset review information that will flow forward into 2022.

MDHHS will use the providers audited 2022 cost report to determine the variable cost and plant cost components that will be applied to the final normal FY22 rate formula.

If a change of ownership occurs which causes there to not be a completed and audited cost report covering at least 7 months of 2022 for the previous owner, MDHHS will use the most recent completed annual audited cost report for that owner.

2. Final Audited Rate for October 1, 2022 through September 30, 2023

MDHHS will use the providers audited 2021 cost report to determine the plant cost and long-term asset review information that will flow forward into 2022.

MDHHS will use the providers audited 2022 cost report to determine the plant cost and long-term asset review information that will flow forward into 2023.

MDHHS will use the providers audited 2023 cost report to determine the variable cost and plant cost components that will be applied to the final normal FY23 rate formula.

If a change of ownership occurs which causes there to not be a completed and audited cost report covering at least 7 months of 2023 for the previous owner, MDHHS will use the most recent completed annual audited cost report for that owner.

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Approval Date: AUG 2, 2023

Effective Date: 05/12/2023

Supersedes

TN No.: 09-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

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.

TN NO.: 17-0009

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Effective Date: 10-01-2017

Supersedes

TN No.: New Page

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) 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):
 - $\text{Monthly QMI payment} = ([\text{per-bed QMI amount}] \times [\text{Medicaid utilization scale percentage}] \times [\text{resident satisfaction survey adjustment percentage}] \times [\text{number of licensed nursing facility beds}]) / [\text{number of eligible payment months}]$

TN NO.: 17-0009

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Supersedes

TN No.: New Page

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. 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 the Patient Driven Payment Model (PDPM) to set payment rates. The Minimum Data Set (MDS) shall be employed to calculate a PDPM score which will be used to determine a patient's acuity.
2. The payment rates associated with the PDPM categories 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. $\text{Payment} = (\text{percentage} * \text{Medicare SNF PPS PDPM rate}) * \text{billed XIX days}.$
3. The patient's PDPM 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.
6. For dates of service between October 1, 2019 and December 31, 2019, State Veterans Homes may continue to be reimbursed under the Resource Utilization Group-IV (RUG-IV) for Medicaid residents with an MDS assessment with an Assessment Reference Date (ARD) prior to October 1, 2019. RUG-IV rates during this period will be set as a percentage of the fiscal year 2019 Medicare SNF PPS RUG-IV rates. Reimbursement will be set using PDPM for residents with an ARD on or after October 1, 2019, and reimbursement will be based solely on PDPM for dates of service on or after January 1, 2020.

TN NO.: 19-0005

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Supersedes

TN No.: 17-0014

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

O. Direct Care Worker Wage Increase for Personal Care Services

Beginning October 1, 2024, a direct care worker wage increase consistent with the final State fiscal year budget will be available for eligible clinical and non-clinical direct care workers providing in-person direct care for Medicaid beneficiaries in Medicaid-certified nursing facilities. This payment will apply to base hourly wages that were in effect on September 30th of the previous fiscal year and includes any associated share of employer Federal Insurance Contributions Act (FICA) payroll taxes.

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. All rates are published at www.michigan.gov/medicaidproviders.

- Eligible clinical direct care workers include: Registered nurses, licensed practical nurses, competency-evaluated nursing assistants, and respiratory therapists employed by Medicaid-certified nursing facilities.
- Eligible non-clinical workers whose costs are reported in the following job classifications in the nursing facility institutional cost reports shared with the department include: Other housekeeping, other maintenance worker, other plant operations, other laundry, dining room assistants, other dietary worker, other medical records, other social services, other diversion therapy, beauty and barber, gift, flower, coffee and canteen worker employed by Medicaid-certified nursing facilities.

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TN No.: New Page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Michigan

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(LONG-TERM-CARE FACILITIES)

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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Supersedes
TN No. 85-14

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Michigan

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(LONG-TERM-CARE FACILITIES)

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.

TN No. 90-34 Approval Date 09-27-92 Effective Date 10-01-90
Supersedes
TN No. 88-12

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Michigan

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(LONG-TERM-CARE FACILITIES)

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. Rebased 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 retroactive 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.

TN No. 90-34 Approval Date 03-27-92 Effective Date 10-01-90

Supersedes

TN No. 88-12

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

VIII. Appeals Procedure

The appeals procedure can be initiated by a provider upon receipt of a notice of adverse action, and allows the provider an opportunity to submit additional evidence and receive prompt administrative review with respect to such issues the state agency determines appropriate.

TN NO.: 19-0008

Approval Date: NOV 25, 2019

Effective Date: 11/01/2019

Supersedes

TN No.: 12-09

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

Continued in Section VIII, Page 3.

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Supersedes

TN No.: 12-09

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

A. Procedure

1. Once a notice of adverse action is issued, a provider may request an appeal 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 Michigan Administrative Code.

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TN No.: 12-09

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

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

B. 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 JV.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).

C. 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 PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Michigan

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES
(LONG-TERM-CARE FACILITIES)

IX. Overpayments

Overpayments which have been made to individual providers will be assessed against, and recovered from, providers consistent with 42 CFR Section 447.

TN No. 90-34 Approval Date 03-27-92 Effective Date 10-01-90
Supersedes
TN No. 86-04

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)

R400.340I. 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.

(l) "Notice", when notification by the department is indicated or required, means notice which meets the requirement of section 71(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. (1) 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. (1) 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.

Rev. 7/1/79

(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.

Rev. 7/1/79

ST.PLAN-Supp.A-4.19-D; Kuerbitz; 10/5/88

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 representative, 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 certification 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.

Rev. 7/1/79

- (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.

Rev. 7/1/79

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.

Rev. 7/1/79

HOSPITAL AND HOSPITAL-SKILLED NURSING FACILITY COMPLEX STATISTICAL DATA		INTERMEDIARY USE ONLY <input type="checkbox"/> AUDITED <input type="checkbox"/> DESK REVIEWED		DATE RECEIVED INTERMEDIARY NUMBER
--	--	--	--	--

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	a. VOLUNTARY NONPROFIT <input type="checkbox"/> CHURCH <input type="checkbox"/> OTHER (Specify)	b. PROPRIETARY <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> PARTNERSHIP <input checked="" type="checkbox"/> CORPORATION <input type="checkbox"/> OTHER (Specify)	c. GOVERNMENT <input type="checkbox"/> FEDERAL <input type="checkbox"/> STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> CITY <input type="checkbox"/> CITY-COUNTY <input type="checkbox"/> HOSPITAL DISTRICT <input type="checkbox"/> OTHER (Specify)
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4. TYPE OF HOSPITAL	a. <input type="checkbox"/> GENERAL - SHORT TERM <input type="checkbox"/> PSYCHIATRIC <input type="checkbox"/> SPECIALTY - LONG TERM <input type="checkbox"/> GENERAL - LONG TERM <input type="checkbox"/> CHRONIC DISEASE <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> SPECIALTY - SHORT TERM	b. MEDICARE CERTIFIED KIDNEY TRANSPLANT HOSPITAL <input type="checkbox"/> YES <input type="checkbox"/> NO
---------------------	---	--

5. HEALTH CARE PROGRAMS	<input type="checkbox"/> TITLE V <input type="checkbox"/> TITLE XVIII <input type="checkbox"/> 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

HOSPITAL AND HOSPITAL-SKILLED NURSING FACILITY COMPLEX STATISTICAL DATA	PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____
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PART II - HOSPITAL STATISTICS

INPATIENT - ALL PATIENTS		GENERAL SERVICE	SPECIAL CARE UNITS			
			ICU	CCU	OTHER (SPECIFY)	
		1	2	3	4	5
1	Beds (excluding newborn) available at beginning of period					
2	Beds (excluding newborn) available at end of period					
3	Total bed days available (excluding newborn)					
4	Aged, pediatric and maternity inpatient days					
5	Other than aged, pediatric and maternity inpatient days (excl. newborn)					
6	Total inpatient days (excluding newborn) (Sum of lines 4 and 5)					
7	Percent occupancy (line 6 ÷ line 3)	%	%	%	%	%
8	Total newborn inpatient days					
INPATIENT - HEALTH CARE PROGRAMS						
9	TITLE V					
	a. Inpatient days (excluding newborn)					
	b. Newborn inpatient days					
10	TITLE XVIII					
	a. Aged, pediatric and maternity inpatient days (excluding kidney acquisition days)					
	b. Kidney acquisition days (aged, pediatric and maternity)					
	c. Total aged, pediatric and maternity inpatient days (Sum of lines 10a and 10b)					
	d. Other than aged, pediatric and maternity inpatient days (excluding kidney acquisition days)					
	e. Kidney acquisition days (other than aged, pediatric and maternity)					
	f. Total other than aged, pediatric and maternity inpatient days (Sum of lines 10d and 10e)					
	g. Total inpatient days (excluding kidney acquisition days) (Sum of lines 10c and 10f)					
	h. Total kidney acquisition days (Sum of lines 10b and 10e)					
	i. Total Part A inpatient days (Sum of lines 10g and 10h)					
	j. Total Part B inpatient days (SEE INSTRUCTIONS)					
	k. Part B inpatient days when Part A benefits are not available (SEE INSTRUCTIONS)					
11	TITLE XIX					
	a. Inpatient days (excluding newborn)					
	b. Newborn inpatient days					
OUTPATIENT - HEALTH CARE PROGRAMS		TITLE V	TITLE XVIII	TITLE XIX	ALL OTHER	TOTAL (SUM OF COLS 1-6)
12	Number of occasions of service (exclusive of renal dialysis treatments)					

PART III - OTHER HOSPITAL DATA

1	Amount of accelerated payments outstanding as of end of cost reporting period - title XVIII	\$
2	Average number of employees on payroll for the period (full-time equivalent) - excludes nonpaid workers	
3	Average number of nonpaid workers for the period (full-time equivalent) for which reimbursement is claimed	
4	Number of renal dialysis treatments (inpatient and outpatient)	
	a. Total - All Hospital Patients	
	b. Title V	
	c. Title XVIII	
	d. Title XIX	
5	Number of admissions (excluding newborn)	
	a. Total - All Hospital Inpatients	
	b. Title V	
	c. Title XVIII	
	d. Title XIX	
6	Number of discharges including deaths (excluding newborn)	
	a. Total - All Hospital Inpatients	
	b. Title V	
	c. Title XVIII	
	d. Title XIX	
7	Average length of stay	
	a. Total (Part II, line 6 ÷ sum of cols 1-5) + Part III, line 6a)	
	b. Title V (Part II, line 9a ÷ sum of cols 1-5) + Part III, line 6b)	
	c. Title XVIII (Part II, line 10i ÷ sum of cols 1-5) + Part III, line 6c)	
	d. Title XIX (Part II, line 11a ÷ sum of cols 1-5) + Part III, line 6d)	

Form Approved
OMB No. 72-R1010

HOSPITAL AND HOSPITAL-SKILLED NURSING FACILITY COMPLEX STATISTICAL DATA	PROVIDER NO.:	PERIOD:
	HOSPITAL _____	FROM _____ TO _____

