RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

BRIAN CALLEY
LT. GOVERNOR

June 20, 2016

Ms. Victoria Wachino
Centers for Medicare & Medicaid Services
Children and Adults Health Programs Group
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244

RE: Proposed §1115 Demonstration, Pathway to Integration

Dear Ms. Wachino:

The Michigan Department of Health and Human Services (MDHHS) is requesting approval of its proposed §1115 Demonstration, Pathway to Integration.

This proposed §1115 Demonstration will allow MDHHS to integrate the coverages of all services and supports eligible populations served through our current multiple §1915(b) and §1915(c) waivers that serve individuals with serious mental illness, substance use disorders, intellectual and developmental disabilities, and serious emotional disturbances.

This demonstration waiver will raise the bar on physical and behavioral health integration, strengthen the SUD continuum of services and promote further value based payment methodologies between Medicaid Health Plans (MHPs) and Prepaid Inpatient Health Plans (PIHPs) serving this specialty service population.

If you have any questions, please contact Jacqueline Coleman at (517) 241-7172 or via e-mail at ColemanJ@michigan.gov.

Thank you for your consideration of this request.

Sincerely,

Rick Snyder
Governor

cc: Nick Lyon, Director, MDHHS

# Pathway to Integration
# Michigan's §1115 Waiver Proposal for Persons with Severe Mental Illness, Substance use Disorders, Intellectual and Developmental Disabilities and Children with Serious Emotional Disturbances
# To the
# Centers for Medicare and Medicaid Services
# US Department of Health and Human Services
# June 21, 2016

## State of Michigan
## Rick Snyder Governor

Nick Lyon, Director
Michigan Department of Health and Human Services

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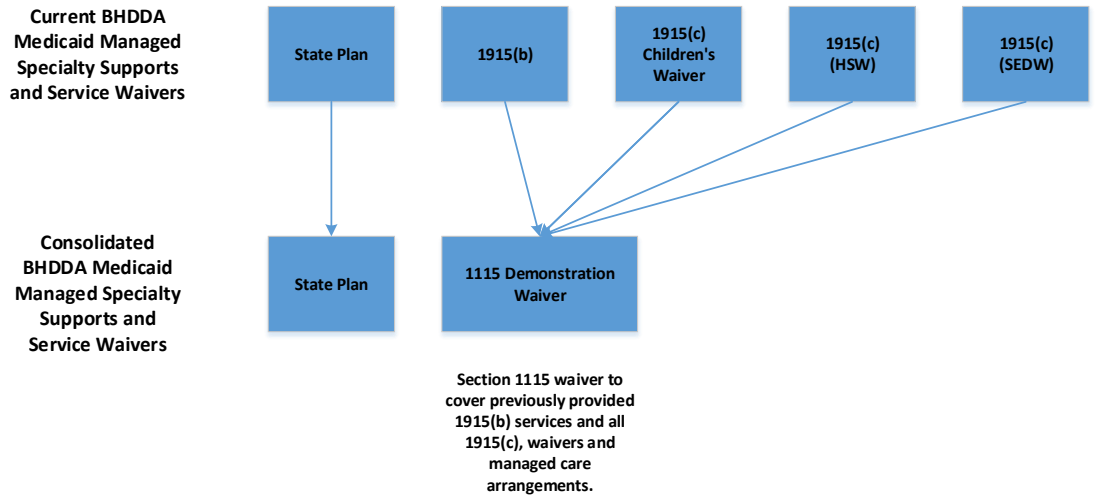
# I. Introduction

Michigan has a long standing commitment to community supports and inclusion. The state continues to focus on enhancing systems capacity to further improve the functioning, capabilities, and recovery/resiliency for persons with Severe Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual/Developmental Disabilities (I/DD), and Children with Serious Emotional Disturbances (SED)[1]. With this commitment and focus in mind, the State of Michigan is seeking approval from the Centers for Medicare and Medicaid Services (CMS) for a §1115 Demonstration Waiver that will combine under a single waiver authority all services and eligible populations served through its §1915(b) and its multiple §1915(c) waivers. Under this consolidated waiver authority, Michigan is seeking broad flexibility to further develop and evaluate the outcomes associated with quality and value-based payment and financing approaches for integrated care (physical, behavioral and SUD) initiatives for all Specialty Service Populations on a statewide basis. The chart below, describes the current waivers and populations consolidated under this §1115 Waiver application.

***Pathway to Integration Waiver Consolidation***




[1] Also known as Specialty Service System/Populations.

Since 1998, Michigan has operated a behavioral health carve-out for the Specialty Service Populations using county-sponsored Prepaid Inpatient Health Plans (PIHPs). Physical healthcare, including a benefit for persons with mild and/or moderate behavioral health disorders, is operated through profit and not-for-profit Medicaid Health Plans (MHPs). Funding for SUD services was traditionally managed by regional Coordinating Agencies (CAs), which contracted for the delivery of SUD services. In 2013, to better integrate behavioral health and SUD services, CAs were dissolved and incorporated into the PIHP management and governance structures. Currently, the PIHPs are responsible for all SUD service and supports (except for certain medically monitored supports) regardless of severity of condition.

## II. Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

Since 2011, Michigan has been reinventing its healthcare system on multiple payer and provider levels. In 2013, Michigan was awarded the Centers for Medicare and Medicaid Services (CMS), State Innovation Model (SIM) Design award that resulted in the development of Michigan's "Blueprint for Health Innovation" (Blueprint)[2]. The Blueprint's overarching vision is to provide better health and better care at lower costs for every Michigan citizen. Michigan was also one of the early States to seek and expand Medicaid coverage through its Healthy Michigan Plan (HMP). The HMP now covers over 580,000 Michigan citizens and provides access to the full array of Specialty Services included in this application.

Through the development of both the Blueprint and HMP, it was identified that a major driver of unnecessary hospital/emergency department utilization was related to service access patterns of persons with behavioral health and/or substance use disorders. These facts, combined with the acknowledgement of the need for introducing incentives to reward performance and the achievement of improved health outcomes, the Medical Services Administration (MSA) and the Behavioral Health and Developmental Disabilities Administration (BHDDA) of the Michigan Department of Health and Human Services (MDHHS) engaged in numerous discussions regarding the efficiency and effectiveness of its multiple Specialty Service waivers. As a result of these discussions, MDHHS determined that the broader flexibility allowed through a §1115 Waiver will enable the state to incentivize the Specialty Services System to better align with other healthcare providers and improve the population health objectives for this very vulnerable and often underserved population.

In 2013, to better integrate behavioral health and SUD, MDHHS combined the former SUD CAs funding and service responsibility within ten (10) PIHPs. This multi-year effort has improved the effectiveness of the benefit design as well as the treatment and support services provided to

[2] http://www.michigan.gov/documents/mdch/Michigan_Blueprint_APPENDICES_REMOVED_454499_7.pdf

individuals who have SUD. To further our efforts, MDHHS has been engaged in the Centers for Medicare and Medicaid Services (CMS) Innovation Accelerator Program (IAP) for SUD and is committed to further develop and improve on the state's comprehensive array of effective treatment and supports (including the access to the array of behavioral health services as deemed medically necessary) for persons with co-occurring disorders, and to ensure more consistent use of industry-standard benchmarks for refining medical necessity criteria, promoting the use of evidence-based services and strengthening provider qualifications and state oversight. The flexibilities permitted under a §1115 Waiver will not only enable the state to consolidate multiple programs and streamline payment systems, but will also give the state expenditure authority for coverage of a broader array of residential services (regardless of facility size), expand other behavioral health services, and begin the development of value-based incentives that reward achievement of performance objectives.

Building upon the strong foundation of covered benefits, evidence based practices (EBPs) and service delivery infrastructure, the state believes that offering a full continuum of SUD treatment and recovery supports based on American Society of Addiction Medicine (ASAM) criteria, will result in improved outcomes and sustained recovery for this Specialty Services population.

The state of Michigan seeks to accomplish these efforts by:

- Enhancing provider competency related to the use of ASAM criteria through access to care procedures and within treatment programs;
- Expanding the treatment continuum of residential care including medically necessary use of qualified residential treatment facilities regardless of the size of the facility, withdrawal management programming and medication assisted treatment and recovery;
- Expanding the use of recovery coach delivered support services; and
- Establishing coordination of care models between SUD providers, primary care and other behavioral health providers.

## 2) Include the rationale for the §1115 Demonstration.

Since 1998, Michigan has financed and delivered the majority of its Specialty Service System through managed care arrangements, although the multiple behavioral health §1915(c) Waivers are slightly outside the traditional §1915(b) managed care payment structure. Currently, all of Michigan's behavioral health §1915(c) Waivers include enrollment caps and eligibility requirements based on institutional levels of care. The Children's Waiver Program (CWP) and the Waiver for Children with Serious Emotional Disturbances (SEDW) are still operated by the state under a Fee-for-Service (FFS) arrangement. Each of these waivers require separate actuarial payments, separate reporting of expenditures, and various cost settlement arrangements based on the actual services delivered. Through this §1115 Waiver authority, Michigan intends to remove and/or expand certain enrollment caps (based on legislative

appropriation and who meets eligibility criteria), advance the use of needs-based eligibility criteria, and to finance these programs under a single managed care arrangement. In order to maintain budget neutrality, current enrollment caps for the §1915(c) Waivers will not be changed.

When approved, this consolidated waiver will result in seamless coordinated care and resolve the cost effectiveness issue related to the current §1915(b) Managed Specialty Service and Supports (MSS&S) Waiver.

