STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

March 2009

Dear Prepaid Inpatient Health Plan and Community Mental Health Services Program Providers (CMHSP):

This letter provides:

- Information regarding a cost adjustment for Fiscal Years (FY) 2008 and 2009, and
- Guidance for when and how the cost adjustment will be applied and processed.

Recognizing that current Medicaid screens do not fully cover the CMHSPs' costs for providing Children's Home and Community Based Services Waiver Program (CWP) services, over the past year we have explored alternatives for providing additional Medicaid funding to CMHSPs. As a result, we have sought and received approval from the Centers for Medicare & Medicaid Services (CMS) to implement a cost adjustment for FY 2008 and FY 2009.

Background Information Regarding the Cost Adjustment

The adjustor payment will enable your agency to earn additional federal Medicaid dollars to partially cover the cost of CWP services that were previously funded with non-Medicaid resources. The cost adjustment for FY 2008 and FY 2009 dates of service will be computed based on statewide paid claim data following the process identified below and the CMS-approved methodology outlined in *Appendix I-2: Rates, Billing and Claims* (attached).

Cost Adjustment Processing Information

In order to analyze data and process an adjustor payment for FY 2008 dates of service during August 2009, you must submit all outstanding claims to Medicaid Management Information System (MMIS) for FY 2008 dates of service by May 6, 2009 (pay cycle 18). Although you have up to 12 months from the date of service to bill Medicaid, payment for claims submitted after May 6, 2009, will not be included in the calculation of the adjustment payment. Please note, the adjustor payment for each of the approved years will be calculated only once, and will be based only on paid claim data available at the deadline from the Michigan Department of Community Health (MDCH) Data Warehouse (pended/rejected claim data will not be considered). Based on this calculation, an adjustor payment will be issued once a year in the form of a gross adjustment.

For each CMHSP, paid claim data will be analyzed for billable CWP service codes for each procedure for which there was one or more claim. For those procedures billed by only one CMHSP, the existing screen will be used and no adjustment will be made. The following eight codes will be excluded from adjustment: E1340, E1399, S5165, S5199, T1999, T2028, T2029, T2039. The attached document (*Appendix I-2: Rates, Billing and Claims*) provides a complete explanation of the CMS-approved methodology that will be used for this cost adjustment.

Please direct questions to Joan Deschamps at 517-241-5768, e-mail Deschampsj@michigan.gov or to Debbie Milhouse-Slaine at 517-241-5768, e-mail Milhouse@michigan.gov.

Sincerely,

Stephen Fitton, Acting Director
Medical Services Administration

Michael J. Head, Director
Mental Health and Substance Abuse Administration

Appendix I: Financial Accountability

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Overview: Provider payment rates in the form of Medicaid fee screens are established by the Medicaid Agency, published on the Medicaid web site and are available to providers, waiver participants and the general public. All waiver service providers are paid uniformly at the lesser of their charges or the established Medicaid fee screen. Because Medicaid fee screens have not kept pace with increasing costs, many CMHSPs must use local, non-Medicaid resources to fund the costs that exceed the Medicaid fee screens. As additional state appropriations to the MDCH are not available to support an increase in Medicaid fee screens for CWP services, the MDCH has developed a methodology for adjusting payments to CMHSPs for services provided to CWP consumers. For purposes of this discussion, the term "interim screen" or "interim fee screen" refers to the established Medicaid fee screen used to pay claims as submitted to the Medicaid invoice processing system (detailed in I-2 b. below). The term "final fee screen" is used to denote the adjusted maximum amount payable for each service, determined via the methodology outlined below at year-end. Those providers whose costs / charges exceeded the interim screen will provide the non-federal share (i.e., 1-FMAP) for the Medicaid payment difference accruing from the final fee screens, and will do so in the form of an intergovernmental transfer. Payments to providers will be adjusted to final once a year. The final fee screens are set to the Medicare Physicians Fee Schedules where applicable, and to the 90 percentile of provider charges for those without a fee published within the Medicare Physicians Fee Schedule. Detail regarding the proposed method for determining the final fee screen for each waiver and state plan service available to CWP participants is outlined under "Methodology Detail" below.