PART IV – SUBPROVIDER AND SKILLED NURSING FACILITY STATISTICS

INPATIENT – ALL PATIENTS		SUBPROVIDER		SKILLED NURSING FACILITY	
		I	II	CERTIFIED PORTION	NONCERTIFIED PORTION
		1-	2	3	4
1	Beds (excluding newborn) available at beginning of period				
2	Beds (excluding newborn) available at end of period				
3	Total bed days available (excluding newborn)				
4	Aged, pediatric and maternity inpatient days				
5	Other than aged, pediatric and maternity inpatient days (excluding newborn)				
6	Total inpatient days (excluding newborn) (Sum of lines 4 and 5)				
7	Percent occupancy (line 6 ÷ line 3)	%	%	%	%
8	Total newborn inpatient days				
INPATIENT – HEALTH CARE PROGRAMS					
9	TITLE V				
	a. Inpatient days (excluding newborn)				
	b. Newborn inpatient days				
10	TITLE XVIII				
	a. Aged, pediatric and maternity inpatient days (excluding kidney acquisition days)				
	b. Kidney acquisition days (aged, pediatric and maternity)				
	c. Total aged, pediatric and maternity inpatient days (Sum of lines 10a and 10b)				
	d. Other than aged, pediatric and maternity inpatient days (excluding kidney acquisition days)				
	e. Kidney acquisition days (other than aged, pediatric and maternity)				
	f. Total other than aged, pediatric and maternity inpatient days (Sum of lines 10d and 10e)				
	g. Total inpatient days (excluding kidney acquisition days) (Sum of lines 10c and 10f)				
	h. Total kidney acquisition days (Sum of lines 10b and 10e)				
	i. Total Part A inpatient days (Sum of lines 10g and 10h)				
	j. Total Part B inpatient days (SEE INSTRUCTIONS)				
	k. Part B inpatient days when Part A benefits are not available (SEE INSTRUCTIONS)				
11	TITLE XIX				
	a. Inpatient days (excluding newborn)				
	b. Newborn inpatient days				

PART V – OTHER SUBPROVIDER AND SKILLED NURSING FACILITY DATA

		SUBPROVIDER		SKILLED NURS. FACILITY
		I	II	
1	Amount of accelerated payments outstanding as of end of cost reporting period – title XVIII	\$	\$	\$
2	Average number of employees on payroll for the period (full-time equiv.) – excludes nonpaid workers			
3	Average number of nonpaid workers for the period (full-time equiv.) for which reimbursement is claimed			
4	Number of renal dialysis treatments			
	a. Total – All Patients			
	b. Title V			
	c. Title XVIII			
	d. Title XIX			
5	Number of admissions (excluding newborn)			
	a. Total – All Inpatients			
	b. Title V			
	c. Title XVIII			
	d. Title XIX			
6	Number of discharges including deaths (excluding newborn)			
	a. Total – All Inpatients			
	b. Title V			
	c. Title XVIII			
	d. Title XIX			
7	Average length of stay			
	a. Total (Part IV, line 6 ÷ Part V, line 6a)			
	b. Title V (Part IV, line 9a ÷ Part V, line 6b)			
	c. Title XVIII (Part IV, line 10i ÷ Part V, line 6c)			
	d. Title XIX (Part IV, line 11a ÷ Part V, line 6d)			

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES				PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____	WORKSHEET A	
COST CENTER (OMIT CENTS)	SALARIES	OTHER	TOTAL (COL 1 + 2)	RECLASSIFICATIONS (FR WKSTS A-1 - A-6)	RECLASSIFIED TRIAL BALANCE (COL 3 ± 4)	ADJUSTMENTS TO EXPENSES (INCREASES & DECREASES) (FR WKST A-B)	(1) NET EXPENSES FOR COST ALLOCATION (COL 5 ± 6)
	1	2	3	4	5	6	7
1 GENERAL SERVICE COST CENTERS							
2 Depreciation - Buildings & Fixtures							
3 Depreciation - Movable Equipment							
4 Employee Health & Welfare							
5 Administrative & General							
6 Maintenance & Repairs							
7 Operation of Plant							
8 Laundry & Linen Service							
9 Housekeeping							
10 Dietary							
11 Cafeteria							
12 Maintenance of Personnel							
13 Nursing Administration							
14 Central Services & Supply							
15 Pharmacy							
16 Medical Records & Library							
17 Social Service							
18 Nursing School							
19 Intern-Resident Service (in approved teaching program)							
20							
21 ANCILLARY SERVICE COST CENTERS							
22 Operating Room							
23 Recovery Room							
24 Delivery Room & Labor Room							
25 Anesthesiology							
26 Radiology - Diagnostic							
27 Radiology - Therapeutic							
28 Radioisotope							
29 Laboratory							
30 Blood							
31 Blood Storing, Processing & Administration							
32 Intravenous Therapy							
33 Oxygen (Inhalation) Therapy							
34 Physical Therapy							
35 Occupational Therapy							
36 Speech Pathology							

RECLASSIFICATIONS AFFECTING ADMINISTRATIVE AND GENERAL EXPENSES			PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____	WORKSHEET A.1	
ITEM	DEPRECIATION BUILDINGS & FIXTURES 1	DEPRECIATION MOVABLE EQUIPMENT 2	EMPLOYEE HEALTH & WELFARE 3	ADMINISTRATIVE & GENERAL 4	INTEREST EXPENSE 5	UTILIZATION REVIEW - SNF 6
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, Past 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 (Sum 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 62	TRANSFER TO WORKSHEET A, COL 4, LINE 63

RECLASSIFICATION OF DIETARY EXPENSE

PROVIDER NO.1

PERIOD:

HOSPITAL

FROM
TO

WORKSHEET A-2

PART I - RECLASSIFICATION OF EXPENSES

DESCRIPTION	TOTAL EXPENSES (FROM WKST A, COL 3, LINE AS INDICATED)	ANALYSIS OF DIETARY EXPENSES	TOTAL (SUM OF COLS 1 & 2)	ALLOCATION OF TOTAL UNIDENTIFIED DIETARY EXPENSES	
				RATIO	AMOUNT
1 Dietary (From Worksheet A, col 3, line 10)		\$			
Identified Expenses (1)					
2 Dietary (2)		\$	\$	COL 3, LINE 2 + COL 3, LINE 6	COL 4, LINE 2 X COL 2, LINE 7
3 Cafeteria	(line 11)			COL 3, LINE 3 + COL 3, LINE 6	COL 4, LINE 3 X COL 2, LINE 7
4 Nursery	(line 51)			COL 3, LINE 4 + COL 3, LINE 6	COL 4, LINE 4 X COL 2, LINE 7
5				COL 3, LINE 5 + COL 3, LINE 6	COL 4, LINE 5 X COL 2, LINE 7
6 TOTAL (Sum of lines 2-5)	\$	\$	\$	1.0000	\$
7 Unidentified Dietary Expenses (line 1 minus line 6)		\$			

PART II - TRANSFER OF RECLASSIFIED EXPENSES

ITEM	AMOUNT
1 Cafeteria (line 3, sum of columns 2 and 5) (Add on Worksheet A, column 4, line 11)	\$
2 Nursery (line 4, sum of columns 2 and 5) (Add on Worksheet A, column 4, line 51)	
3 (line 5, sum of columns 2 and 5) (Add on Worksheet A, column 4, line as appropriate)	
4 TOTAL (Sum of lines 1-3) (Deduct on Worksheet A, column 4, line 10)	\$

(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		PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____	WORKSHEET A-3
	ITEM	AMOUNT		
1	Intern-Resident Service - (in approved teaching program) (Add on Worksheet A, column 4, line 19)	\$		
2	Intern-Resident Service - (not in approved teaching program) (Add on Worksheet A, column 4, line 61)			
3	Intravenous Therapy (Add on Worksheet A, column 4, line 32)			
4	Oxygen (Inhalation) Therapy (Add on Worksheet A, column 4, line 33)			
5				
6				
7	TOTAL (Sum of lines 1-6) (Deduct on Worksheet A, col. 4, line 14)	\$		

RECLASSIFICATION OF LABORATORY EXPENSE		PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____	WORKSHEET A-4
	ITEM	AMOUNT		
1	Blood (Add on Worksheet A, column 4, line 30)	\$		
2	Blood Storing, Processing, & Administration (Add on Worksheet A, column 4, line 31)			
3	Electrocardiology (Add on Worksheet A, column 4, line 37)			
4	Electroencephalography (Add on Worksheet A, column 4, line 38)			
5				
6				
7	TOTAL (Sum of lines 1-6) (Deduct on Worksheet A, col. 4, line 29)	\$		

RECLASSIFICATION OF RADIOLOGY - DIAGNOSTIC		PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____	WORKSHEET A-5
	ITEM	AMOUNT		
1	Radiology-Therapeutic (Add on Worksheet A, column 4, line 27)	\$		
2	Radioisotope (Add on Worksheet A, column 4, line 28)			
3	Electrocardiology (Add on Worksheet A, column 4, line 37)			
4	Electroencephalography (Add on Worksheet A, column 4, line 38)			
5				
6				
7	TOTAL (Sum of lines 1-6) (Deduct on Worksheet A, col. 4, line 26)	\$		

FORM APPROVED OMB No. 72-R-1010		PERIOD: FROM _____ TO _____		HOSPITAL _____		PROVIDER NO.: _____		RECLASSIFICATIONS - OTHER	
WORKSHEET A-6		DECREASE		INCREASE		EXPLANATION OF RECLASSIFICATION ENTRY		CODE	
AMOUNT (2)		COST CENTER		LINE NO.		AMOUNT (2)		COST CENTER	
1		2		3		4		5	
2		3		4		5		6	
3		4		5		6		7	
4		5		6		7		8	
5		6		7		8		9	
6		7		8		9		10	
7		8		9		10		11	
8		9		10		11		12	
9		10		11		12		13	
10		11		12		13		14	
11		12		13		14		15	
12		13		14		15		16	
13		14		15		16		17	
14		15		16		17		18	
15		16		17		18		19	
16		17		18		19		20	
17		18		19		20		21	
18		19		20		21		22	
19		20		21		22		23	
20		21		22		23		24	
21		22		23		24		25	
22		23		24		25		26	
23		24		25		26		27	
24		25		26		27		28	
25		26		27		28		29	
26		27		28		29		30	
27		28		29		30		31	
28		29		30		31		32	
29		30		31		32		33	
30		31		32		33		34	
31		32		33		34		35	
32		33		34		35		36	
33		34		35		36		TOTAL RECLASSIFICATIONS (Sum of col 4 must equal sum of col 7)	
34		35		36		TOTAL RECLASSIFICATIONS (Sum of col 4 must equal sum of col 7)		(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.	
35		36		TOTAL RECLASSIFICATIONS (Sum of col 4 must equal sum of col 7)		(2) Transfer to Worksheet A, col 4, line as appropriate.		FORM SSA-2552 (5-75)	
36		TOTAL RECLASSIFICATIONS (Sum of col 4 must equal sum of col 7)		(2) Transfer to Worksheet A, col 4, line as appropriate.		FORM SSA-2552 (5-75)		8	

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES QUESTIONNAIRE

PROVIDER NO.:

HOSPITAL _____

PERIOD:

FROM _____
TO _____

WORKSHEET A-7

1	Analysis of changes during cost reporting period in capital asset balances of components certified to participate in health care programs. DESCRIPTION	BEGINNING BALANCE 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6
			PURCHASE	DONATION	TOTAL		
			2	3	4		
	Land	\$	\$	\$	\$	\$	\$
	Land Improvements						
	Buildings & Fixtures						
	Building Improvements						
	Equipment						
	Fixed						
	Movable						
	TOTAL	\$	\$	\$	\$	\$	\$

- 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	HDW ACQUIRED: ENTER LETTER SYMBOL(1)	DATE OBLIGATION INCURRED	COST	EXPENSES INCLUDED ON WKST A, COL 3, RELATED TO CAPITAL EXPENDITURES					TOTAL (SUM OF COLS 4, 5, 6, 8)
				DEPRECIATION	INTEREST	RENT	OTHER		
							EXPENSE	AMOUNT	
	1	2	3	4	5	6	7	8	9
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.