Additionally, Michigan seeks to enhance the effectiveness of its SUD treatment and recovery system. The benefit design, service access, and quality enhancements proposed as part of this demonstration are intended to supports three areas of strategic focus:

**Strategic Focus One: Physical Health Integration and Care Coordination Design**
The integration of behavioral health and physical health care is a statewide priority and is the crux of the demonstration of this waiver application. Over the past several years, the state has received a SIM grant and a planning grant for Certified Community Behavioral Health Clinics (CCBHC) as evidence of the state's overall commitment to physical health/behavioral health integration. The MDHHS has supported and funded the establishment of learning communities within the behavioral health service system that are providing guidance on integration and coordination of care practices at the regional level. This work has focused on mental health and SUD services. It has led to the acceptance of behavioral health workers in primary care clinics, community health clinics, and even emergency departments. As a result, Screening, Brief Intervention, and Referral to Treatment (SBIRT) is increasingly utilized for adults and adolescents within the primary care environment.

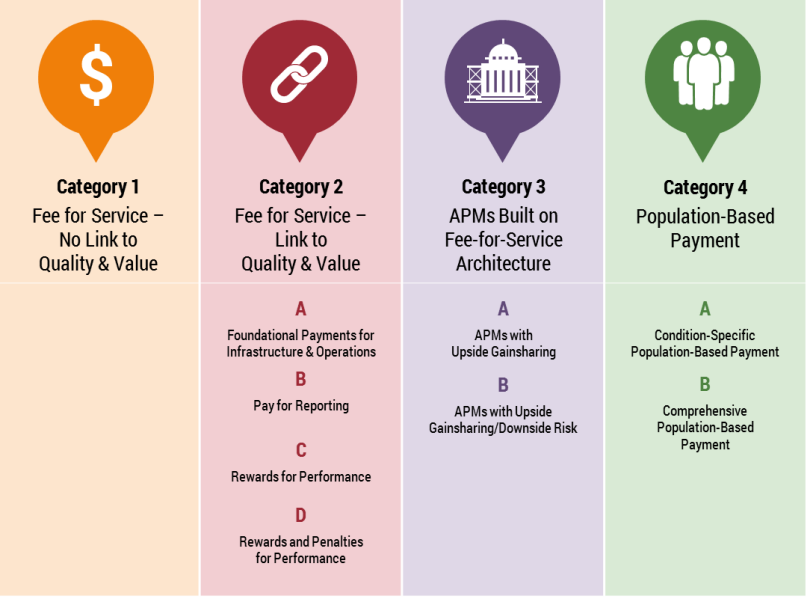
Through this waiver, Michigan also intends to adapt and test an established model of care coordination to further expand integrated care between systems and providers. The Collaborative Care Model (CCM) is an evidence-based approach that has proven to be clinically sound and cost-effective for a variety of behavioral health conditions. This model utilizes the integration of primary care providers, care managers, and psychiatric consultants to provide care and monitor progress. This model provides proven consumer supports and focuses on connecting community agencies, hospital-based services, behavioral health, and medical specialists as part of the provision of care. Michigan's overall healthcare system will begin to formalize this model of care as part of this waiver and through the grant work that is underway. It will formalize the process of referrals and level of care transitions that will decrease the number of people who do not follow through at these critical times in care. Additionally, Peer Recovery Coaches will be used to enhance the referral and care transition process for an added layer of support for the SUD service system.

**Strategic Focus Two: Strengthening the SUD Care Continuum**
Through participation in the CMS IAP, the state has received technical assistance and exposure to national experts on a number of topics relevant to Michigan's goals to strengthen the

continuum of SUD services throughout the state. While Michigan has historically maintained a robust network of SUD providers and services, the prohibition against Medicaid reimbursement for services provided to certain adults in an Institution for Mental Disease (IMD) setting has resulted in a disjointed benefit package and the inability to ensure access to needed services.

This waiver application seeks to remove treatment gaps through coverage of residential services, initially focusing on ensuring capacity to ASAM levels 3.1 and 3.2 and throughout the demonstration expanding statewide capacity for higher-end ASAM levels (i.e., 3.7 and 4). In addition to rounding out SUD residential services, the state will also develop incentives to ensure coordination within and across levels of care by utilizing the Collaborative Care Model, recovery supports and other SUD services to improve care transitions, referrals and promote provider collaborations.

Finally, Michigan intends to utilize the §1115 Waiver authority to align requirements for use of ASAM criteria and development of care coordination requirements to test various value-based payment opportunities as described in the Health Care Payment & Learning Access Network (HCP-LAN) Alternative Payment Model (APM) Framework white paper. The state will coordinate SIM, CCBHC and behavioral health redesign efforts to advance populations based payment mechanisms such as those listed in 'Category 4 below:




**Strategic Focus Three: Promoting Value-Based Payment**

Michigan has a long history of implementing Medicaid managed care models for both the physical health and specialty behavioral health benefits, seeking to reward value versus volume of services. Historically, however, value-based reimbursement has largely been focused within these separate areas rather than across them. With Michigan's recent re-procurement of Medicaid managed care physical health and mild/moderate behavioral health services, the state implemented additional integration of care standards that are mirrored in the Specialty

Services Prepaid Inpatient Health Plan contracts as well. These standards require specific integration and collaboration efforts in order to receive withheld performance bonuses. For the current fiscal year, these standards are being jointly operationalized and are presently focused on adults living with Severe Mental Illness (SMI) and limited to process measures. The state intends to build from this foundation to apply value-based payment principles to Medicaid contracting across populations and promote downstream value-based payment designs between managed care organizations and their provider networks. This will be inclusive of individuals with SUD, DD, and children with SED, where applicable and where appropriate consents are obtained. The state also intends to move to increasingly value-based payment based upon process measures to incentivize population health outcomes measures.

A consolidated §1115 Waiver design will support the testing and application of value-based payment design across these populations, including the testing, adaptation, and expansion of evidence-based care coordination and integration models across populations that historically have received less focus in integrated care modeling (i.e. SUD and I/DD populations). This approach also recognizes the individualization of supports for beneficiaries by recognizing overall healthcare needs versus the need to specifically slot beneficiaries into discrete populations in order to access necessary supports and services. Recognizing these overall healthcare needs, the virtual integration of plans and providers as noted in the white paper by the Health Care Payment & Learning Access Network (HCP-LAN) Alternative Payment Model (APM), "Category 4 represents the furthest departure from traditional FFS payments, while simultaneously ensuring that providers possess the strongest possible incentives to deliver high quality and efficient care."

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

This proposal is not solely focused on cost savings, but rather on improving upon Michigan's robust coverage and service array, including the expanded use of peer recovery supports for persons with SUD, self-determined arrangements, and SUD delivery reforms. The goal of this demonstration is to create an evaluation that tests and creates incentives for both quality and cost outcomes between traditional MHPs and Michigan's Specialty Services System[3]. These incentives would be specifically targeted for persons with SMI, SUD, I/DD and SED. Key indicators would include:

- Joint identification and tracking of high risk/utilizing populations
- Prevention of modifiable risk factors[4]
- Access to care incentives
- Pilot demonstrations through Accountable Systems of Care
- Enhancement of co-occurring (SMI/SUD) services

[3] Integrated Care Resource Center, Technical Assistance Brief: State Options for Integrating Physical and Behavioral Health Care, MCO/PCCM and BHO Partnership Facilitated by Financial Alignment.

[4] Obesity, smoking cessation, homelessness, substance use, diabetes and cardiovascular disease management.

- Use of “Specialized Complex Care Managers” for individuals considered “High Utilizers”

Since many of the cost drivers related to “High Utilizers” occur from increased emergency department usage or inpatient hospital utilization, testing what quality and clinical measures actually decrease utilization and tracking where savings actually accrues (hospitals, health plans and PIHP’s) for this population will be one of the demonstration’s major evaluation components.

Additionally, as Michigan aligns its full continuum of SUD treatment and recovery supports services based on ASAM criteria and utilizing Evidence Based Practices (EBPs), Michigan will evaluate the impact of this new continuum by measuring the change in the number of people engaged in in recovery support services, the length of time in formal treatment, and improvement in overall physical health.

To meet these objectives, Michigan has recently implemented an integrated care analytics program (known as Care Connect 360or CC 360) that enables the state and providers to access retrospective Medicaid claims and encounter data for both behavioral health and physical healthcare services, including prescription drug information. Through an existing contract, Michigan will conduct an evaluation to measure and monitor the outcomes for the Pathway to Integration Waiver. The following is a partial list of quality indicators to be refined and measured during the demonstration with additional CMS technical assistance specifically for the enhanced SUD services.

- Enhance/incentivize the ability of Specialty Service System payers and providers to work with traditional MHPs and to jointly develop measures to identify high risk populations within this Specialty Service System. This includes strategies to identify individuals with substance use issues or disorders.
- Develop linkages that directly impact social determinants of health, including the use and dissemination of models to prevent homelessness and early intervention models that promote clinical practices for serving youth and adults with SUD.
- Increase rate of outpatient services including assignment of a primary care physician, physician office, or clinic visits (including home health and urgent care) per 1000 member months.
- Decrease rate of Emergency Department (ED) visits per 1,000 member months.
- Decrease in hospital admissions for these specific populations (both medical and psychiatric).
- Track the rate of follow up appointments kept with Specialty Service System providers.

In addition to the quality data measures already captured, Michigan will incorporate several quality measures related to the effectiveness of SUD treatment services including those required by CMS as described in SMD # 15-003 Regarding New Service Delivery Opportunities for Individuals with Substance Use Disorder.

