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State/Territory Name: Michigan

State Plan Amendment (SPA) #: MI 17-0003

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850



Financial Management Group

MAY 08 2017

Mr. Chris Priest, Director
Medical Services Administration
Department of Community Health
400 South Pine
Lansing, MI 48933

RE: Michigan State Plan Amendment (SPA) 17-0003

Dear Mr. Priest:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 17-0003 effective for services on or after January 1st, 2017, updates language to reflect that provider payments will be stopped when an acceptable hospital cost report is not submitted to the department within 30 days of notice of delinquency. Restitution of withheld payments will be made by the State agency after receipt of an acceptable cost report.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 17-0003 is approved effective January 1st, 2017. We are enclosing the HCFA-179 and the amended plan pages.

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

Sincerely,

A black rectangular box redacting the signature of Kristin Fan.

Kristin Fan
Director

Enclosure

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

1. TRANSMITTAL NUMBER:

17 - 0003

2. STATE:

Michigan

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

4. PROPOSED EFFECTIVE DATE
January 1, 2017

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 413.24

7. FEDERAL BUDGET IMPACT:

a. FFY 2017 \$0

b. FFY 2018 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Page 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19-A, Page 3

10. SUBJECT OF AMENDMENT:

Updates language to reflect that provider payments will be stopped when an acceptable hospital cost report is not submitted to the department within 30 days of notice of delinquency. Restitution of withheld payments will be made by the State agency after receipt, of an acceptable cost report.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Chris Priest, Director

Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Chris Priest

14. TITLE:

Director, Medical Services Administration

15. DATE SUBMITTED:

February 22, 2017

16. RETURN TO:

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

Attn: Erin Black

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

MAY 08 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JAN 01 2017

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPE NAME:

Kristin Fan

22. TITLE:

Director, FMCO

23. REMARKS:

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 MSA DEPARTMENT. If the AN ACCEPTABLE cost report is not submitted within 30 days of the notice of delinquency, ~~a second notice of delinquency will be issued. If the cost report is not submitted within 30 days of a second 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.: 17-0003

Approval Date MAY 0, 8 2017

Effective Date: 01/01/2017

Supersedes

TN No.: 15-0014