DESCRIPTION	DATE WRITTEN NOTICE SUBMITTED	DATE APPROVED	DATE OF NOTICE OF DISAPPROVAL RECD.	APPEAL OF DENIAL	
	1	2	3	DATE	STATUS OF APPEAL
	1	2	3	4	5
a.					
b.					
c.					
d.					

(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

ADJUSTMENTS TO EXPENSES		PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8	
DESCRIPTION (1)	BASIS FOR ADJUSTMENT (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED		
			COST CENTER	LINE NO.	
	1	2	3	4	
1. Investment income on commingled restricted and unrestricted funds (chapter 2)		\$			
2. Trade, quantity, time and discounts on purchases (chapter 8)					
3. Rebates and refunds of expenses (chapter 8)					
4. Rental of provider space by suppliers (chapter 8)					
5. Telephone service (pay stations excluded) (chapter 21)					
6. Television and radio service (chapter 21)					
7. Parking lot (chapter 21)					
8. Remuneration applicable to provider-based radiologists for professional services (chapter 21)					
9. Remuneration applicable to provider-based pathologists for professional services (chapter 21)					
10. Remuneration applicable to provider-based anesthesiologists for professional services (chapter 21)					
11. Remuneration applicable to provider-based cardiologists for professional services (chapter 21)					
12. Remuneration applicable to provider-based neurologists for professional services (chapter 21)					
13.					
14.					
15.					
16.					
17. Home office costs (chapter 21)					
18. Sale of scrap, waste, etc. (chapter 23)					
19. Nonallowable costs related to certain capital expenditures (chapter 24)		\$			
20. Adjustment resulting from transactions with related organizations (chapter 10)	Fr Wkst A-8-1				
21. Laundry and linen service					
22. Cafeteria - employees, guests, etc.					
23. Rental of living quarters to employees and others					
24. Sale of medical and surgical supplies to other than patients					
25. Sale of drugs to other than patients					
26. Sale of medical records and abstracts					
27. Nursing school (tuition, fees, textbooks, uniforms, etc.)					
28. Vending machines					
29. Income from imposition of interest, finance or penalty charges (chapter 21)					
30.					
31.					
32. SUBTOTAL (Sum of lines 1-31) (Carry forward to page 11, Worksheet A-8, line 33)		\$			

(1) Description - all line references in this column pertain to the Provider Reimbursement Manual, Part I.

(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		PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8	
DESCRIPTION (1)	BASIS FOR ADJUSTMENT (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED		
			COST CENTER	LINE NO.	
	1	2	3	4	
33. SUBTOTAL (Brought forward from page 10, Worksheet A-8, line 32)		\$			
34.					
35.					
36.					
37.					
38.					
39.					
40.					
41.					
42.					
43.					
44.					
45.					
46.					
47.					
48.					
49.					
50.					
51.					
52.					
53.					
54.					
55.					
56.					
57.					
58. SUBTOTAL (Sum of lines 33-57)		\$			
59. Grants, gifts, and income designated by donor for specific expenses (chapter 6)					
60. Utilization Review - physicians' compensation (chapter 21)					
61. Depreciation - buildings and fixtures					
62. Depreciation - movable equipment					
63.					
64. TOTAL (line 58 plus or minus the sum of lines 59-63) (Transfer to Worksheet A, column 6, line 72)		\$			

(1) Description - all line references in this column pertain to the Provider Reimbursement Manual Part I.

(2) Basis for adjustment (SEE INSTRUCTIONS).

- A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-1
--	--	--	------------------------

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:

LOCATION AND AMOUNT INCLUDED ON WORKSHEET A, COLUMN 5				AMOUNT ALLOWABLE IN COST	NET ADJUSTMENT (COL. 4 MINUS COL. 5)
LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT		
1	2	3	4	5	6
1.			\$	\$	\$
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.	TOTALS (Sum of lines 1-9) (Transfer col. 6, lines 1-9 to What A, col. 6, lines as appropriate) (Transfer col. 6, line 10 to What A-8, col. 2, line 20)		\$	\$	\$

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 part of the requested information, the cost report will be considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

SYMBOL (1)	NAME	PERCENT OWNERSHIP OF PROVIDER	RELATED ORGANIZATION(S)		
			NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

(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) specify.

DEPRECIATION	PROVIDER NO.:	PERIOD:	WORKSHEET A-8-2
	HOSPITAL _____	FROM _____ TO _____	

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) \$ _____	Yes	No
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?		
	If Yes: A. Was Accelerated Depreciation Claimed On Assets Acquired On Or After August 1, 1970? (See Provider Reimbursement Manual, Part I, chapter 1)		
	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 Substantial Decrease In Health Insurance Proportion 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

	1	2
1	1965 Operating Cost Related to Patient Care	\$ _____
2	Less: Actual Depreciation -- included on line 1	\$ _____
3	Lower of rental charge or estimated straight-line depreciation on rented depreciable type assets	(col 1, lines 2 + 3) \$ _____
4	Adjusted 1965 Operating Cost (line 1 minus line 3, column 2)	\$ _____
5	Current Year's Allowable Cost (SEE INSTRUCTIONS)	\$ _____
6	Less: Actual Depreciation -- included on line 5	\$ _____
7	Lower of rental charge or estimated straight-line depreciation on rented depreciable type assets	(col 1, lines 6 + 7) \$ _____
8	Adjusted Current Year's Allowable Cost (line 5 minus line 7, column 2)	\$ _____
9	Lower of lines 4 or 8 above	\$ _____
10	Percentage Allowance (SEE INSTRUCTIONS)	%
11	Gross Allowance (line 9 x line 10)	\$ _____
12	Less: Estimated depreciation on assets rented in 1965 (Same fiscal period for which cost is reported on line 1)	\$ _____
13	Adjusted Allowance (line 11 minus line 12)	\$ _____

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)

	BUILDINGS & FIXTURES 1	MOVABLE EQUIPMENT 2
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 5) (SEE INSTRUCTIONS)	
5	Adjustment to Depreciation on Owned Assets (line 3 minus line 4) (Transfer to Worksheet A-8, 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				PROVIDER NO.: HOSPITAL _____	
COST CENTER (OMIT COSTS)	NET EXPENSES FOR COST ALLOCATION (FROM WKST A, COLUMN 7)	DEPRECIATION BUILDINGS & FIXTURES	DEPRECIATION MOVABLE EQUIPMENT	EMPLOYEE HEALTH & WELFARE	
	1	2	3	4	
1 GENERAL SERVICE COST CENTERS					1
2 Depreciation-Buildings & Fixtures	\$	\$			2
3 Depreciation-Movable Equipment			\$		3
4 Employee Health & Welfare				\$	4
5 Administrative & General					5
6 Maintenance & Repairs					6
7 Operation of Plant					7
8 Laundry & Linen Service					8
9 Housekeeping					9
10 Dietary					10
11 Cafeteria					11
12 Maintenance of Personnel					12
13 Nursing Administration					13
14 Central Services & Supply					14
15 Pharmacy					15
16 Medical Records & Library					16
17 Social Service					17
18 Nursing School					18
19 Intern-Resident Service (in approved teaching program)					19
20					20
21 ANCILLARY SERVICE COST CENTERS					21
22 Operating Room					22
23 Recovery Room					23
24 Delivery Room & Labor Room					24
25 Anesthesiology					25
26 Radiology-Diagnostic					26
27 Radiology-Therapeutic					27
28 Radiology					28
29 Laboratory					29
30 Blood					30
31 Blood Storing, Processing & Administration					31
32 Intravenous Therapy					32
33 Oxygen (Inhalation) Therapy					33
34 Physical Therapy					34
35 Occupational Therapy					35
36 Speech Pathology					36
37 Electrocardiology					37
38 Electroencephalography					38
39 Medical Supplies Charged to Patients					39
40 Drugs Charged to Patients					40
41 Renal Dialysis					41
42 Kidney Acquisition					42
43					43
44					44
45 INPATIENT ROUTINE SERVICE COST CENTERS					45
46 Adults & Pediatrics (General Routine Care)					46
47 Intensive Care Unit					47
48 Convalescent Care Unit					48
49					49
50					50
51 Nursery					51
52 Skilled Nursing Facility - Certified					52
53 Skilled Nursing Facility - Noncertified					53
54 OUTPATIENT SERVICE COST CENTERS					54
55 Clinic					55
56 Emergency					56
57					57
58 OTHER REIMBURSABLE COST CENTERS					58
59 Home Health Agency					59
60 Ambulance Services					60
61 Intern-Resident Service (not in approved teaching program)					61
62 SUBTOTALS (Sum of lines 2-61)	\$	\$	\$	\$	62
63 NONREIMBURSABLE COST CENTERS					63
64 Gift, Flower, Coffee Shops & Canteen					64
65 Research					65
66 Physicians' Private Offices					66
67 Nonpaid Workers					67
68					68
69 TOTAL EXPENSES (Sum of lines 62-68)	\$	\$	\$	\$	69

COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: _____
					HOSPITAL _____
COST CENTER (OMIT CENTS)	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
	11	12	13	14	
1 GENERAL SERVICE COST CENTERS					1
2 Depreciation—Buildings & Fixtures					2
3 Depreciation—Movable Equipment					3
4 Employee Health & Welfare					4
5 Administrative & General					5
6 Maintenance & Repairs					6
7 Operation of Plant					7
8 Laundry & Linen Service					8
9 Housekeeping					9
10 Dietary					10
11 Cafeteria	\$				11
12 Maintenance of Personnel		\$			12
13 Nursing Administration			\$		13
14 Central Services & Supply				\$	14
15 Pharmacy					15
16 Medical Records & Library					16
17 Social Service					17
18 Nursing School					18
19 Intern-Resident Service (in approved teaching program)					19
20					20
21 ANCILLARY SERVICE COST CENTERS					21
22 Operating Room					22
23 Recovery Room					23
24 Delivery Room & Labor Room					24
25 Anesthesiology					25
26 Radiology—Diagnostic					26
27 Radiology—Therapeutic					27
28 Radioisotopes					28
29 Laboratory					29
30 Blood					30
31 Blood Storing, Processing & Administration					31
32 Intravenous Therapy					32
33 Oxygen (Inhalation) Therapy					33
34 Physical Therapy					34
35 Occupational Therapy					35
36 Speech Pathology					36
37 Electrocardiology					37
38 Electroencephalography					38
39 Medical Supplies Charged to Patients					39
40 Drugs Charged to Patients					40
41 Renal Dialysis					41
42 Kidney Acquisition					42
43					43
44					44
45 INPATIENT ROUTINE SERVICE COST CENTERS					45
46 Adults & Pediatrics (General Routine Care)					46
47 Intensive Care Unit					47
48 Coronary Care Unit					48
49					49
50					50
51 Nursery					51
52 Skilled Nursing Facility - Certified					52
53 Skilled Nursing Facility - Noncertified					53
54 OUTPATIENT SERVICE COST CENTERS					54
55 Clinic					55
56 Emergency					56
57					57
58 OTHER REIMBURSABLE COST CENTERS					58
59 Home Health Agency					59
60 Ambulance Services					60
61 Intern-Resident Service (not in approved teaching program)					61
62 SUBTOTALS (Sum of lines 12-61)	\$	\$	\$	\$	62
63 NONREIMBURSABLE COST CENTERS					63
64 Gift, Flower, Coffee Shops & Canteen					64
65 Research					65
66 Physicians' Private Offices					66
67 Nonpaid Workers					67
68					68
69 TOTAL EXPENSES (Sum of lines 62-68)	\$	\$	\$	\$	69