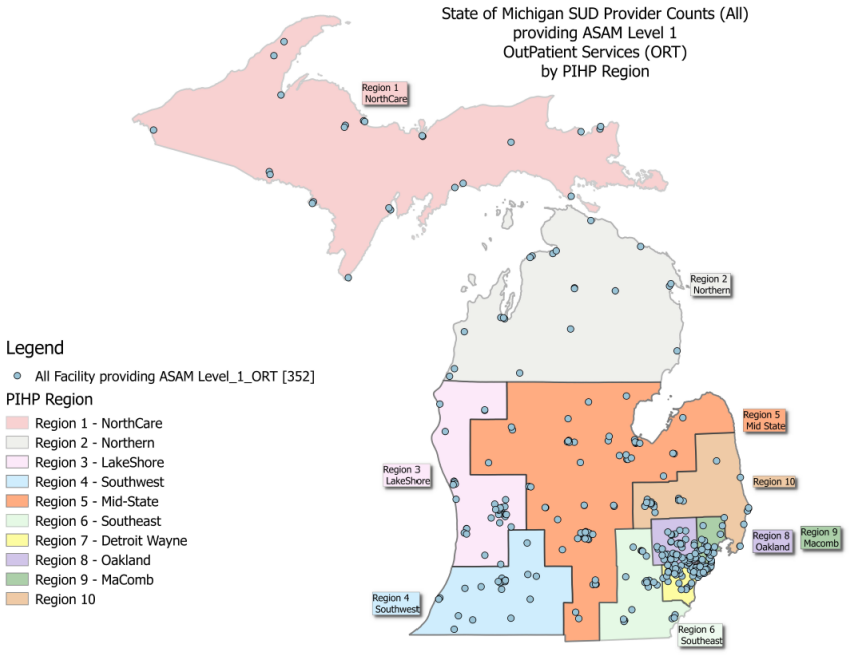
4. Describe where the 1115 Demonstration will operate, i.e., statewide, or in specific regions within the State. If the 1115 Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the 1115 Demonstration will operate.

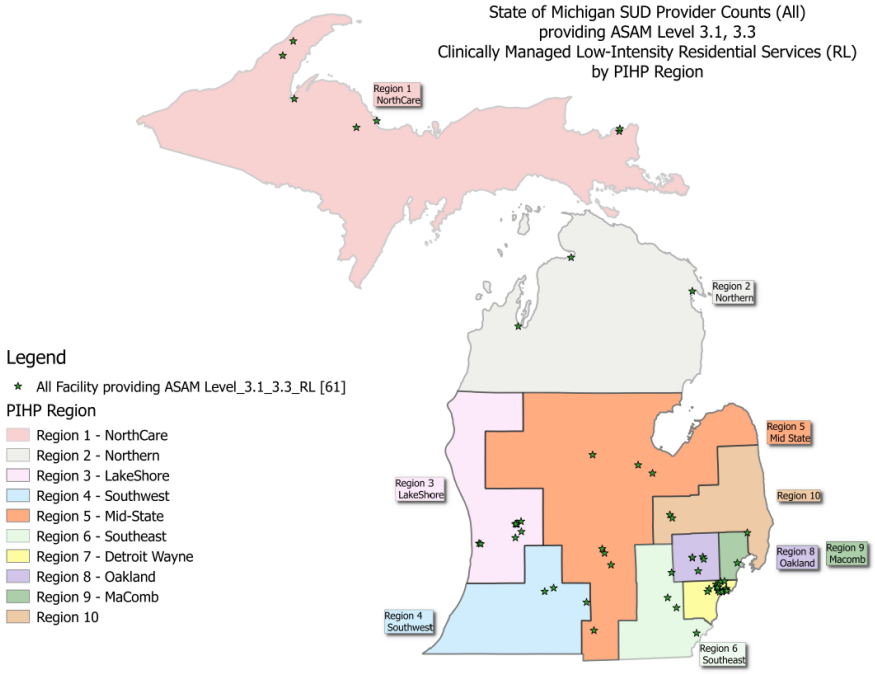
The Demonstration will operate statewide.

5. Include the proposed timeframe for the §1115 Demonstration

Michigan proposes to implement this §1115 Waiver on October 1, 2016. Demonstration Year (DY) 1, will include the development of the evaluation, collection of baseline data, and preparation of the system to develop care management systems/protocols for "High Utilizers" between the traditional Medicaid Health Plans and the Specialty Service System. Building off of the care management systems/protocols, DY 1 will also include care coordination agreements between MHPs, PIHPs, and the Specialty Service System providers (if not already in place) including for persons with SUD. DY 1 will also focus on ensuring statewide capacity for ASAM level 3.1 and developing an approach for expanding provider and service capacity for ASAM levels up to and including 3.7 and 4.

Michigan's decision to focus DY1 on ASAM level 3.1 arose after a recent exercise conducted by the state from CMS IAP SUD initiatives, which revealed an opportunity to increase SUD residential services capacity for this level of care. Using data from the most recently completed National Survey of Substance Abuse Treatment Services (N-SSATS) questionnaire, the state conducted an inventory of SUD services across ASAM levels to identify by PIHP region where services currently exist. The resulting maps (*see an example below*) reflect all of the Michigan providers that responded to the NSSATs survey in 2015 that identified as substance abuse facilities. Note that the inventory does not include facilities providing substance abuse services that identified as both mental health and substance abuse facilities, so the results are likely underrepresenting SUD capacity. 352 unduplicated facilities were associated with one of the 10 PIHP regions. Duplicates were identified through the same or similar latitude and longitude coordinates. Facilities with identical addresses were also considered duplicates.




NSSATs is an annual survey that is administered to government and privately-owned facilities that provide substance abuse treatment services by the Substance Abuse and Mental Health Services Administration (SAMHSA) and provides information on the location, characteristics, and use of alcohol and drug abuse treatment facilities and services throughout the 50 states. Included in NSSATs is a searchable database of facilities approved by state substance abuse agencies for the provision of substance abuse treatment, which is the source for the attached maps. (http://findtreatment.samhsa.gov) One limitation of the survey is its voluntary nature. A

second limitation of the survey is that it represents a point-in-time look at each responding facility by asking the facility to report on their system and clients on a particular day.

As part of participation in the CMS IAP for SUD, Michigan continues to identify additional resources for conducting an inventory of SUD provider and service capacity with the goal of using state licensing and claims/encounter data to inform where and how the state should either seek to identify residential providers that are not currently accepting Medicaid or otherwise develop SUD residential capacity.

DY 2 will build off of the expanding treatment continuum of residential care, outpatient withdrawal management, and medication assisted treatment for persons with SUD and the development of shared savings/risk models between PIHPs and MHPs. This phased approach will also align the Specialty Service System with other state initiatives including the implementation of the Blueprints Accountable Systems of Care (ACS) and Michigan's desire to be one of the pilot states to develop CCBHCs and the implementation of a Prospective Payment System (PPS) for certain populations covered under the application.

6. Describe whether the 1115 Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

This Demonstration will not change or modify other components of the State's current Medicaid program and Children's Health Insurance Program (CHIP).

## III. Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the 1115 Demonstration.

No eligibility changes will be affected by this demonstration.

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the 1115 Demonstration, to the extent those standards or methodologies differ from the State plan.

No new eligibility changes will be affected by this demonstration. Previous eligibility changes for persons enrolled in the SEDW and the CWP will be transferred and included in this application.

3) Specify any enrollment limits that apply for expansion populations under the 1115 Demonstration.

There are no enrollment limits for expansion populations under this Demonstration.

4) Provide the projected number of individuals who would be eligible for the 1115 Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

As stated above, Michigan intends to maintain the current service array and where possible explore the expansion of enrollment caps for certain services previously provided through its §1915(c) CWP and SEDW programs. All current HSW enrollee's and services (including HSW enhanced payments) will now be covered under this §1115 waiver authority. Anticipated beneficiaries served under this waiver and current enrolment caps are outlined below:

- §1915(c) HSW = 8268
- §1915(c) SEDW = 969
- §1915(c) CWP = 469
- Estimated Demonstration Including §1915(b)/(c) Populations = 220,000

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the §1115 Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the §1115 Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State) (if additional space is needed, please supplement your answer with a Word attachment).

Michigan will apply spousal impoverishment rules for individuals receiving HCBS under the §1115 Demonstration.

6) Describe any changes in eligibility procedures the State will use for populations under the §1115 Demonstration, including any eligibility simplifications that require §1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013) (if additional space is needed, please supplement your answer with a Word attachment).

None.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014 (if additional space is needed, please supplement your answer with a Word attachment).

Not Applicable.

# IV. Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the §1115 Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

_X_Yes __No (if no, please skip questions 3-7)

2) Indicate whether the cost sharing requirements under the §1115 Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

__ Yes _X_No (if no, please skip questions 8-11)

There are no cost sharing requirements under this Demonstration.

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the §1115 Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the §1115 Demonstration:

Individuals who qualify for Specialty Services are also covered for all mandatory and optional services as approved in the Michigan state plan or as authorized or modified under this waiver. All state plan, former §1915(b) and §1915(c) waiver services are covered under this §1115 waiver. This includes individuals with Autism Spectrum Disorder and individuals eligible for Michigan Special Children's Special Health Insurance Program (aka MIChild) and the Healthy Michigan Plan (HMP). The eligibility criteria described in this section only applies to the services previously covered by the §1915(b) Waiver and multiple §1915(c) waivers. Michigan is not reducing or limiting any benefits previously offered. Michigan will be developing and adding coverage of Permanent Supportive Housing services targeted at individuals with chronic homelessness and high utilizing populations within the Specialty Service System.