Responsible Entity (-ies): Within MDCH, Michigan's Single State Medicaid Agency, the Medical Services Administration (MSA) establishes the interim fee screens (i.e., provider payment rates); the Mental Health and Substance Abuse Administration (MH&SAA) in collaboration with MSA implements the methodology that results in the final fee screens. Oversight of the final fee screen (rate) determination methodology is provided by the staff of MSA and MH&SAA. Both the interim and final fee screens are reviewed by the Budget, Accounting and Audit Offices within MDCH.

Public Comment: The interim and final fee screens are presented and comments solicited from attendees of the CWP track of the annual CWP – HSW conference. This conference is well publicized and well attended by waiver participants, their families and friends, and a wide variety of the key/invested stakeholders.

Informing Waiver Participants About Service Rates: As noted in the overview, above, the rates are published on the MDCH web site. The interim and final fee screens are also available to participants as well as the general public in written form when requested.

Methodology Detail: The methodology outlined below combines the strengths of Medicare's RBRVS-based Physician's Fee Schedule, the 90th percentile of charges method used by third party payers throughout the health care industry, and pricing conventions from Michigan's current CWP fee screens [applicable to procedures provided to more than one beneficiary at a time and/or those eligible for a holiday premium rate]. The goal of the adjustment is assure the federal reimbursement for these Medicaid covered services is calculated based on their full cost and reimbursed consistent with the applicable Federal Medical Assistance Percentages. The steps of the "adjust interim to final fee screens" methodology are the following:

1) Draw from the MDCH Data Warehouse the fee for service claims experience for the beneficiary ID #'s of CWP enrollees [qualifying those ID against PT 77 and the CMH Clinic specialty code 0253] for FY 2006, Q4 FY 2006, and FY 2007. For each procedure for which there was one or more claim(s), query the Data Warehouse for: a) the billing CMHSP, b) a distinct count of the beneficiaries receiving, c) the total units claimed, d) the total charges and, e) the total payments. Perform a parallel query for those procedures subject to holiday premium payments for the holidays within each of the date ranges, subtract the units, charges and payments for the holiday dates from the base data to assure no duplication and display them separately [at the bottom of each of the date range tabs]. **Note:** CMHSP's are bound by their Medicaid Provider Agreements and Master Contracts with MDCH to assure their charges are determined consistent with Generally Accepted Accounting Principles and OMB Circular A-O87.

2) Remove from fee screen adjustment to final consideration those claimed procedures for which adjustment makes no sense [e.g., the item and payment amount is prior authorized, includes up to "x" items for a maximum charge, or the items covered under the fee screen are diverse and charges aren't necessarily the same, etc.]. The follow eight codes will be excluded from adjustment: E1340, E1399, S5165, S5199, T1999, T2028, T2029, T2039.

3) Calculate average charge per unit [total charges/total units] for each CMHSP billing for each procedure, and array the average unit charges for each procedure in descending order.

4) Review each of the claimed procedures for a corresponding "non-facility fee" within the Medicare Physicians Fee Schedule for Michigan, and where one exists set it as the final CWP fee screen.

5) Where claimed procedures have no corresponding fee within the Medicare Physicians Fee Schedule for Michigan, calculate the 90th percentile of the arrayed average unit charges and set the result as the final CWP fee screen.

6) Consistent with the existing CWP fee screen protocol, the screens for procedures provided to more than one beneficiary at a time, are designated with a TT modifier and will be set at 75% of the corresponding unmodified procedure's final fee screen (e.g., final fee screen for T1005 TT will be set at 75% of T1005's adjusted screen).

7) Also consistent with the existing CWP fee screen protocol, the screens for procedures eligible for a holiday premium and provided on holidays will be set at 150% of the corresponding unmodified procedure's final fee screen (e.g., adjusted fee screen for H2015 provided on Christmas day will be set at 150% of H2015's adjusted screen).

For those procedures billed by only one CMHSP and to which none of the above rules apply, the existing screen will be used and no adjustment to final will be made.

The State of Michigan is requesting approval to implement a cost adjustment for fiscal years 2008 and 2009, with the understanding that no facility will be paid more than the cost of providing services. Michigan agrees to work with CMS to clarify the policy regarding OHCDS rate setting requirements. Changes will be implemented in conjunction with the October 1, 2010 renewal process.