COST ALLOCATION - STATISTICAL BASIS			PROVIDER NO.: HOSPITAL _____	
COST CENTER (STATISTICAL BASIS)	DEPRECIATION BUILDINGS & FIXTURES (SQUARE FEET)	DEPRECIATION MOVABLE EQUIPMENT (DOLLAR VALUE OR SQUARE FEET)	EMPLOYEE HEALTH & WELFARE (GROSS SALARIES)	
1 GENERAL SERVICE COST CENTERS	2	3	4	1
2 Depreciation—Buildings & Fixtures				2
3 Depreciation—Movable Equipment				3
4 Employee Health & Welfare			\$	4
5 Administrative & General				5
6 Maintenance & Repairs				6
7 Operation of Plant				7
8 Laundry & Linen Service				8
9 Housekeeping				9
10 Dietary				10
11 Cafeteria				11
12 Maintenance of Personnel				12
13 Nursing Administration				13
14 Central Services & Supply				14
15 Pharmacy				15
16 Medical Records & Library				16
17 Social Service				17
18 Nursing School				18
19 Intern-Resident Service (in approved teaching program)				19
20				20
21 ANCILLARY SERVICE COST CENTERS				21
22 Operating Room				22
23 Recovery Room				23
24 Delivery Room & Labor Room				24
25 Anesthesiology				25
26 Radiology—Diagnostic				26
27 Radiology—Therapeutic				27
28 Radioisotope				28
29 Laboratory				29
30 Blood				30
31 Blood Storing, Processing & Administration				31
32 Intravenous Therapy				32
33 Oxygen (Inhalation) Therapy				33
34 Physical Therapy				34
35 Occupational Therapy				35
36 Speech Pathology				36
37 Electrocardiology				37
38 Electroencephalography				38
39 Medical Supplies Charged to Patients				39
40 Drugs Charged to Patients				40
41 Renal Dialysis				41
42 Kidney Acquisition				42
43				43
44				44
45 INPATIENT ROUTINE SERVICE COST CENTERS				45
46 Adults & Pediatrics (General Routine Care)				46
47 Intensive Care Unit				47
48 Coronary Care Unit				48
49				49
50				50
51 Nursery				51
52 Skilled Nursing Facility - Certified				52
53 Skilled Nursing Facility - Noncertified				53
54 OUTPATIENT SERVICE COST CENTERS				54
55 Clinic				55
56 Emergency				56
57				57
58 OTHER REIMBURSABLE COST CENTERS				58
59 Home Health Agency				59
60 Ambulance Services				60
61 Intern-Resident Service (not in approved teaching program)				61
62 SUBTOTALS (Sum of lines 4-61)			\$	62
63 NONREIMBURSABLE COST CENTERS				63
64 Gift, Flower, Coffee Shops & Canteen				64
65 Research				65
66 Physicians' Private Offices				66
67 Nonpaid Workers				67
68				68
69 COST TO BE ALLOCATED (Per Worksheet B)	\$	\$	\$	69
70 UNIT COST MULTIPLIER				70

FORM SSA-2552 (5-79)

COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO.: HOSPITAL _____
COST CENTER (STATISTICAL BASIS)	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURSING HOURS OF SERVICE)	CENTRAL SERVICES SUPPLY (COSTED REQUISITIONS)	
	11	12	13	14	
1 GENERAL SERVICE COST CENTERS					1
2 Depreciation—Buildings & Fixtures					2
3 Depreciation—Movable Equipment					3
4 Employee Health & Welfare					4
5 Administrative & General					5
6 Maintenance & Repairs					6
7 Operation of Plant					7
8 Laundry & Linen Service					8
9 Housekeeping					9
10 Dietary					10
11 Cafeteria					11
12 Maintenance of Personnel					12
13 Nursing Administration					13
14 Central Services & Supply				\$	14
15 Pharmacy					15
16 Medical Records & Library					16
17 Social Service					17
18 Nursing School					18
19 Intern-Resident Service (in approved teaching program)					19
20					20
21 ANCILLARY SERVICE COST CENTERS					21
22 Operating Room					22
23 Recovery Room					23
24 Delivery Room & Labor Room					24
25 Anesthesiology					25
26 Radiology—Diagnostic					26
27 Radiology—Therapeutic					27
28 Radioisotope					28
29 Laboratory					29
30 Blood					30
31 Blood Storing, Processing & Administration					31
32 Intravenous Therapy					32
33 Oxygen (Inhalation) Therapy					33
34 Physical Therapy					34
35 Occupational Therapy					35
36 Speech Pathology					36
37 Electrocardiology					37
38 Electroencephalography					38
39 Medical Supplies Charged to Patients					39
40 Drugs Charged to Patients					40
41 Renal Dialysis					41
42 Kidney Acquisition					42
43					43
44					44
45 INPATIENT ROUTINE SERVICE COST CENTERS					45
46 Adults & Pediatrics (General Routine Care)					46
47 Intensive Care Unit					47
48 Coronary Care Unit					48
49					49
50					50
51 Nursery					51
52 Skilled Nursing Facility - Certified					52
53 Skilled Nursing Facility - Noncertified					53
54 OUTPATIENT SERVICE COST CENTERS					54
55 Clinic					55
56 Emergency					56
57					57
58 OTHER REIMBURSABLE COST CENTERS					58
59 Home Health Agency					59
60 Ambulance Services					60
61 Intern-Resident Service (not in approved teaching program)					61
62 SUBTOTALS (Sum of lines 12-61)				\$	62
63 NONREIMBURSABLE COST CENTERS					63
64 Gift, Flower, Coffee Shops & Canteen					64
65 Research					65
66 Physicians' Private Offices					66
67 Nonpaid Workers					67
68					68
69 COST TO BE ALLOCATED (Per Worksheet B)	\$	\$	\$	\$	69
70 UNIT COST MULTIPLIER					70

FORM SSA-2552 (5-75)

DEPARTMENTAL COST DISTRIBUTION				PROVIDER NO.:
				HOSPITAL:
COST CENTER	TOTALS	RATIO OF COST TO CHARGES (COL 1, LINE a + COL 1, LINE b) TO WKST D. COL 1		HOSPITAL (COL 2 X 3b)
		1	2	
1 ANCILLARY SERVICE COST CENTERS	(1)			1
2 Operating Room	a \$ b \$		\$	2
3 Recovery Room	a \$ b \$		\$	3
4 Delivery Room & Labor Room	a \$ b \$		\$	4
5 Anesthesiology	a \$ b \$		\$	5
6 Radiology - Diagnostic	a \$ b \$		\$	6
7 Radiology - Therapeutic	a \$ b \$		\$	7
8 Radioisotope	a \$ b \$		\$	8
9 Laboratory	a \$ b \$		\$	9
10 Blood	a \$ b \$		\$	10
11 Blood Storing, Processing & Administration	a \$ b \$		\$	11
12 Intravenous Therapy	a \$ b \$		\$	12
13 Oxygen (Inhalation) Therapy	a \$ b \$		\$	13
14 Physical Therapy	a \$ b \$		\$	14
15 Occupational Therapy	a \$ b \$		\$	15
16 Speech Pathology	a \$ b \$		\$	16
17 Electrocardiology	a \$ b \$		\$	17
18 Electroencephalography	a \$ b \$		\$	18
19 Medical Supplies Charged to Patients	a \$ b \$		\$	19
20 Drugs Charged to Patients	a \$ b \$		\$	20
21 Renal Dialysis	a \$ b \$		\$	21
22	a \$ b \$		\$	22
23	a \$ b \$		\$	23
24 OUTPATIENT SERVICE COST CENTERS				24
25 Clinic	a \$ b \$		\$	25
26 Emergency	a \$ b \$		\$	26
27	a \$ b \$		\$	27
28 HOME HEALTH AGENCY	a \$ b \$		\$	28
29 TOTAL	a \$ b \$		\$	29

(1) a - Column 1 (Total cost from Worksheet B, column 21, lines 22-41, lines 43 and 44, lines 55-57, and line 59) (See special instructions for line 21)
Columns 3-10 (Total cost distributed)

b - Column 1 (Gross charges all patients in provider complex-from provider records)
Columns 3-10 (Gross charges all patients in indicated provider component-from provider records)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICES TO HEALTH CARE PROGRAMS

PROVIDER NO.:

HOSPITAL _____

PERIOD:

FROM _____

TO _____

WORKSHEET D

CHECK ONE:

☐ HOSPITAL

☐ SUBPROVIDER I

☐ SUBPROVIDER II

☐ SKILLED NURSING FACILITY

COST CENTER		RATIO OF COST TO CHARGES (FR WKST C. COL 2)	HEALTH CARE PROGRAM INPATIENT CHARGES				HEALTH CARE PROGRAM INPATIENT EXPENSES									
			TITLE V	TITLE XVIII		TITLE XIX	TITLE V (1) (COL 1 X COL 2)	TITLE XVIII (2)		TITLE XIX (1) (COL 1 X COL 8)						
				PART A	PART B			PART A (COL 1 X COL 3)	PART B (COL 1 X COL 4)							
		1	2	3	4	5	6	7	8	9						
1	ANCILLARY SERVICE COST CENTERS										1					
2	Operating Room		\$	\$		\$	\$	\$		\$	2					
3	Recovery Room										3					
4	Delivery Room & Labor Room										4					
5	Anesthesiology										5					
6	Radiology - Diagnostic				\$				\$		6					
7	Radiology - Therapeutic										7					
8	Radioisotope										8					
9	Laboratory										9					
10	Blood										10					
11	Blood Storing, Processing and Administration										11					
12	Intravenous Therapy										12					
13	Oxygen (Inhalation) Therapy										13					
14	Physical Therapy										14					
15	Occupational Therapy										15					
16	Speech Pathology										16					
17	Electrocardiology										17					
18	Electroencephalography										18					
19	Medical Supplies Charged to Patients										19					
20	Drugs Charged to Patients										20					
21	Renal Dialysis										21					
22											22					
23											23					
24	OUTPATIENT SERVICE COST CENTERS										24					
25	Clinic										25					
26	Emergency										26					
27											27					
28	TOTAL		\$	\$	\$	\$	\$	\$	\$	\$	28					

(1) Transfer the amounts in column 6 and column 9, line 28, to Worksheet E-5, Part I, column as appropriate, line 1.

(2) Transfer the amounts in column 7 and column 8, line 28, to Worksheet E, Part I, column as appropriate, line 1.