**Specialty Service and Supports Eligibility Criteria and Service Array (formally known as Section 1915(b)(3) Supports) for individuals with SMI, SED, or I/DD.**

Medicaid beneficiaries with mental illness, serious emotional disturbance or intellectual/developmental disabilities are eligible for services within the Specialty Service System when their needs exceed the benefits provided by traditional MHPs. Eligibility to

receive services is based on medical necessity criteria as outlined below and described in the established Medicaid guidelines. All Specialty Services are provided through the PIHPs.

**Medical Necessity Criteria**

Mental health, intellectual/developmental disabilities, and co-occurring substance use disorder services are supports, services, and treatments:

- Necessary for screening and assessing the presence of a mental illness, developmental disability and/or
- Required to identify and evaluate a mental illness, developmental disability and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability.
- Expected to arrest or delay the progression of a mental illness, developmental disability; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

**Determination Criteria**

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient mental health care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

| In general, MHPs are responsible for outpatient mental health in the following situations: | In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations: |
|---|---|
| -The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability.<br><br>-The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports. | -The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills).<br><br>-The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past.<br>Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse.<br><br>-The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year.<br>(Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.)<br>The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment. |

| Specialty Service and Supports for SMI, SED, I/DD Populations |
| --- |
| **Community Living Supports** |
| **Enhanced Medical Equipment Supplies** |
| **Enhanced Pharmacy** |
| **Environmental Modifications (including vehicle modifications)** |
| **Family Support and Training** |
| **Fiscal Intermediary Services** |
| **Housing Assistance** |
| **Peer Directed and Operated Support Services (MH or DD)** |
| **Personal Emergency Response System (PERS)** |
| **Prevention Services – Direct Model** |
| **Respite Care** |
| **Skill Building Assistance** |
| **Supported Employment Services** |
| **Supports Coordination** |
| **Transportation** |
| Additional Coverages |
| **Permanent Supportive Housing** |

**Specialty Service and Supports Eligibility, Service Reforms and Service Array for Persons with Substance Use Disorders (SUD).**

Any Medicaid beneficiary with SUD is eligible for services within the Specialty Service System. Eligibility to receive services is based on medical necessity criteria that are outlined below and described in the Medicaid established guidelines.

**Medical Necessity Criteria**

The medical necessity criteria are to be applied in the following manner when determining the needs of an individual:

- Necessary for screening and assessing the presence of substance use disorder; and/or
- Required to identify and evaluate substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of substance use disorder; and/or
- Expected to arrest or delay the progression of substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

**Determination Criteria**

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

**Additional Eligibility Reforms**

Regardless of severity, all Medicaid beneficiaries for SUD services will qualify for the reformed benefit package based upon their medical need for service. It is the intent that fidelity to the amount, scope, and duration of the continuum of services outlined below will be monitored and align with ASAM criteria. Modifications to SUD state plan services are outlined in Appendix A. Under this demonstration, Michigan's reformed SUD benefit will build on the state's current comprehensive, evidence-based approach to service design and will be modified to align with the array of SUD services under the HMP. The specific services that will be offered as part of the SUD service continuum include:

- Early Intervention
- Outpatient Therapy – inclusive of ASAM Levels 1, 2.1 and 2.5
- Residential Treatment – inclusive of ASAM Levels 3.1, 3.3, 3.5 and 3.7
- Withdrawal Management – inclusive of ASAM Levels 1-WM, 2-WM, 3.2-WM and 3.7-WM
- Opioid Treatment Program (Level 1)

The Early Intervention level of care (0.5) is currently offered as a benefit and will continue to be included as part of this continuum with a more formal designation than it has now. The access systems are required to provide education and resource information as part of their programming already. This is consistent with ASAM expectations for individuals who are at risk of developing a SUD yet there is not sufficient information to document a formal SUD diagnosis after an assessment has been completed. Similar to how SBIRT works, the individual will be able to return to the assessment center/component of a program for a set number of brief follow up visits for more education and information gathering to assist in determining if more intensive interventions are needed.

Outpatient Therapy and Residential Treatment are currently available and will continue to be offered. The descriptions will be delineated to reflect the areas as described by ASAM so the dimensions can be accurately utilized. Level 4 services are available through the physical health care system that all Medicaid beneficiaries receive. Medication assisted treatment, with methadone, through Opioid Treatment Programs will continue as a service in the continuum. Additionally, other medications that can be used to treat opioid addiction (Buprenorphine, Vivitrol, etc.) through office based settings will continue to be available through the established pharmacy benefit that is part of the overall Medicaid benefit. The following tables detail the medication and authorization requirements and the specific assessment guidelines and benefit descriptions for SUD services based on specific assessment guidelines. No predetermined limits of care will be established for these services.

| Medication | Prior Authorization/Limit | Availability |
|---|---|---|
| **Methadone** | No | Opioid Treatment Program only |
| **Buprenorphine** | Yes, unless provided in OTP – 12 months initial | Pharmacy Benefit |
| **Naltrexone long acting injection** | No | Pharmacy Benefit, physician administered |
| **Acamprosate** | No | Pharmacy Benefit |
| **Naloxone** | No | Pharmacy Benefit |

| ASAM Level of Care | Title | Service Description | Treatment Methods and Supports | Provider |
|---|---|---|---|---|
| **0.5** | Early Intervention | Assessment and education for at-risk individuals.<br><br>Screening, Brief Intervention, and Referral to Treatment (SBIRT). | Assessment/screening<br>Didactics/education<br><br>Medically managed care | Network access/assessment service.<br><br>Managed care/fee for service physical health care system. |
| **1** | Outpatient Services | Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies. | Assessment<br>Treatment planning<br>Individual, group, family therapy<br>Didactic/education<br>Psychiatric evaluation<br>Medication review<br>Peer supports<br>Recovery supports<br>Case management<br>Crisis Intervention | State licensed outpatient program; accredited by national organization; and state licensed and/or certified staff. |

| | | | | |
|---|---|---|---|---|
| **2.1** | Intensive Outpatient Services | 9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability. | Assessment<br>Treatment planning<br>Individual, group, family therapy<br>Didactic/education<br>Psychiatric evaluation<br>Medication review<br>Peer supports<br>Recovery supports<br>Case management<br>Crisis Intervention | State licensed outpatient program; accredited by national organization; and state licensed and/or certified staff. |
| **2.5** | Partial Hospitalization Services | 20 or more hours of service/week for multidimensional instability not requiring 24-hour care. | Assessment<br>Treatment planning<br>Individual, group, family therapy<br>Didactic/education<br>Psychiatric evaluation<br>Medication review<br>Peer supports<br>Recovery supports<br>Case management<br>Crisis Intervention | State licensed outpatient program; accredited by national organization; and state licensed and/or certified staff. |
| **3.1** | Clinically Managed Low-Intensity Residential Services | 24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment. | SUD/health/nursing assessment<br>Treatment planning<br>Individual, group, family therapy<br>Didactic/education<br>Psychiatric evaluation<br>Medication review<br>Peer supports<br>Recovery supports<br>Case management<br>Crisis Intervention | State licensed residential program; accredited by national organization; and state licensed and/or certified staff. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010. |
| **3.3** | Clinically Managed Population-Specific High-Intensity Residential Services | 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment. | SUD/health/nursing assessment<br>Treatment planning<br>Individual, group, family therapy<br>Didactic/education<br>Psychiatric evaluation<br>Medication review<br>Peer supports<br>Recovery supports<br>Case management<br>Crisis Intervention | State licensed residential program; accredited by national organization; and state licensed and/or certified staff. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010. |
| **3.5** | Clinically Managed High-Intensity Residential Services | 24-hour care with trained counselors to stabilize multidimensional imminent danger and | SUD/health/nursing assessment<br>Treatment planning<br>Individual, group, family therapy | State licensed residential program; accredited by national organization; and state licensed and/or certified staff. This may |

| | | | | |
|---|---|---|---|---|
| | | prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community. | Didactic/education<br>Psychiatric evaluation<br>Medication review<br>Peer supports<br>Recovery supports<br>Case management<br>Crisis Intervention | include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010. |
| **3.7** | Medically Monitored Intensive Inpatient Services | 24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor availability. | SUD/health/nursing assessment<br>Treatment planning<br>Individual, group, family therapy<br>Didactic/education<br>Psychiatric evaluation<br>Medication review<br>Peer supports<br>Recovery supports<br>Case management<br>Crisis Intervention | State licensed residential program; accredited by national organization; and state licensed and/or certified staff. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010. |
| **4** | Medically Managed Intensive Inpatient Services* | 24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage patient in treatment. | Medically managed care | Licensed inpatient hospital setting, managed care/fee for service physical health care system. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010. |
| **OTP** | Opioid Treatment Program | Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder. | SUD/health/nursing assessment<br>Treatment planning<br>Individual, group, family therapy<br>Didactic/education<br>Psychiatric evaluation<br>Medication review<br>Peer supports<br>Recovery supports<br>Case management<br>Crisis Intervention | State licensed and federally certified Opioid Treatment Program (Methadone); and state licensed and/or certified staff. |
| **1-WM** | Ambulatory Withdrawal Management Without On-site Monitoring | Mild withdrawal with daily or less than daily outpatient supervision. | SUD/health/nursing assessment<br>Treatment planning<br>Didactic/education<br>Psychiatric evaluation<br>Peer supports<br>Recovery supports<br>Case management | State licensed detoxification program; accredited by national organization; and state licensed and/or certified staff. |
| **2-WM** | Ambulatory Withdrawal Management with Extended | Moderate withdrawal with all day withdrawal management and support and supervision; | SUD/health/nursing assessment<br>Treatment planning<br>Didactic/education<br>Psychiatric evaluation | State licensed detoxification program; accredited by national organization; and state |

