

## **Table of Contents**

**State/Territory Name: Michigan**

**State Plan Amendment (SPA)#: 23-0028**

This file contains the following documents in the order listed

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

**DEPARTMENT OF HEALTH & HUMAN SERVICES**  
Centers for Medicare & Medicaid Services  
601 E. 12th St., Room 355  
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

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December 18, 2023

Meghan E. Groen  
Senior Deputy Director  
Behavioral and Physical Health and Aging Services Administration  
Michigan Department of Health and Human Services  
400 S Pine St 7th Fl  
Lansing, MI 48933-2250

Re: Michigan State Plan Amendment (SPA) 23-0028

Dear Director Groen:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid Alternative Benefit Plan (ABP) State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0028. This SPA clarifies language regarding prior authority requirements and maximum benefits for skilled maintenance therapy.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a) of the Social Security Act and 42 CFR 447. We hereby inform you that Medicaid State plan amendment 23-0028 is approved effective January 1, 2024. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Keri Toback at 312-353-1754 or via email at [keri.toback@cms.hhs.gov](mailto:keri.toback@cms.hhs.gov).

Sincerely,

James G. Scott, Director  
Division of Program Operations

Enclosures  
cc: Erin Black

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER 23 — 0028	2. STATE MI						
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT							
5. FEDERAL STATUTE/REGULATION CITATION 1902(a) of the Social Security Act and 42 CFR 447		3. PROPOSED EFFECTIVE DATE January 1, 2024							
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  Supplement to Attachment 3.1-A Page 8 Supplement to Attachment 3.1-A Page 9 Supplement to Attachment 3.1-A Page 12a Supplement to Attachment 3.1-A Page 22		6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a FFY 2023 \$0 b FFY 2024 \$0							
9. SUBJECT OF AMENDMENT This SPA clarifies language regarding prior authority requirements and maximum benefits for skilled maintenance therapy.		8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Supplement to Attachment 3.1-A Page 8 (TN# 14-0016) Supplement to Attachment 3.1-A Page 9 (TN# 02-06) Supplement to Attachment 3.1-A Page 12a (TN# 22-0017) Supplement to Attachment 3.1-A Page 22 (TN# 17-0001)							
10. GOVERNOR'S REVIEW (Check One) <table style="width:100%; margin-top: 10px;"> <tr> <td style="width: 50%;"><input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT</td> <td style="width: 50%;"><input checked="" type="checkbox"/> OTHER, AS SPECIFIED:</td> </tr> <tr> <td><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED</td> <td></td> </tr> <tr> <td><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL</td> <td></td> </tr> </table>				<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT	<input checked="" type="checkbox"/> OTHER, AS SPECIFIED:	<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		<input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT	<input checked="" type="checkbox"/> OTHER, AS SPECIFIED:								
<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED									
<input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL									
11. TYPED NAME Meghan Groen		15. RETURN TO Behavioral and Physical Health and Aging Services Administration Office of Strategic Partnerships & Medicaid Administrative Services – Federal Liaison Capitol Commons Center – 7 <sup>th</sup> Floor 400 South Pine Lansing, Michigan 48933  Attn: Erin Black							
12. TITLE Senior Deputy Director		14. SIGNATURE OF STATE AGENCY OFFICIAL							
13. DATE SUBMITTED October 23, 2023		16. DATE RECEIVED 10/23/2023							
FOR CMS USE ONLY									
18. EFFECTIVE DATE OF APPROVED MATERIAL 01/01/2024		17. DATE APPROVED 12/18/2023							
PLAN APPROVED - ONE COPY ATTACHED									
20. TYPED NAME OF APPROVING OFFICIAL James G. Scott		19. SIGNATURE OF APPROVING OFFICIAL							
22. REMARKS		21. TITLE OF APPROVING OFFICIAL Director, Division of Program Operations							

## 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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#### **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)

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TN NO.: 23-0028

Approval Date: 12/18/2023

Effective Date: 1/01/2024

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***

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Reserved Page

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TN NO.: 23-0028

Approval Date: 12/18/2023

Effective Date: 1/01/2024

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***

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Except For State Veterans Homes, the following services are excluded from the nursing facility per diem rate:

1. Physical therapy, as defined in 1.a. Prior Authorization is required 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.

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TN NO.: 23-0028

Approval Date: 12/18/2023

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Supersedes  
TN No.: 22-0017

**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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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;

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TN NO.: 23-0028

Approval Date: 12/18/2023

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Supersedes

TN No.: 17-0001