COMPUTATION OF INPATIENT ROUTINE SERVICE COST		PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____	WORKSHEET D-1 PART I	
CHECK ONE: <input type="checkbox"/> HOSPITAL <input type="checkbox"/> SUBPROVIDER I <input type="checkbox"/> SUBPROVIDER II <input type="checkbox"/> SKILLED NURSING FACILITY					
PART I - TITLE XVIII (MEDICARE)					
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 8½% (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 8½% (line 9 x 1.085)				\$
MEDICARE GENERAL INPATIENT CARE PER DIEM COSTS (Including the Inpatient Routine Nursing Salary Cost Differential Adjustment Factor)					
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 7 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 22 minus line 23)				\$
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 (lessor of line 24 or line 27)				\$
SPECIAL CARE UNITS (EXCLUDING NURSERY)					
SPECIAL CARE UNIT	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL 1 ÷ 2)	MEDICARE DAYS	COST APPLICABLE TO MEDICARE (COL 3 X 4)
	1	2	3	4	5
29 Intensive Care Unit	\$		\$		
30 Coronary Care Unit	\$		\$		
31	\$		\$		
32	\$		\$		
33	TOTAL MEDICARE INPATIENT GENERAL ROUTINE AND SPECIAL CARE SERVICE COST (Sum of lines 28-32, col 5) (Transfer to Wkst E, Part I, Line 3)				\$

COMPUTATION OF INPATIENT ROUTINE SERVICE COST	PROVIDER NO.:	PERIOD:	WORKSHEET D-1 PART II
	HOSPITAL _____	FROM _____ TO _____	
CHECK ONE: <input type="checkbox"/> HOSPITAL <input type="checkbox"/> SUBPROVIDER I <input type="checkbox"/> SUBPROVIDER II			

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 I, col 3, 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 I, 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

GENERAL INPATIENT ROUTINE SERVICE		TITLE V	TITLE XIX
		1	2
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

COST CENTERS	DAYS		AVERAGE PER DIEM	REIMBURSABLE COSTS	
	TITLE V	TITLE XIX		TITLE V	TITLE XIX
	1	2		3	5
			(FROM)	(COL 1 X COL 3)	(COL 2 X COL 3)
52	Nursery		LINE 45 \$		
53	SPECIAL CARE UNITS Intensive Care Unit		LINE 29 \$		
54	Coronary Care Unit		LINE 30 \$		
55			LINE 31 \$		
56			LINE 32 \$		
57	TOTAL INPATIENT GENERAL ROUTINE, NURSERY AND SPECIAL CARE COSTS (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 I, line 2)			\$	\$

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

PROVIDER NO.:

HOSPITAL:

PART I - NOT IN APPROVED TEACHING PROGRAM

COST CENTER		PERCENT OF ASSIGNED TIME	EXPENSE ALLOCATION	TOTAL INPATIENT DAYS - ALL PATIENTS
		1	2	3
1	Total cost of services rendered	100 %	\$	1
2	Hospital Inpatient Routine Services:			2
3	Adults & Pediatrics (General Routine Care)	%	\$	3
4	Intensive Care Unit			4
5	Coronary Care Unit			5
6				6
7				7
8	Nursery			8
9	SUBTOTAL (Sum of lines 3-8)	%	\$	9
10	Subprovider I - Inpatient Routine Service			10
11	Subprovider II - Inpatient Routine Service			11
12	Skilled Nursing Facility - Certified			12
13	Skilled Nursing Facility - Noncertified			13
14	Home Health Agency			14
15	SUBTOTAL (Sum of lines 9-14)	%	\$	15
16	Hospital Outpatient Services:			16
17	Clinic	%	\$	17
18	Emergency			18
19				19
20	SUBTOTAL (Sum of lines 17-19)	%	\$	20
21	TOTAL (Sum of lines 15 and 20)	100 %	\$	21

PART II - IN AN APPROVED TEACHING PROGRAM (PART B INPATIENT ROUTINE COSTS ONLY)

COST CENTERS		EXPENSES ALLOCATED TO COST CENTERS ON WKST B, COL 19
		1
1	Hospital Inpatient Routine Services:	
2	Adults & Pediatrics (General Routine Care)	\$
3	Intensive Care Unit	
4	Coronary Care Unit	
5		
6		
7	SUBTOTAL (Sum of lines 2-6)	\$
8	Subprovider I - Inpatient Routine Service	
9	Subprovider II - Inpatient Routine Service	
10	Skilled Nursing Facility - Certified	
11	TOTAL (Sum of lines 7-10)	\$

PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)

COST CENTERS		NOT IN APPROVED TEACHING PROGRAM	
		REFERENCE (FROM) PART I, COL 9 LINE	AMOUNT
		1	2
1	Hospital		
2	Inpatient	9	\$
3	Outpatient	20	
4	TOTAL Hospital (Sum of lines 2 and 3)		\$
5	Subprovider I	10	
6	Subprovider II	11	
7	Skilled Nursing Facility - Certified	12	
8	TOTALS (Sum of lines 4-7)	21	\$

**APPORTIONMENT OF HOSPITAL-BASED PHYSICIAN REMUNERATION
FOR PROFESSIONAL SERVICES - COMBINED BILLING**

PROVIDER NO.:

HOSPITAL:

PERIOD:

FROM

TO

WORKSHEET D-3

CHECK ONE:

☐ HOSPITAL

☐ SUBPROVIDER I

☐ SUBPROVIDER II

MEDICAL SPECIALTY DEPARTMENT	TOTAL REMUNER- ATION APPLICABLE TO PROFES- SIONAL SERVICES (1)	TOTAL CHARGES - ALL PATIENTS (1)	RATIO OF REMUNER- ATION TO CHARGES (COL 1 ÷ 2)	HEALTH CARE PROGRAM CHARGES					PROFESSIONAL SERVICE REMUNERATION APPLICABLE TO HEALTH CARE PROGRAMS				
				TITLE V INPATIENT	TITLE XVIII		TITLE XIX INPATIENT	INPATIENT & OUTPATIENT KIDNEY ACQUISITION	TITLE V INPATIENT (COL 3 X 4a)	TITLE XVIII		TITLE XIX INPATIENT (COL 3 X 4d)	INPATIENT & OUTPATIENT KIDNEY ACQUISITION (COL 3 X 4e)
					INPATIENT	OUTPATIENT- PART B				INPATIENT (COL 3 X 4b)	OUTPATIENT- PART B (COL 3 X 4c)		
	1	2	3	4a	4b	4c	4d	4e	5a	5b	5c	5d	5e
1. Radiology - Diagnostic	\$	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2. Radiology - Therapeutic													
3. Radioisotope													
4. Pathology													
5. Anesthesiology													
6. Electrocardiology													
7. Electroencephalography													
8.													
9.													
10.													
11.													
12. TOTAL (Sum of lines 1-11) (2)								\$	\$	\$	\$	\$	\$

(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. If gross combined charges for professional and provider components are used on Worksheet C, gross combined charges must be used in column 2 and in columns 4a through 4e. If gross charges for provider component only are used on Worksheet C, gross charges for professional component only must be used in column 2 and in columns 4a through 4e.

(2) Transfer the amounts on line 12, column(s):

4e
5a and 5d
5b
5c
5e

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**

 PROVIDER NO.:
HOSPITAL _____

 PERIOD:
FROM _____
TO _____

**WORKSHEET E
PART I**
PART I - COMPUTATION OF NET COST OF MEDICARE COVERED SERVICES

DESCRIPTION	HOSPITAL		SUBPROVIDER I		SUBPROVIDER II		SKILLED NURSING FACILITY	
	PART A	PART B	PART A	PART B	PART A	PART B	PART A	PART B
	1	2	3	4	5	6	7	8
1 Inpatient ancillary services (From Wkst D, cols 7 & 8, line 28)	\$	\$	1 \$	\$	1 \$	\$	1 \$	\$
2 Outpatient services (From Wkst C, col 7, line 29a)			2		2		2	
3 Inpatient routine services (From Wkst D-1, Part I, line 33)			3		3		3	
4 Intern and resident services (From Wkst D-2, Part I, col 9, Part II, col 5, or Part III, col 6, as appropriate)			4		4		4	
5 Utilization review-physicians' compensation (From provider records)			5		5		5	
6 Hospital-based pathologists remuneration - SNF inpatients (From Supplemental Wkst D-4, line 5)			6		6		6	
7 Ambulance services (From Supplemental Wkst D-5, col 2, line 5)			7		7		7	
8 Kidney acquisition costs-supplementary to inpatient routine and inpatient ancillary service costs (From Supplemental Wkst D-6, Part I, line 6)			8		8		8	
9			9		9		9	
10			10		10		10	
11 SUBTOTAL (Sum of lines 1-10)	\$	\$	11 \$	\$	11 \$	\$	11 \$	\$
12 Differential in charges between semiprivate accommodations and less than semiprivate accommodations	()		12 ()		12 ()		12 ()	
13 Total kidney acquisition charges billed to Medicare under Part B (From provider records)	()		13 ()		13 ()		13	
14 SUBTOTAL (Part A - line 11 minus sum of lines 12 and 13) (Part B - sum of lines 11 and 13)	\$	\$	14 \$	\$	14 \$	\$	14 \$	\$
15 Amounts paid and payable by Workmen's Compensation	()		15 ()		15 ()		15 ()	
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)	()		16 ()		16 ()		16	
17 Outpatient professional services rendered by hospital-based physicians - Combined Billing (From Wkst D-3, col 5c, line 12)			17		17		17	
18 SUBTOTAL (Part A - line 14 minus sum of lines 15 and 16) (Part B - sum of lines 14 and 17)	\$	\$	18 \$	\$	18 \$	\$	18 \$	\$
19 Part B deductibles billed to Medicare patients (exclude coinsurance amts.)		()	19	()	19	()	19	()
20 Net Cost - Part B (line 18 minus line 19)	\$		20	\$	20	\$	20	\$
21 80% of Net Cost (line 20) - reimbursable expenses	\$		21	\$	21	\$	21	\$
22 Inpatient professional services rendered by hospital-based radiologists and pathologists-Combined Billing (From Wkst D-3, col 5b, line 12)			22		22		22	
23 Part A deductibles and coinsurance billed to Medicare patients	\$		23 \$		23 \$		23 \$	
24 Bad debts for deductibles and coinsurance, net of bad debt recoveries	()		24 ()		24 ()		24 ()	
25 Net deductibles and coinsurance billed to Medicare patients (line 23 minus line 24)	\$		25 \$		25 \$		25 \$	
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)	\$	\$	26 \$	\$	26 \$	\$	26 \$	\$