| | | | | |
|---|---|---|---|---|
| | On-Site Monitoring | at night has supportive family or living situation. | Peer supports<br>Recovery supports<br>Case management | licensed and/or certified staff. |
| **3.2-WM** | Clinically Managed Residential Withdrawal Management | Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery. | SUD/health/nursing assessment<br>Treatment planning<br>Didactic/education<br>Psychiatric evaluation<br>Peer supports<br>Recovery supports<br>Case management | State licensed detoxification program; accredited by national organization; and state licensed and/or certified staff. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010. |
| **3.7-WM** | Medically Monitored Inpatient Withdrawal Management | Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring. | SUD/health/nursing assessment<br>Treatment planning<br>Didactic/education<br>Psychiatric evaluation<br>Peer supports<br>Recovery supports<br>Case management | State licensed detoxification program; accredited by national organization; and state licensed and/or certified staff. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010. |
| **4-WM** | Medically Managed Intensive Inpatient Withdrawal Management* | Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability. | Medically managed care | Licensed inpatient hospital setting, managed care/fee for service physical health care system. This may include settings regardless of bed size that are within the definition of IMDs at 42 CFR 435.1010. |

*Benefit is available through the physical health care benefits of Medicaid coverage, not part of the specialty behavioral health system

The SUD service system will provide the necessary treatment and support services to office based opioid treatment provided through the primary care system. Withdrawal Management, currently referenced in our system as "sub-acute detoxification," will continue to be a service and will be expanded in scope to reference all levels. Level 4 services, like those for inpatient care, will continue to be available through the physical healthcare system regardless of the size of facility.

In addition, Michigan Medicaid will continue to provide a full array of primary and acute care treatment services as described under the state plan and elsewhere in this waiver, including inpatient hospital services, outpatient pharmacy services, and SBIRT.

To support the use of the established medical necessity criteria, and make them more representative of "clinical necessity" that is needed for SUD treatment, the Six Dimensions of Multidimensional Assessment, part of the ASAM Criteria, will be incorporated into the

assessment process for any individual seeking SUD related services. These dimensions include a detailed review of the following areas:

1. Dimension 1 – Acute Intoxication and/or Withdrawal Potential
2. Dimension 2 – Biomedical Conditions and Complications
3. Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications
4. Dimension 4 – Readiness to Change
5. Dimension 5 – Relapse, Continued Use, or Continued Problem Potential
6. Dimension 6 – Recovery/Living Environment

There are numerous considerations that need to be addressed in each dimension. These considerations fit within the established framework of the assessment process and the required medical necessity criteria. The ASAM dimensions will be incorporated so that each area is a standard part of the assessment and level of care determination process. The assessment procedures that are required through accreditation and licensing standards do not conflict with the information that is needed to make a level of care determination based on ASAM, therefore no barriers exists for the system to make this change. This effort will be supported through the training process that was described in network development above.

The benefits available in this demonstration will not have preset limits or fee capitations placed on them. There will be individual determination of medical and clinical necessity for each beneficiary for initial and ongoing care needs. The PIHP will employ its established utilization management system for continued stay reviews which will also apply the ASAM criteria to support individual treatment and support needs.

The following treatment services must be provided to all eligible beneficiaries for the identified level of care in each managed care region of the state. Michigan's SUD benefits include a continuum of care that ensures that individuals can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. This list also reflects the various services and supports that are available within each level of care.

**Intensive Home and Community Based Supports** and **Service Eligibility Criteria for Adults and Children with Intellectual and Development Disabilities (Formerly known as Habilitation Supports Waiver (HSW) and Children's Waiver Program (CWP).**

The following eligibility criteria combines the §1915(c) HSW and §1915(c) CWP populations that are to be consolidated into this §1115 Waiver. Enrollment caps and specific eligibility criteria for services still remain and are outlined in section III of this application.

**Eligibility Criteria**

Current assessments of the participant reflect evidence of a developmental disability based on either **1 <u>or</u> 2 <u>and</u>** the participant must also have needs that meet the requirements in **<u>3</u>**, below.

1) The participant (of any age) has a severe, chronic condition that meets **all** of the following requirements:
   a) Is attributable to a mental or physical impairment or a combination of mental and physical impairments;
   b) Is manifested before the beneficiary is 22 years old;
   c) Is likely to continue indefinitely;
   d) Results in substantial functional limitations in 3 or more of the following areas of major life activity:
      i) Self-care
      ii) Receptive and expressive language
      iii) Learning
      iv) Mobility
      v) Self-direction
      vi) Capacity for independent living (applies to children age 16 and older)
      vii) Economic self-sufficiency (applies to children age 16 and older)
   e) Reflects the beneficiary's need for a combination and sequence of special, interdisciplinary, or generic care.
2) The participant is age birth to age 9 and has a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in 1 above if services are not provided.

3) The participant's intellectual or functional limitations indicate that s/he would be eligible for health, habilitative, and active treatment services provided at the Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID) level of care. The following are the eligibility criteria:

   - Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.
   - Active treatment includes aggressive and consistent implementation of a program of specialized and generic training, treatment, health services, and related services.
   - Active treatment is directed toward the acquisition of behaviors necessary for the participant to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.
   - Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

- Necessary services include, for those participants who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs) until it has been demonstrated that the participant is developmentally incapable of acquiring them.
- Participants must need and be receiving training targeted toward amelioration of these basic skill deficit areas.
- The participant must live full-time in a community based setting (not in a hospital, ICF/IID, nursing facility, correctional facility or child caring institution) while receiving services.
- The participant must receive support and service coordination (and/or Targeted Case Management for persons in the CWP) and at least one other community-based Long Term Service and Support each month to maintain eligibility.
- Must reside in a facility that is 12 beds or fewer.

**Additional Eligibility Criteria for Intensive Home and Community Based Supports Service**

The participant must be one of the following:

a. Eligible for MICHILD
b. Eligible for the former HSW benefit package, eligible for Medicaid full scope and coverage under any of the "regular" Medicaid programs (e.g., Healthy Michigan, SSI, TANF, Healthy Kids, Transitional MA, etc.) **OR**
c. Qualify for Medicaid services as a family of one for individuals under age 18, living full time in the community with their birth or adoptive parent or with a legal guardian who is a relative and eligible for Medicaid as a "family-of-one" because they meet these needs-based clinical criteria and also meet the disability criteria for SSI.

| **Habilitation Support Services** |
|---|
| **Community Living Supports** |
| **Enhanced Medical Equipment Supplies** |
| **Enhanced Pharmacy** |
| **Environmental Modifications** |
| **Family Training** |
| **Goods and Services** |
| **Non Family Training** |
| **Out of Home Non-Vocational Habilitation** |
| **Prevocational Services** |
| **Personal Emergency Response System (PERS)** |
| **Respite** |

| Private Duty Nursing |
| --- |
| Supported Employment |
| Supports Coordination |

| Services for Children with Intellectual/Developmental Disability |
| --- |
| Community Living Supports |
| Specialized Medical Equipment & Supplies |
| Environmental Modifications (including vehicle modifications) |
| Family Training |
| Fiscal Intermediary Services |
| Non Family Training |
| Specialty Services/Therapies (Music, Recreational, Art, massage) |
| Respite |
| Enhanced Transportation |
| Non Family Training |
| Fencing |

**SED Service Eligibility Criteria and Service Array**

The child/youth must meet all MDHHS criteria for the state psychiatric hospital for children, as specified in the Michigan Medicaid Provider Manual - INPATIENT ADMISSION CRITERIA: CHILDREN THROUGH AGE 21. The consumer must meet all elements of three admission criteria: diagnosis, Severity of Illness (signs, symptoms, functional impairments and risk potential) and Intensity of Service.

In addition, the child/youth must demonstrate serious functional limitations that impair the ability to function in the community. As appropriate for age, functional limitation is identified using the Child and Adolescent Functional Assessment Scale (CAFAS®), the Preschool and Early Childhood Functional Assessment Scale (PECFAS®) or the Devereux Early Childhood Assessment Scales (DECA):

- CAFAS® score of 90 or greater for children age 7 to 12; OR
- CAFAS® score of 120 or greater for children age 13 to 18; OR
- For children age 4 to 7, elevated PECFAS® subscale scores in at least one of these areas: self-harmful behaviors, mood / emotions, thinking / communicating or behavior towards others; OR
- For children age 2-4, scores in the concern range across Devereux Early Childhood Assessment (DECA) Clinical Version scales: Protective factor scales (initiative, self-control, and attachment) that are in the Concern Range with a Total Protective Factor T-score of 40 or below and/or elevated scores on one or more of the behavioral concerns

scales (Attention Problems, Aggression, Withdrawal/Depression, Emotional Control Problems) with a T-score of 60 or above.

- The participant must live in a community based setting (not in a hospital, ICF/IID, nursing facility, correctional facility or child caring institution) while receiving services.
- The participant must receive Wraparound and at least one other community-based Long Term Service and Support each month to maintain eligibility.

**Additional Eligibility Criteria**

The participant must be one of the following:

a. Eligible for MIChild
b. Eligible for Medicaid full scope and coverage under any of the "regular" Medicaid programs (e.g., Healthy Michigan, SSI, TANF, Healthy Kids, Transitional MA, etc.) **OR**
c. Under age 18, living full time in the community with their birth or adoptive parent or with a legal guardian who is a relative and eligible for Medicaid as a "family-of-one" because they meet these needs-based clinical criteria and also meet the disability criteria for SSI.
d. Be under the age of 18 when approved for the 1115. If the child turns 18 and continues to meet all non-age related eligibility criteria, and continues to need the additional supports and services covered by the Waiver for this target population, the child can remain on the waiver up to their 21st birthday.

| Services for Children with Serious Emotional Disturbance |
|---|
| **Community Living Supports** |
| **Family Support and Training** |
| **Non Family Training** |
| **Children's Therapeutic Foster Care** |
| **Therapeutic Overnight Camping** |
| **Transitional Services** |
| **Wraparound** |
| **Specialty Therapies (Music, Recreational and Art)** |
| **Family Training** |
| **Respite** |

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used?

Federal Employees Health Benefit Package
State Employee Coverage
Commercial Health Maintenance Organization

Secretary Approved

The Demonstration will not include benchmark-equivalent coverage.

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the 1115 Demonstration will provide benefits that differ from the Medicaid or CHIP State plan.

Although the benefits specifications and qualification for Medicaid or CHIP state plan services will not differ, the SUD service and supports will require that the authorization and utilization of services align with the ASAM criteria as outlined in section III of the application. Appendix A outlines the SUD services that require state licensure and align services with the ASAM criteria. The SUD services that also overlap with the LTSS will remain unchanged by this application. All SUD state plan and former §1915(b) services will continue to be based on the medical necessity to receive those services.

6) Indicate whether Long Term Services and Supports will be provided.

_X__ Yes (if yes, please check the services that are being offered) ___ No

| X | Long Term Service and Supports |
|---|---|
| X | Respite |
| X | Community Living Supports |
| X | Private Duty Nursing |
| X | Supported/Integrated Employment |
| X | Out of Home Non Vocational Habilitation |
| X | Goods and Services |
| X | Environmental Modifications (Home Accessibility Adaptations) |
| X | Supports and Service Coordination |
| X | Enhanced Pharmacy |
| X | Personal Emergency Response System (PERS) |
| X | Community Transition Services |
| X | Enhanced Medical Equipment and Supplies (Including Vehicle Modifications) |
| X | Family Training |
| X | Non Family Training |
| X | Specialty Therapies (Music, Art, Massage) |
| X | Children Therapeutic Foster Care |

| | |
|---|---|
| **X** | Therapeutic Overnight Camping |
| **X** | Transitional Services |
| **X** | Fiscal Intermediary Services |
| **X** | Prevocational Services |

7) Indicate whether premium assistance for employer-sponsored coverage will be available through the §1115 Demonstration.

__Yes (if yes, please address the questions below)
_X_No (if no, please skip this question)

a) Describe whether the State currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program.

b) Include the minimum employer contribution amount.

c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing.

d) Indicate how the cost effectiveness test will be met.

8) If different from the State Plan, provide the premium amounts by eligibility group and income level.

There are no premium amounts included in this Demonstration.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State Plan (an example is provided).

The Demonstration will not require copayments, coinsurance and/or deductibles.

10) Indicate if there are any exemptions from the proposed cost sharing.

Cost sharing is not a component of this Demonstration.

# V. Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

__Yes
_X_ No

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

A vital component of this demonstration is the alignment of quality and financial incentives between traditional Medicaid Health Plans and Michigan's Specialty Service System. Michigan, in concert with the development of the ASC and its pursuit to be one of the pilot demonstration states for the Certified Community Behavioral Health Clinic Services, intends to advance integrated care services for the entire Specialty Services population. These changes will require PIHPs and their CMHSP providers to meet quality reporting requirements, develop and expand SUD provider systems, and partner with traditional health plans to ensure access for persons with mild and moderate behavioral health disorders. These linkages are intended to identify and provide education, prevention, and treatment of modifiable health risk factors, provide SBIRT for SUD at primary care settings, provide housing first initiatives, provide incentives for increased access to primary care, and the coordinated tracking of "High Utilizers" of emergency department usage and hospital admissions/readmissions.

In order to further standardize the SUD assessment process and level of care criteria, there will be ongoing training and education on the application of the ASAM at all levels of SUD care. The PIHPs will be required to ensure that their providers and/or the intake agencies within their networks are all appropriately trained/educated in the application and use. PIHPs will provide evidence of initial training and ongoing training of providers during site reviews conducted by MDHHS. Additionally, as part of quality monitoring during DHHS site reviews, records will be reviewed to determine appropriate application and fidelity to the established assessment and early intervention processes and to determine if the PIHP is appropriately monitoring providers and taking necessary corrective action.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ☐ Managed care
- ☐ Managed Care Organization (MCO)
- X Prepaid Inpatient Health Plans (PIHP)
- ☐ Prepaid Ambulatory Health Plans (PAHP)
- ☐ Primary Care Case Management (PCCM)
- ☐ Health Homes
- ☐ Other (please describe)

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option

Michigan's will continue to use a single Specialty Service System on a statewide basis for State Plan and the former §1915(b) and §1915(c) Waiver beneficiaries who meet Specialty Service Criteria. This includes persons enrolled in the MICHILD program and expansion populations.

5) If the Demonstration will utilize a managed care delivery system:

The Demonstration will use Medicaid PIHPs

a) **Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations (if additional space is needed, please supplement your answer with a Word attachment)?**

   Enrollment into the Michigan's Specialty Service System will continue to be mandatory based on the criteria described in Section II.

b) **Indicate whether managed care will be statewide, or will operate in specific areas of the state (if additional space is needed, please supplement your answer with a Word attachment);**

   The managed care delivery system will be statewide

c) **Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state. If additional space is needed, please supplement your answer with a Word attachment);**

There will not be a phased in or rollout of managed care within this Demonstration. Michigan has operated its specialty Service System using PIHPs since 1998.

**d) Describe how will the state assure choice of MCOs, access to care and provider network adequacy (if additional space is needed, please supplement your answer with a Word attachment); and**

This §1115 Waiver will maintain the use of a managed care delivery structure using ten (10) recently procured PIHPs[5] who contract for service delivery with forty-six (46) CMHSP's and other non-for profit providers. As outlined in the table below, seven (7) of the PIHPs are formed by multiple CMHSP's (aka. Regional Entities) and three (3) are stand-alone PIHPs/CMHSPs.

| CMHSP's/County/City | Type of program | Name of Entity |
|---|---|---|
| Pathways CMH **(Alger, Delta, Luce, Marquette) Copper Country CMH (Baraga, Houghton, Keewanaw, Ontonagon)** Hiawatha CMH **(Chippewa, Mackinac, Schoolcraft)** Northpointe CMH **(Menominee, Dickinson, Iron) Gogebic CMH** | **PIHP** | **Northcare Network** |
| AuSable CMH **(Oscoda, Ogemaw, Iosco) Central Wellness Network (Manistee, Benzie)** North Country CMH **(Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, Otsego)** Northern Lakes CMH **(Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, Wexford)** Northeast CMH **(Alcona, Alpena, Montmorency, Presque Isle)** | **PIHP** | **Northern Michigan Regional Entity** |
| Allegan CMH | **PIHP** | **Lake Shore Regional Entity** |

[5] See 2013 Application for Participation for Specialty Prepaid Inpatient Health Plans

| CMHSP's/County/City | Type of program | Name of Entity |
|---|---|---|
| Muskegon CMH<br>Network 180<br>**(Kent) Ottawa CMH West MI CMH (Lake, Mason, Oceana)** | | |
| Barry CMH<br>Berrien CMH<br>Kalamazoo CMH<br>Pines CMH **(Branch)**<br>St. Joseph CMH<br>Summit Pointe CMH<br>**(Calhoun)** Van Buren CMH<br>Woodlands CMH **(Cass)** | **PIHP** | **Southwest Michigan Behavioral Health** |
| Bay-Arenac CMH **(Bay, Arenac)** CMH for Central MI **(Clare, Gladwin, Isabella, Mecosta, Midland, Osceola)** CEI CMH **(Clinton, Eaton, Ingham) Gratiot CMH Huron** CMH Ionia CMH<br>LifeWays CMH **(Jackson, Hillsdale)**<br>Montcalm CMH<br>Newaygo CMH<br>Saginaw CMH<br>Shiawassee CMH<br>Tuscola CMH | **PIHP** | **Mid State Health Network** |
| Washtenaw CMH<br>Lenawee CMH<br>Livingston CMH<br>Monroe CMH | **PIHP** | **CMH Partnership of Southeast Michigan** |
| Detroit-Wayne CMH | **PIHP** | **Detroit-Wayne Mental Health Authority** |
| Oakland CMH | **PIHP** | **Oakland County CMH Authority** |
| Macomb CMH | **PIHP** | **Macomb County CMH Services** |
| Genesee Health System<br>Lapeer CMH<br>Sanilac CMH<br>St. Clair CMH | **PIHP** | **Region 10 PIHP** |

Timeliness of access to services is monitored quarterly through Michigan's Mission Based Performance Indicator System (MMBPIS) and verified through the Quality Assessment and Performance Improvement Program via an External Quality Review (EQR). Adequacy of the provider network is monitored by the State Agency, EQR and by the PIHPs through comprehensive network capacity assessments.