**CALCULATION OF REIMBURSEMENT SETTLEMENT - TITLE XVIII
PART A AND PART B SERVICES**

PROVIDER NO.:
HOSPITAL _____

PERIOD:
FROM _____
TO _____

WORKSHEET E-
PART II

PART II - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

DESCRIPTION	HOSPITAL			SUBPROVIDER I			SUBPROVIDER II			SKILLED NURSING FACILITY	
	PART A	PART B		PART A	PART B		PART A	PART B		PART A	PART B
	1	2		3	4		5	6		7	8
1. Reasonable cost of title XVIII - Part A and Part B services			1			1			1		
2. Cost of services (From Part I, line 14)	\$	\$	2	\$	\$	2	\$	\$	2	\$	\$
3. Allowable return on equity capital (From Supplemental Wkst F, Part III, col. 3, line 5)			3			3			3		
4. Renal dialysis cost in excess of limitation (From Supplemental Wkst E-3, sum of cols. 1-3, line 11)		()	4			4			4		
5. TOTAL reasonable cost of title XVIII - Part A and Part B services (Sum of lines 2 and 3 minus line 4)	\$	\$	5	\$	\$	5	\$	\$	5	\$	\$
6. Ratio of Part A and Part B cost to total cost for each provider component			6			6			6		
7. Charges for title XVIII - Part A and Part B services			7			7			7		
8. Inpatient ancillary services (SEE INSTRUCTIONS)	\$		8	\$		8	\$		8	\$	
9. Outpatient services (SEE INSTRUCTIONS)			9			9			9		
10. Inpatient routine services (From provider records)			10			10			10		
11. Intern and resident services (From provider records)			11			11			11		
12. Hospital-based pathologists professional charges - SNF inpatients (From Supp. Wkst D-4, line 4 - EXCL. PROVIDER COMPONENT IF COMBINED CHG)			12			12			12		
13. Ambulance services (From Supplemental Wkst D-5, col. 1, line 5)			13			13			13		
14. Kidney acquisition charges - supplementary to inpatient routine and inpatient ancillary service charges (From Supplemental Wkst D-6, Part II, line 4)			14			14			14		
15.			15			15			15		
16. TOTAL charges for title XVIII - Part A and Part B services (Sum of lines 8-15)	\$		16	\$		16	\$		16	\$	
17. Customary charges			17			17			17		
18. Aggregate amount actually collected from patients liable for payment for services on a charge basis (From provider records)	\$		18	\$		18	\$		18	\$	
19. 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)	\$		19	\$		19	\$		19	\$	
20. Ratio of line 18 to line 19 (not to exceed 1.0000)			20			20			20		
21. TOTAL customary charges (line 16 x line 20)	\$		21	\$		21	\$		21	\$	
22. 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 Wksts E-4, Part I, line 1, or E-4-1, Part I, line 2, as appropriate)	\$		22	\$		22	\$		22	\$	
23. Excess of reasonable cost over customary charges (Sum of Part A and Part B costs on line 5 minus line 21) (Transfer to Supplemental Wksts E-4, Part II, line 3, or E-4-1, Part III, line 3, as appropriate)	\$		23	\$		23	\$		23	\$	
24. Excess reasonable cost applicable to Part A and Part B (line 6 each column x line 23)	\$	\$	24	\$	\$	24	\$	\$	24	\$	\$

**CALCULATION OF REIMBURSEMENT SETTLEMENT - TITLE XVIII
PART A AND PART B SERVICES**

PROVIDER NO.:

HOSPITAL

PERIOD:

FROM

TO

**WORKSHEET E
PART III**

PART III - COMPUTATION OF REIMBURSEMENT SETTLEMENT

DESCRIPTION	HOSPITAL			SUBPROVIDER I			SUBPROVIDER II			SKILLED NURSING FACILITY	
	PART A	PART B		PART A	PART B		PART A	PART B		PART A	PART B
	1	2		3	4		5	6		7	8
1 Net cost of Medicare covered services, excluding return on equity capital and adjustments for Part B costs (From Part I, line 26)	\$	\$	1	\$	\$	1	\$	\$	1	\$	\$
2 Reimbursable return on equity capital (Part A - from Supplemental Wkst F, Part III, col 3, line 5) (Part B - from Supplemental Wkst F, Part III, col 4b, line 5)			2			2			2		
3 Renal dialysis cost in excess of limitation (From Supplemental Wkst E-3, sum of cols 1-3, line 12)		()	3			3			3		
4 SUBTOTAL (Sum of lines 1 and 2 minus line 3)	\$	\$	4	\$	\$	4	\$	\$	4	\$	\$
5 Excess reasonable cost (Part A - from Part II, line 24) (Part B - from Part II, line 24 x .80)	()	()	5	()	()	5	()	()	5	()	()
6 SUBTOTAL (line 4 minus line 5)	\$	\$	6	\$	\$	6	\$	\$	6	\$	\$
7 Reimbursable bad debts (From Wkst E-2, line 12)			7			7			7		
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)	()		8	()		8	()		8	()	
9 TOTAL COST - current cost reporting period (Sum of lines 6 and 7 minus line 8)	\$	\$	9	\$	\$	9	\$	\$	9	\$	\$
10 Recovery of unreimbursed cost under cost limits (From Supplemental Wkst E-4-1, Part II, line 5)			10			10			10		
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)			11			11			11		
12 80% of recovery of unreimbursed cost under lower of cost or charges (line 11) - Part B			12			12			12		
13 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets			13			13			13		
14 Recovery of excess depreciation resulting from provider termination or a decrease in Medicare utilization	()	()	14	()	()	14	()	()	14	()	()
15 Unrefunded charges to beneficiaries for excess costs erroneously collected, based on correction of cost limit	()		15	()		15	()		15	()	
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)	\$	\$	16	\$	\$	16	\$	\$	16	\$	\$
17 Total interim payments (From Wkst E-1, line 4)	()	()	17	()	()	17	()	()	17	()	()
18 Balance due provider/Medicare program (line 16 minus line 17) (Indicate overpayment in brackets)	\$	\$	18	\$	\$	18	\$	\$	18	\$	\$

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED TO TITLE XVIII
(MEDICARE) BENEFICIARIES

PROVIDER NO.:

PERIOD:

FROM:

TO:

WORKSHEET E-1

CHECK ONE:

☐ HOSPITAL☐ SUBPROVIDER I☐ SUBPROVIDER II☐ SKILLED NURSING FACILITY

DESCRIPTION	CATEGORY 1 INPATIENT PART A		CATEGORY 2 INPATIENT PART B		CATEGORY 3 OUTPATIENT PART B	
	MO, DAY, YR	AMOUNT	MO, DAY, YR	AMOUNT	MO, DAY, YR	AMOUNT
1 Total interim payments paid to provider		\$		\$		\$
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 "NONE."		\$		\$		\$
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 "NONE." (1)	Program to Provider	a		\$		\$
		b				
		c				
		d				
		e				
	Provider to Program	f	()	()	()	()
		g	()	()	()	()
		h	()	()	()	()
		i	()	()	()	()
		j	()	()	()	()
SUBTOTAL (Sum of lines 3a-3e minus sum of lines 3f-3j)		k		\$		\$
4 TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 and 3k) (Transfer to Wkst E, Part III, column as appropriate, line 17)		\$		\$		\$

TO BE COMPLETED BY INTERMEDIARY

5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE." (1)	Program to Provider	a		\$		\$
		b				
		c				
	Provider to Program	d	()	()	()	()
		e	()	()	()	()
		f	()	()	()	()
SUBTOTAL (Sum of lines 5a-5c minus sum of lines 5d-5f)		g		\$		\$
6 Determined net settlement amount (balance due) based on the cost report (1)	Program to Provider	a		\$		\$
	Provider to Program	b	\$ ()	\$ ()	\$ ()	\$ ()
7 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		INTERMEDIARY NUMBER		SIGNATURE OF AUTHORIZED PERSON		DATE (MO, DAY, YR)

(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.

**CALCULATION OF REIMBURSABLE BAD DEBTS
TITLE XVIII - PART B**

PROVIDER NO.1

PERIOD:

HOSPITAL

FROM
TO

WORKSHEET E-2

	DESCRIPTION	HOSPITAL	SUBPROVIDER I	SUBPROVIDER II	SKILLED NURSING FACILITY
		1	2	3	4
1	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)	\$	\$	\$	\$
2	Allowable return on equity capital (Col 1 - Amount \$ _____ entered in col 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)				
3	SUBTOTAL (Sum of lines 1 and 2)	\$	\$	\$	\$
4	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)				
5	Balance to be recovered from Medicare (Part B) patients (line 3 minus line 4)	\$	\$	\$	\$
6	Deductibles and coinsurance billed to Medicare (Part B) patients	\$	\$	\$	\$
7	Bad debts for deductibles and coinsurance, net of bad debt recoveries	()	()	()	()
8	Net deductibles and coinsurance billed to Medicare (Part B) patients (line 6 minus line 7)	\$	\$	\$	\$
9	Unrecovered from Medicare (Part B) patients (line 5 minus line 8) (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)	\$	\$	\$	\$
10	Gross bad debts (lesser of line 7 or line 9)	\$	\$	\$	\$
11	Bad debts applicable to professional component and unallowable under title XVIII (line 10 x ratio on line 15)				
12	Reimbursable bad debts (line 10 minus line 11) (Transfer to Wkst E, Part III, cols 2, 4, 6, 8, as appropriate, line 7)	\$	\$	\$	\$

**CALCULATION OF PERCENTAGE OF BAD DEBTS FOR OUTPATIENT SERVICES APPLICABLE TO
PROFESSIONAL COMPONENT OF HOSPITAL-BASED PHYSICIANS - COMBINED BILLING**

13	Professional component charges of hospital-based physicians included in deductibles and coinsurance on line 6	\$			
14	Deductibles and coinsurance (professional component and provider component) billed to Medicare (Part B) patients (From line 6)	\$			
15	Ratio of line 13 + line 14 (Multiply ratio times line 10 and enter results on line 11)				

CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER NO.:	PERIOD:	WORKSHEET E-5
<input type="checkbox"/> TITLE V	<input type="checkbox"/> TITLE XIX	HOSPITAL	FROM _____ TO _____	PART I AND PART II

PART I - COMPUTATION OF NET COST OF COVERED SERVICES

DESCRIPTION		HOSPITAL	SUBPROVIDER I	SUBPROVIDER II
		1	2	3
1	Inpatient ancillary services (From Wkst D, col 6 or 9, line 28)	\$	\$	\$
2	Inpatient routine services (From Wkst D-1, Part II, line 57)			
3	Intern and resident services (From Wkst D-2, Part I, col 8 or 10, lines 9, 10, and 11)			
4	Ambulance Services (From Supplemental Wkst D-5, col 2, line 4 or 6)			
5				
6	SUBTOTAL (Sum of lines 1-5)	\$	\$	\$
7	Differential in charges between semiprivate accommodations and less than semiprivate accommodations	()	()	()
8	SUBTOTAL (line 6 minus line 7)	\$	\$	\$
9	Inpatient professional services rendered by hospital-based physicians - Combined Billing (From Wkst D-3, col 5a or 5d, line 12)			
10	Amounts paid and payable by Workmen's Compensation	()	()	()
11	SUBTOTAL (Sum of lines 8 and 9 minus line 10)	\$	\$	\$
12	Deductibles and coinsurance billed to health care program inpatients	\$	\$	\$
13	Bad debts for deductibles and coinsurance, net of bad debt recoveries.	()	()	()
14	Net deductibles and coinsurance billed to health care program inpatients (line 12 minus line 13)	\$	\$	\$
15	Net cost of covered services to health care program inpatients, excluding return on equity capital (line 11 minus line 14)	\$	\$	\$

**PART II - COMPUTATION OF LESSER OF REASONABLE COST
OR CUSTOMARY CHARGES**

DESCRIPTION		HOSPITAL	SUBPROVIDER I	SUBPROVIDER II
		1	2	3
1	Reasonable cost of inpatient services			
2	Cost of services (From Part I, line 8)	\$	\$	\$
3	Allowable return on equity capital (From Supplemental Wkst F, Part III, line 4 or line 6)			
4	TOTAL reasonable cost of inpatient services (Sum of lines 2 and 3)	\$	\$	\$
5	Charges for inpatient services			
6	Inpatient ancillary services (SEE INSTRUCTIONS)	\$	\$	\$
7	Inpatient routine services (From provider records)			
8	Ambulance services (From Supplemental Wkst D-5, col 1, line 4 or 6)			
9				
10	TOTAL charges for inpatient services (Sum of lines 6-9)	\$	\$	\$
11	Customary charges			
12	Aggregate amount actually collected from patients liable for payment for services on a charge basis (From provider records)	\$	\$	\$
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)	\$	\$	\$
14	Ratio of line 12 to line 13 (Not to exceed 1.0000)			
15	TOTAL customary charges (line 10 x line 14)	\$	\$	\$
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)	\$	\$	\$
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)	\$	\$	\$