Although freedom of choice will continue to be waived, PIHPs will be required (as non-provider entities) to arrange Medicaid service contracts to ensure the independent evaluation of eligibility, assessment, and the development of the Individual Plan of Service to ensure compliance with Home and Community Based Setting (HBCS) final rules. Although model configuration may be optional (based on state approval), the independent evaluation of eligibly and assessment does not include the provision of emergency services that may result in a preliminary plan of service or functions related to hospital preadmission screening or discharge planning. For PIHPs who contract with CMHSPs, the PIHP will be required to monitor the CMHSP's self-referral and utilization patterns related to consumer choice and best value criteria. MDHHS will play a vital role in the policy development and promulgation of these rules as part of its HBCS statewide transition plan.

**e) Describe how the managed care providers will be selected/procured (if additional space is needed, please supplement your answer with a Word attachment).**

In April 2013, Michigan required its 18 PIHPs to consolidate to 10 through an Application for Participation of Specialty Prepaid Inpatient Health Plans. As outlined above, Michigan intends to continue the use of this managed care delivery system within this §1115 application but holds the ability to contract outside of the PIHP and CMHSP system if the managed care entity and/or providers cannot meet the service delivery, quality, financial and reporting requirements as determined by the state.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

All State Plan and Waiver services will be included as part of this §1115 Demonstration.

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration

_X__Yes
___ No

The Demonstration will provide personal care and long term services and supports including options for both self-direction/determination models including the use of fiscal intermediaries. Waiver participants have opportunities for both employer and budget authority. Participants may elect to control their individual budget for all services or can direct a single service for which participant direction is an option. Fiscal Intermediaries are available to provide financial management services.

The participant may also exercise employer authority to directly employ or contract with chosen providers. There are two options for participants choosing to directly employ workers, the Choice Voucher System and/or Agency with Choice. A participant may select one or both options. Through a Purchase of Service Agreement, a participant may directly contract with a professional provider or an agency provider.

In the first option, the participant is employer of record and the Fiscal Intermediary (FI) serves as Employer Agent to handle. The FI processes payroll and performs other administrative and support functions. In this model the participant directly recruits, hires and manages employees. Detailed guidance to PIHP entities is provided in the Self-Determination Implementation Technical Advisory.

In the Agency with Choice model, participants may contract with an agency that splits the employer duties between the agency and participant. The participant is the managing employer and has the authority to select, hire, supervise and terminate workers. As co-employer, the agency is the employer of record and handles the administrative and legal employer functions. The agency may provide assistance in recruiting and hiring workers. Detailed guidance to PIHP entities is provided in the Self-Determination Implementation Technical Advisory.

PIHPs and their contract providers are the primary entities that support participants who direct their services. Supports coordinators, supports coordinator assistants, or independent support brokers (or other qualified provider chosen by the participant) are responsible for providing support to participants in arrangements that support self-determination by working with them through the Person Centered Planning (PCP) process to develop an IPOS and an individual budget. The supports coordinator, supports coordinator assistant, or independent supports broker is responsible for obtaining authorization of the individual budget and IPOS and for monitoring the IPOS, individual budget, and arrangements. Supports coordinators, supports coordinator assistants, or independent supports brokers (or other qualified provider chosen by the participant) make sure that participants receive the services to which they are entitled and that the arrangements are implemented smoothly. A variety of options for independent advocacy are available. These options include: utilizing a network of allies in the PCP process, using an Independent Facilitator to facilitate the planning process and retaining an independent supports broker for assistance throughout the planning and implementing the IPOS and individual budget. The primary roles of the independent supports broker are to assist the participant in determining the best way to implement the participant's IPOS and acquire

services and supports. The supports broker helps the participant explore the availability of community services and supports, access housing and employment, and makes the necessary arrangements to link the participant with those supports. Supports brokerage services offer practical skills training to enable participants to remain independent, including the provision of information on recruiting/hiring/managing workers, effective communication, and problem solving. When a participant uses an independent supports broker, the supports coordinator or supports coordinator assistant has a more limited role in planning and implementation of arrangements so that the assistance provided is not duplicated. Authorization of the IPOS and individual budget cannot be delegated to an independent supports broker by the PIHP.

Through its contract with MDHHS, each PIHP is required to offer information and education to participants on participant direction. Each PIHP also offers support to participants in these arrangements. This support can include offering training for workers, offering peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises. Each PIHP is required to contract with fiscal intermediaries to provide financial management services. A fiscal intermediary performs a number of essential tasks to support participant direction while assuring accountability for the public funds allotted to support those arrangements. The fiscal intermediary has four basic areas of performance:

- Function as the employer agent for participants directly employing workers to assure compliance with payroll tax and insurance requirements
- Ensure compliance with requirements related to management of public funds, the direct employment of workers by participants, and contracting for other authorized goods and services
- Facilitate successful implementation of the arrangements by monitoring the use of the budget and providing monthly budget status reports to participant and agency
- Offer supportive services to enable participants to direct the services and supports they need

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

There will be no fee-for-service payments made under this Demonstration.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

The MDHHS has retained Milliman Inc. to develop actuarially sound rates using published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board, CMS,

and federal regulations to ensure compliance with 42 CFR §438.6(c). Capitation rates will include all State Plan, §1915(b) and §1915(c) Waivers as outlined in Exhibit 1. Capitation rate values will be developed using PIHP submitted encounter data and Medicaid Utilization Net Cost Reports (MUNC) and will vary by benefit type and program code. Program code categories include the TANF, and the Aged, Blind, and Disabled (DAB) populations. Rate adjustment factors will be developed to reflect age, gender and geographic region for each benefit category. As with the current §1915(b) and §1915(c) Waivers, PIHPs are responsible for all Medicaid beneficiaries within a geographic catchment area who meet criteria for the Specialty Service System. Because of this broad responsibility, the Per Member Per Month (PMPM) payments will be based on the entire Medicaid eligible population as opposed to enrolled beneficiaries.

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

Quality based payments related to the Demonstration goals as outlined in section I, will be developed as part of phase 2 of the demonstration. MDHHS intends to hold back up to 1.0% of capitation payments to be redistributed based on meeting the demonstration expectations through the implementation of complex care management, joint PIHP and MHP performance incentives, and meeting quality/cost indicators to be further defined in the evaluation component of the demonstration. MDHHS plans to continue incentive payments outside of the normal capitation methodology to PIHPs who service foster children and children in Child Protective Services (CPS) with Serious Emotional Disturbances under this §1115 Demonstration.

# VI. Implementation of Demonstration

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

Upon submission and anticipated approval of October 1, 2016 Michigan proposes to implement the benefit and spending authority effective October 1, 2016. Phase 1 of the demonstration will include the development of the demonstration based on CMS's timeframe to submit final evaluation. This will include the collection of baseline data and preparing the system to develop care management systems/protocols for "High Utilizers" between the traditional Medicaid Health Plans and the Specialty Service System. Phase 1 will also include care coordination agreements between MHPs, PIHPs and the Specialty Service System providers (if not already in place) including for persons with SUD. The enhancement of provider competency related to the use of ASAM criteria, the expanded use of recovery coaches and the use of residential treatment facilities regardless of the size of the facility.

Phase 2 will build off of the expanding treatment continuum of residential care, outpatient withdrawal management, medication assisted treatment for persons with SUD, and the development of shared savings/risk models between PIHPs and MHPs. Phase 2 (which may span demonstration years 2 and 3) will include the development of bundled funding and quality incentives for ASC and the implementation of a prospective payment system for Certified Community Behavioral Health Clinics (if chosen as a demonstration state). Beginning on or before January 1, 2017, both traditional health plans and PIHPs will be contractually required to monitor certain quality and integrated care outcomes that lead toward the tracking and implementation of potential shared savings models between traditional health plans, PIHP's and their respective provider networks.

2) Describe how potential participants will be notified/enrolled into the demonstration.

As done currently, new Medicaid beneficiaries will be notified of their Specialty Service System benefits upon enrollment.

3) If applicable describe how the state will contract with managed care organizations to provide demonstration benefits, including whether the state needs to conduct procurement action.

Michigan has contracted with PIHPs for the delivery of Specialty Services since 1998. This §1115 Waver will maintain the use of a managed care delivery structure using ten (10) recently procured PIHPs who contract for service delivery with forty-six (46) CMHSP's and other non-for profit providers.

# VII. Demonstration Financing and Budget Neutrality

This section reflects Michigan's approach for showing budget neutrality, including the data and assumptions used in the development of the cost estimates supporting this §1115 Waiver application.

Required financing and budget neutrality documentation can be found in Appendix D.

# VIII. List of proposed Waivers and Expenditure Authorities

Michigan will seek additional CMS guidance to determine what if any other waiver authorities and/or expenditure authorities are needed to ensure the proper administration of the Demonstration.

<u>1) Provide a list of proposed waivers and expenditure authorities.</u>

- Proper and Efficient Administration
  §1902(a)(4)
  Rationale for Authority: Mandate beneficiaries into a single Prepaid Inpatient Health Plan

- Comparability
  §1902(a)(17)
  Rationale for Authority: This waiver program includes benefits specific to eligibility criteria as described in Section II that will not be available to other Medicaid beneficiaries.

- Amount, Duration, and Scope
  §1902(a)(10)(B)
  To enable the State to offer a different benefit package to the Demonstration participants that varies in amount, duration, and scope from the benefits offered under the State Plan.