CALCULATION OF REIMBURSEMENT SETTLEMENT <input type="checkbox"/> TITLE V <input type="checkbox"/> TITLE XIX	PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____	WORKSHEET E-5 PART III
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PART III - COMPUTATION OF REIMBURSEMENT SETTLEMENT

DESCRIPTION		HOSPITAL	SUBPROVIDER I	SUBPROVIDER II
		1	2	3
1	Net cost of covered services to health care program inpatients, excluding return on equity capital (From Part I, line 15)	\$	\$	\$
2	Reimbursable return on equity capital (From Part II, line 3)			
3	SUBTOTAL (Sum of lines 1 and 2)	\$	\$	\$
4	Excess reasonable cost (From Part II, line 17)	()	()	()
5	Recovery of unreimbursed costs under cost limits (From Supplemental Wkst E-4-1, Part II, line 5)			
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)			
7	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets			
8	Recovery of excess depreciation resulting from provider termination or a decrease in Medicare utilization	()	()	()
9	Unrefunded charges to beneficiaries for excess costs erroneously collected, based on correction of cost limit	()	()	()
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)	\$	\$	\$
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)	()	()	()
12	Balance due provider/health care program (line 10 minus line 11) (Indicate over-payment in brackets)	\$	\$	\$

BALANCE SHEET		FORM 55A-2552 (5-75)	
(To be completed by all providers maintaining fund type accounting records. Nonproprietary providers not maintaining fund type accounting records, should complete the "General Fund" column only)		31	
PROVIDER NO.:	HOSPITAL	TO	FROM
PERIOD:			
FORM APPROVED	OMB No. 72-R-1010	WORKSHEET G	
ASSETS		LIABILITIES AND FUND BALANCES (Omit Cash)	
CASH ON HAND AND IN BANKS		CURRENT LIABILITIES	
1		34	
2		35	
3		36	
4		37	
5		38	
6		39	
7		40	
8		41	
9		42	
10		43	
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466		499	
467		500	
468		501	

STATEMENT OF CHANGES IN FUND BALANCES				PROVIDER NO.: HOSPITAL _____		PERIOD: FROM _____ TO _____		WORKSHEET G-1	
		GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND	
1	Fund balance at beginning of period		\$		\$		\$		\$
2	Net Income (loss) (From Worksheet G-3, line 32)								
3	Total (Sum of line 1 and line 2)		\$		\$		\$		\$
4	Additions (Credit adjustments) (Specify)	\$		\$		\$		\$	
5									
6									
7									
8									
9									
10	Total Additions (Sum of lines 4-9)		\$		\$		\$		\$
11	Subtotal (line 3 plus line 10)		\$		\$		\$		\$
12	Deductions (Debit adjustments) (Specify)	\$		\$		\$		\$	
13									
14									
15									
16									
17									
18	Total Deductions (Sum of lines 12-17)		\$		\$		\$		\$
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		\$		\$		\$		\$

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	PROVIDER NO.:	PERIOD:	WORKSHEET G-2
	HOSPITAL _____	FROM _____ TO _____	

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
1 GENERAL INPATIENT ROUTINE CARE SERVICE			
2 Hospital	\$		\$
3 Subprovider I			
4 Subprovider II			
5 Skilled Nursing Facility - Certified			
6 Skilled Nursing Facility - Noncertified			
7 TOTAL General Inpatient Routine Care Service (Sum of lines 2-6)	\$		\$
8 SPECIAL INPATIENT CARE SERVICE			
9 Intensive Care Unit	\$		\$
10 Coronary Care Unit			
11			
12			
13 TOTAL Special Care Service (Sum of lines 9-12)	\$		\$
14 TOTAL Inpatient Routine Care Service (Sum of lines 7 & 13)	\$		\$
15 Ancillary Service		\$	
16 Outpatient Service			
17 Home Health Agency			
18 Ambulance			
19			
20			
21 TOTAL Patient Revenues (Sum of lines 14-20) (Transfer col 3 to Wkst G-3, line 1)	\$	\$	\$

PART II - OPERATING EXPENSES

1	Operating Expenses (Per Worksheet A, col 3, line 72)	\$
2	Add (Specify)	\$
3		
4		
5		
6		
7		
8	TOTAL Additions (Sum of lines 2-7)	
9	Deduct (Specify)	\$
10		
11		
12		
13		
14	TOTAL Deductions (Sum of lines 9-13)	()
15	TOTAL Operating Expenses (Sum of lines 1 and 8 minus line 14) (Transfer to Worksheet G-3, line 4)	\$

STATEMENT OF REVENUE AND EXPENSES		PROVIDER NO.: HOSPITAL _____	PERIOD: FROM _____ TO _____	WORKSHEET G-3
1	Total patient revenues (From Wkst G-2, Part I, col 3, line 21)			\$ _____
2	Less - Allowances and discounts on patients' accounts			\$ _____
3	Net patient revenues (line 1 minus line 2)			\$ _____
4	Less - Total operating expenses (From Wkst G-2, Part II, line 15)			\$ _____
5	Net income from service to patients (line 3 minus line 4)			\$ _____
6	Other income:			
7	Contributions, donations, bequests, etc.		\$ _____	
8	Income from investments			
9	Revenue from telephone and telegraph service			
10	Revenue from television and radio service			
11	Purchase discounts			
12	Rebates and refunds of expenses			
13	Parking lot receipts			
14	Revenue from laundry and linen service			
15	Revenue from meals sold to employees and guests			
16	Revenue from rental of living quarters			
17	Revenue from sale of medical and surgical supplies to other than patients			
18	Revenue from sale of drugs to other than patients			
19	Revenue from sale of medical records and abstracts			
20	Tuition (Fees, sale of textbooks, uniforms, etc.)			
21	Revenue from gifts, flower, coffee shops, and canteen			
22	Revenue from vending machines			
23	Rental of hospital space			
24	Other (Specify)			
25	Other (Specify)			
26	Total other income (Sum of lines 7 - 25)			\$ _____
27	Total (line 5 plus line 26)			\$ _____
28	Other expenses (Specify):		\$ _____	
29			
30			
31	Total other expenses (Sum of lines 28 - 30)			\$ _____
32	Net income (or loss) for the period (line 27 minus line 31)			\$ _____

MICHIGAN NURSING CARE FACILITY
MICHIGAN SUPERVISED RESIDENTIAL CARE FACILITY
STATISTICAL AND OPERATING COST REPORT INSTRUCTIONS

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".

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

- (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).

Schedule B - Statistical Data

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.

Line 8 -

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:

-11-

<u>No. of Beds in Home</u>	<u>Maximum Allowable Combined Salary Allowance</u>
1 - 49	\$ 18,975
50 - 99	31,625
100 - 149	37,950
150 and over	56,925

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:

<u>Bed Size</u>	<u>Administrators</u>	<u>Median Administrators</u>	<u>Assistant Administrators</u>	<u>Median Assistant Administrators</u>
Up to 25	\$ 7,000-11,000			
25 - 49	\$ 7,000-15,000	\$11,786	\$ 4,000- 7,000	\$ 4,977
50 - 74	\$ 7,000-17,000	\$12,400	\$ 4,000-10,000	\$ 7,400
75 - 99	\$ 8,000-22,000	\$13,521	\$ 5,000-10,000	\$ 7,800
100 - 149	\$ 9,000-23,000	\$12,000	\$ 5,000-13,000	\$ 9,750
150 - 199	\$10,000-25,000	\$15,000	\$ 7,000-15,000	\$10,800
200 - 249	\$12,000-26,000	\$16,719	\$10,000-16,000	\$12,095
250 and over	\$12,000-27,000	\$20,350	\$12,000-18,000	\$15,500

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

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

Name _____

Provider Number _____

Address _____

For Year Ended _____

City _____

Report of (Check One)

_____ Entire Facility
_____ Distinct Part

Licensed As

- ☐ Hospital
☐ Nursing Home
☐ Home for Aged

Certified As

- ☐ Extended Care (Title XVIII)
☐ Skilled Nursing Home
☐ Basic Nursing Home
☐ Residence for the Aged

Type Control

- ☐ Voluntary Non-Profit
☐ Governmental
☐ Proprietary

☐ Individual
☐ Partnership
☐ Corporation
☐ Other

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.

1.

DSS-1876 (11-77)

Provider No. _____

SCHEDULE D, Section 4

SALARIES AND WAGES

	Gross Wages Paid Last Calendar Year per W-2's	Average Hourly Rate of Pay	Total Hours Worked	Remarks
Officers' Salaries and Fees				
Administrator				
Director of Nursing and Assistants				
In-Service Training				
In-Charge Nurses				
Registered Nurses				
Licensed Practical Nurses				
Nurses Aides				
Orderlies				
Medical Records Clerks				
Office and Clerical				
Maintenance				
Housekeeping				
Laundry				
Kitchen				
Occupational Therapists				
Physical Therapists				
Pharmacists				
Speech Therapist				
Other _____				
Total Salaries and Wages Paid as Reported to IRS (W-2's)				

5.

OSS-1876 (11-77)

SCHEDULE D
ANALYSES OF INCOME AND EXPENSES

Provider Number _____

FOR THE _____ ENDED _____, 19 _____

SCHEDULE D, SECTION 1

**SELECTED PATIENT REVENUE (except routine nursing services)
AND OTHER INCOME ACCOUNTS**

Inpatient Revenue:

1. _____ \$ _____
2. _____
3. Oxygen _____
4. Blood and Plasma _____
5. Pharmacy _____
6. X-Ray _____
7. Laboratory _____
8. _____
9. Medical Supplies _____
10. Therapy _____
11. _____
12. Patient Laundry income _____
13. _____

Outpatient Revenue

14. X-Ray _____
15. Laboratory _____
16. Emergency _____
17. Therapy _____
18. _____
19. _____

Other Income:

20. Revenue from meals sold employees, guests, etc. _____
21. Revenue from sale drugs, supplies, laundry to others
than patients. _____
22. Revenue from rental of non-patient facilities _____
23. Purchase discounts (Trade, Quantity, Time, Rebate) _____
24. Contributing donations, bequests, etc. _____
25. Income from Investments _____
26. Other _____
27. _____

Total _____

SCHEDULE D, SECTION 2

OPERATING EXPENSES

1. Nursing Wages \$ _____
2. Nursing Wage Fringes and Payroll Taxes _____
3. Raw Food Costs _____
Sub-Total _____
4. Other Nursing Expenses _____
5. Other Dietary Expenses _____
6. Administrative and General _____
7. Housekeeping _____
8. Laundry and Linen _____
9. Operation and Maintenance of Plant _____
10. Medical Supplies _____
11. Pharmacy _____
12. X-Ray Dept. _____
13. Laboratory Dept. _____
14. Therapy Dept. _____
15. _____
16. Outpatient Dept. _____
17. Depreciation - Buildings _____
18. Depreciation - Equip., etc. _____
19. Purchased Services _____
20. Rent _____
21. Interest _____
22. Property Taxes _____
23. Association Dues _____
24. _____
25. _____
26. _____
27. Total Expenses _____

SCHEDULE D, SECTION 3

DEPRECIATION
(Lines 17 and 18, above)

Description of Property	Date Acquired	Cost or other basis	Depreciation allowed or allowable in prior year	Method computing Depreciation	Life or rate	Depreciation claimed for this year
Buildings		\$ _____	\$ _____	Straight Line		\$ _____
Furniture and Fixtures				" "		
Transportation Equipment				" "		
Machinery & other Equipment				" "		
Other (Specify)				" "		
Fully Depreciated Assets				" "		
				" "		
				" "		
				" "		
				" "		

Totals to lines 17 & 18, Schedule D, Section 2, above

Assessed Valuation - Real Property
exclusive of land \$ _____

Personal Property \$ _____

DSS-1876 (11-77)

4.

SCHEDULE C

Provider Number _____

BALANCE SHEET ACCOUNTS ON _____ 19 ____
(date)

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: | <u>Cost</u> | <u>Reserve</u> | <u>Book Value</u> | |
| a. Land | _____ | _____ | _____ | |
| b. Buildings | _____ | _____ | _____ | |
| c. Leasehold Improvements | _____ | _____ | _____ | |
| d. Equipment | _____ | _____ | _____ | |
| 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 | \$ _____ |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MICHIGAN

Attachment 4.19-E
Page 1

POLICY AND METHODS FOR TIMELY CLAIMS PAYMENT

8/23/79 | The Michigan Department of Social Services defines a "claim" as a "bill for services" in accordance with 42 CFR 447.45(b).

Rev. 8/23/79

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Requirements for Third Party Liability – Identifying Liable Resources

1. Frequency of Data Exchanges

433.138: Determining Liability of Third Parties

(d)(1) – State wage information collection agencies (SWICA): the Michigan Department of Health and Human Services (MDHHS) receives a SWICA file, but no longer uses this file to determine employer sponsored health insurance. Instead, MDHHS uses the Michigan insurance disclosure program that requires health insurance carriers and pharmacy benefit managers to submit member eligibility data on a monthly basis at minimum.

(d)(2) – Commercial health insurance carriers: monthly at minimum

(d)(3) – IV-A: Part of the SWICA exchange

(d)(4) – Workers' compensation: Monthly

– Motor vehicle: MDHHS has a data exchange agreement with the Michigan State Police Traffic Crash Reporting System (TCRS): Weekly

– Trauma codes: Weekly

2. Timeliness of Follow-up

433.138(g)(1)(ii): When appropriate the MDHHS 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.

433.138 (g)(2): Workers Compensation

MDHHS contracts with a vendor who receives a quarterly file from the department of workforce development (DWD) which contains social security numbers utilized for matching purposes.

433.138 (g)(2): Insurance Disclosure Requirement

This program that requires health insurers to disclose eligibility information on all insured Michigan residents monthly, at minimum. This information is used by Michigan to match against the Medicaid eligibility files to identify Medicaid members with insurance coverage.

TN NO.: 21-0017

Approval Date: : JAN 14, 2022

Effective Date: 1/01/2022

Supersedes

TN No.: 07-05

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Requirements for Third Party Liability – Identifying Liable Resources

3. Motor Vehicle Data Match and Tort/Casualty Processing

433.138 (g)(2)(ii): The motor vehicle data exchange agreement allows for matching recipient claims data with the Michigan State Police Traffic Crash Reporting System (TCRS) accident files for potential matches and potential recovery action.

4. Methods for Paid Claim Follow-up

433.138 (g)(3), 433.138 (g)(4): MDHHS identifies and pursues paid claims that are indicative of trauma and injury for the purposes of determining the legal liability of third parties. Once the aggregation of claims meets the threshold, a questionnaire is mailed to the recipient requesting information to determine if recovery is possible. The collection case file maintained by the MDHHS Third Party Electronic Database (TED) contains all information relevant to management of the case.

TN NO.: 21-0017

Approval Date: : JAN 14, 2022

Effective Date: 1/01/2022

Supersedes
TN No.: 07-05

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Requirements for Third Party Liability – Payment of Claims

Guidelines Used to Determine When to Seek Reimbursement from a Liable Third Party

The following criteria are used in selecting claims which will be billed to third party insurers, or will be investigated for further collection action:

433.139 (d)(3); 433.139 (f): Health Insurance

Through analysis of schedules of benefits, payment statistics, and the denial notices sent to us by insurance carriers, certain items and services are excluded from cost avoidance and have been eliminated from post payment billing.

When it is discovered that commercial insurance benefits have been paid to the provider or the insured in duplication of the medical assistance payment to the provider, recovery of amounts that are greater than \$20 is sought from the provider within 12 months of the claim from date of service. Amounts of less than \$20 are pursued directly from the payer within three years of the claim from date of service if staff time permits recovery.

433.139 (f)(2): Thresholds for Seeking Reimbursement

MDHHS uses no accumulation threshold for health insurance reimbursement.

Health insurance recovery action on claim types likely to be covered by insurance occurs when payments made by the MDHHS are greater than \$20.00 for medical services and \$15.00 or greater for pharmacy services.

Personal injury investigative action occurs when hospital bills with trauma diagnoses having billed amounts equal to or greater than \$300 are investigated. Investigative resources which would be required to pursue smaller bills can be used more productively to carry out tasks that yield much higher rates of return.

Casualty cases are pursued when they meet a \$300 threshold for automobile and workers' compensation cases and \$1,000 for general liability and medical malpractice. Cases under the threshold may be pursued if time permits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Requirements for Third Party Liability – Payment of Claims

Third Party Billing Conditions:

1. Monitoring Provider Compliance:
433.139 (b)(1); 433.139 (b)(3): Cost Avoidance

Claims are processed in an automated environment, according to configurable table rules. These rules describe avoidance criteria in terms of claim content and provider supplied insurance explanation codes on claims. When the claim conditions match the configured table rules, the cost avoidance edits prevent payment, and tell providers that other insurance is available to bill prior to Michigan Medicaid.

433.139 (c): The State requires the provider to utilize all other resources to their fullest extent before presenting the claim to Medicaid for payment. Providers must secure other insurance adjudication response(s) which must include claim adjustment reason codes (CARCS) prior to billing Medicaid.

433.139 (b)(3): If the insurance provided by a non-custodial parent has restrictions for services received outside a service area, the dependents are treated as uninsured. This kind of insurance information is either not added to the dependent's eligibility record on MMIS or it is removed when the situation is identified. This assures that access to medical care is not precluded or diminished by provider concerns about payment when a non-custodial parent is uncooperative in claiming insurance benefits.

Michigan complies with the following requirements.

- SSA section 1902 (a)(25)(e): the requirement for states to apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services.
- SSA section 1902 (a)(25)(e): the requirement for states to make payments without regard to potential third party liability for pediatric preventive services, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Michigan

Requirements for Third Party Liability – Payment of Claims

- SSA section 1902 (a)(25)(f): State flexibility to make payments without regard to potential third party liability for up to 100 days for claims related to child support enforcement beneficiaries.

433.139 (b)(1); 433.139 (d): Providers are monitored for compliance with insurance billing requirements through post payment recovery responses. If a report of prior payment to either the provider or the insured person is received, the amount paid by the insurer is recouped from the provider.

2. 433.139 (d), 433.139 (f): Provider Based Billing, also Called “Disallowment” Nationally

Provider based billing occurs when Medicare (parts a, b and d), Medicare advantage insurance coverage, Medicare supplemental insurance coverage, and other commercial health insurance coverage is discovered after Medicaid has paid provider claims. Under provider-based billing, Medicaid produces notices that are sent to the providers of service with instructions to bill Medicare or the other health insurance carrier. If payment is received from Medicare or the other health insurance carrier, providers need to adjust their original Medicaid claim. If an adjustment is not received, or if the provider does not forward a copy of the Medicare or other health insurance carrier denial, Medicaid will recoup its payment 30 days from the date of the provider based billing.

3. 433.139 (d), 433.139 (f): insurance Based Billing, also Called “Direct Billing” Nationally

Insurance based billing occurs when Medicare advantage insurance coverage, Medicare supplemental insurance coverage, or other commercial health insurance coverage is found after Medicaid has paid provider claims and after a provider’s timely filing allowance has expired with these carriers. Under insurance based billing, Medicaid produces and sends claims to the other health insurance carrier directly for payment recovery purposes.

Revision: HCFA-PM-91-8 (MB)
October 1991

ATTACHMENT 4.22-C
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: MICHIGAN

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

TN No. 91-30

Supersedes

Approval Date 07-06-92

Effective Date 10-01-91

TN No. N/A

HCFA ID: 7985E

State/Territory: _____

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.

TN No. 93-24
Supersedes
TN No. N/A

Approval Date 10-20-93

Effective Date 7-1-93

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Program Administration

Citation

Sanctions for MCOs and PCCMs

1932(e)
42 CFR 428.726

- (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:
- (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.
- (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).

____ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

TN NO.: 03/13

Approval Date: 12/9/2003

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

06/01/86

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.

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

Attachment 4.33-A
Page 1
OMB NO.: 0938-0193

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.

TN No. 87-11

Supersedes

TN No. N/A

Approval Date 08/26/87

Effective Date 01/01/87



JOHN ENGLER, Governor

DEPARTMENT OF PUBLIC HEALTH

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P.O. BOX 30195, LANSING, MICHIGAN 48909

VERNICE DAVIS ANTHONY, MPH, Director

November 25, 1991

**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.



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.

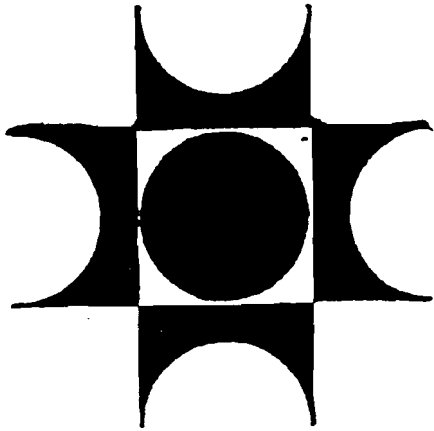
In addition to this memorandum, this mailing contains a reprinting of the federal statutory change along with a short article on practical considerations regarding implementation that should be shared with your legal advisor and those responsible for implementation of this new requirement.

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", 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:

"(f)(1) For purposes of subsection (a)(1)(Q) and sections 1819 (c)(2)(E), 1833(r), 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:

"(8) 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. 13951) 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. 1395i-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)."

(e) 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 (42U.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
LAYERS 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

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JUNE 1995

Attachment 4.35-A
Page 1

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):

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Attachment 4.35-B
Page 1

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.)

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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

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.)

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Page 1

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.

☒ 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 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

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.

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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 total 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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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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Page 1

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.)

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Supersedes

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Page 1

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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TN No. 94-21

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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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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

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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.

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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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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

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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

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.

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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

(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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Michigan

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

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.

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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.

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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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Michigan

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.

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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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperation with Medicaid Integrity Program Efforts

<u>Citation</u>	4.43 Cooperation with Medicaid Integrity Program Efforts
1902(a)(69) of the Act, P.L. 109-171 (section 6034)	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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperation with Medicaid Integrity Program Efforts

<u>Citation</u>	4.44	Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States
1902(a)(80) of the Social Security Act, P.L. 111-148 (section 6505)		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.

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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) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L. 111-152	4.45	<u>Provider Screening and Enrollment</u> The State Medicaid agency gives the following assurances:
42 CFR 455 Subpart E		PROVIDER SCREENING <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416		TERMINATION OR DENIAL OR ENROLLMENT <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Cooperation with Medicaid Integrity Program Efforts

Citation

42 CFR 455.432	SITE VISITS <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 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

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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.