- Freedom of Choice
  §1902(a)(23)(A)

To enable the State to restrict Demonstration participants to receive benefits through PIHPs and CMHSPs.
Rationale for Authority: beneficiaries enrolled in the program must receive services through a PIHP

- Choice of Coverage
  §1932(a)(3)
  Rationale for Authority: To enable the State to assign Demonstration participants to PIHPs based on geography and to permit participant choice of provider, but not plan.

- Reasonable Promptness Section
  §1902(a)(8)
  To enable the State to limit enrollment for Demonstration eligible population in order to remain under the annual budget neutrality limits under the Demonstration.

- Methods of Administration: Transportation §1902(a)(4), insofar as it incorporates 42 CFR 431.53
  To enable the State to assure transportation to and from providers for the Demonstration participants.

- Eligibility Standards
  §1902(a)(17)
  To enable the State to apply different eligibility methodologies and standards to the Demonstration eligible population than are applied under the State Plan.

- Retroactive Eligibility Section
  §1902(a)(34)
  To enable the State to not provide coverage for the Demonstration eligible population for any time prior to the first day of the month in which the application was received by the State.

<u>2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.</u>

- Expenditure authority under contracts with managed care entities.

Rationale for Authority: To allow alternative provider payment methodologies for reimbursement on the basis of quality outcomes and to incentivize coordination between traditional health plans and Prepaid Inpatient Health Plans for physical and behavioral healthcare integration.

- IMD Expenditure Authority
  To support access to a full continuum of care to most effectively treat SUD and support recovery for individuals with SUD, Michigan is proposing to extend coverage for services in inpatient and/or residential settings that are within the definition of IMDs at 42 CFR 435.1010. Therefore, Michigan is proposing that CMS grant expenditure authority in qualified facilities for services provided to Medicaid-eligible individuals, regardless of the size of the facility providing SUD treatment.

# IX. Demonstration Administration

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# Appendix A

## Substance Use Disorder Benefits and Service Array

**The following Substance Use Disorder (SUD) benefits include the full array of state plan and §1915(b) benefits that are being modified to reflect their utilization within the ASAM criteria. The services that require substance use disorder licensure and/or the use of specific ASAM criteria include the service description, provider specifications and qualification for the benefit and service.**

Notes: These notes apply to the entire document.

1. Prior authorization is required at the PIHP level for all services therefore we have not specifically addressed prior authorizations for each service in the grid. Decisions regarding the authorization of SUD services the and the medical necessity criteria fall within the ASAM level of care criteria as also described in section III of the waiver titled Specialty Service and Supports Eligibility, Service Reforms and Service Array for persons with SUD.
2. Unless otherwise specified in the grid, the limit on the amount and duration of the service is guided by medical necessity and individual's IPOS.
3. Unless specified in the grid, individuals and agencies must meet the provider requirements and assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served.

## Individual Assessments

**Service: Substance Use Disorder Individual Assessments**
**Scope/Description: Alcohol and/or Drug Service Assessments including: Psychiatric Evaluation, Psychological Testing, Other Assessments and Testing**

**The following limitation(s) applies to the scope of the service:**

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| Per<br>X Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>Other: One per day | _____Day(s)<br>_____Week(s)<br>_____Month(s)<br><br>Other: None | X Individual<br><br>X Agency | Legally Responsible Person<br><br>Relative/Legal Guardian:<br><br>N/A | Provider agency licensed and accredited as substance abuse treatment program. Service provided by Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. |

## Outpatient Care

**Service: Substance Use Disorder Outpatient Care (ASAM Levels 1 and 2)**
**Scope/Description: Behavioral Health Counseling & Therapy, Medication Administration and Review, Group & Family Counseling, Intensive Outpatient, Early Intervention, Crisis Intervention, Recovery Coach (Peer Supports), Brief Intervention & Care Coordination, Recovery Supports and Treatment Planning.**

**The following limitation(s) applies to the scope of the service:**

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>X Other, Describe: ASAM Levels 1 and 2 | _____Day(s)<br><br>Week(s)<br><br>Month(s)<br><br>Other: None | X Individual<br><br>X Agency | Legally Responsible Person<br><br>Relative/Legal Guardian:<br><br>N/A | Service provided by Substance Abuse Treatment Specialist (SATS) or Clinical Service provided by Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS.<br><br>Non-clinical services can be provided by appropriately trained staff when working under the supervision of a SATS or SATP<br><br>A recovery coach or SUD peer specialist must be certified through MDHHS-approved training program. |

Methadone Treatment

**Service: Substance Use Disorder, Methadone**
**Scope/Description: Methadone Administration**

**The following limitation(s) applies to the scope of the service:**

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>Other: | _____Day(s)<br>_____Week(s)<br>_____Month(s)<br><br>Other: | Individual (list types):<br><br>X Agency (list types of agencies): | Legally Responsible Person<br><br>Relative/Legal Guardian:<br><br>N/A | Provider agency licensed and accredited as a methadone clinic. Supervision by licensed physician. Administration by a MD, DO, licensed PA, RN, LPN or pharmacist. |

Sub-Acute Detoxification (Medically Monitored)

**Service: Substance Use Disorder, Sub-Acute Detoxification (ASAM III.7-D)**

**Scope/Description: Alcohol and/or drug services; sub-acute detoxification; medically monitored residential detox**

**The following limitation(s) applies to the scope of the service:**

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>X Other:<br>ASAM III.7-D | _____Day(s)<br>_____Week(s)<br>_____Month(s)<br><br>Other: | Individual (list types):<br><br>X Agency (list types of agencies): This may include Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010. | Legally Responsible Person<br><br>Relative/Legal Guardian:<br><br>N/A | Provider agency licensed and accredited as substance abuse residential detoxification program. Supervision by a licensed physician.<br><br>Staffed 24-hours-per-day, 7 days a week by licensed physician or by a representative of a licensed physician. |

Sub-Acute Detoxification (Clinically Monitored)

**Service: Substance Use Disorder, Sub-Acute Detoxification (ASAM III.2-D)**

**Scope/Description: Alcohol and/or drug services; sub-acute detoxification; clinically monitored residential detox; non-medical or social detox setting.**

**The following limitation(s) applies to the scope of the service:**

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>X Other:<br>ASAM III.2-D | _____Day(s)<br>_____Week(s)<br>_____Month(s)<br><br>Other: | Individual (list types):<br><br>X Agency (list types of agencies): This may include Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010. | Legally Responsible Person<br><br>Relative/Legal Guardian:<br><br>N/A | Provider agency licensed and accredited as substance abuse residential detoxification program. Supervision by a licensed physician.<br><br>Provided under the supervision of a substance abuse treatment specialist. Must have access to licensed medical personal. |

Sub-Acute Detoxification (Ambulatory)

**Service: Substance Use Disorder, Sub-Acute Detoxification Ambulatory (ASAM I-D & ASAM II-D)**

**Scope/Description: Alcohol and/or drug services; ambulatory detoxification without and with extended on-site monitoring. .**

**The following limitation(s) applies to the scope of the service:**

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>X Other:<br>ASAM I-D and II-D | _____Day(s)<br>_____Week(s)<br>_____Month(s)<br><br>Other: | X Individual (list types):<br><br>X Agency (list types of agencies): This may include Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010. | Legally Responsible Person<br><br>Relative/Legal Guardian:<br><br>N/A | Provided under the supervision of a Substance Abuse Treatment Specialist. Must have arrangements for access to licensed medical personnel as needed. Appropriately certified licensed nurses must monitor ASAM level II-D ambulatory detoxification services. |

Residential Services

**Service: Substance Use Disorder, Residential Services (ASAM III-3 & III-5)**
**Scope/Description: Alcohol and/or drug services; short term residential (non-hospital residential treatment program).**

**The following limitation(s) applies to the scope of the service:**

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>X Other:<br>ASAM III-3 and III-5 | _____Day(s)<br>_____Week(s)<br>_____Month(s)<br><br>Other: | Individual (list types):<br><br>X Agency (list types of agencies): This may include Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010. | Legally Responsible Person<br><br>Relative/Legal Guardian:<br><br>N/A | Provider agency licensed and accredited as substance abuse treatment program. The clinical program must be provided under the supervision of a SATS with licensure as a psychologist, master's level social worker, licensed or limited-licensed marriage and family therapist. |

## Targeted Case Management

**Service: Targeted Case Management**

**Scope/Description: Standalone program specific for SUD. Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process.**

**The following limitation(s) applies to the scope of the service:**

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>Other: | _____Day(s)<br>_____Week(s)<br>_____Month(s)<br><br>Other: | X Individual (list types):<br><br>X Agency (list types of agencies): | Legally Responsible Person<br><br>Relative/Legal Guardian:<br><br>N/A | Service provided by Substance Abuse Treatment Specialist (SATS) or Clinical Service provided by Substance Abuse Treatment Practitioner (SATP) when working under the supervision of a SATS. |

## Crisis Residential Services

**Service: Crisis Residential Services**

**Scope/Description: Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay.**

**The following limitation(s) applies to the scope of the service:**

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>Other: | _____Day(s)<br>_____Week(s)<br>_____Month(s)<br><br>Other: | X Individual (list types):<br><br>X Agency (list types of agencies): This may include Residential settings regardless of size that are within the definition of IMDs at 42 CFR 435.1010. | Legally Responsible Person<br><br>Relative/Legal Guardian:<br><br>N/A | Specialized Residential Licensure. On site medication review by a physician, licensed physician assistant, or nurse practitioner under the supervision of a psychiatrist. The program must under the immediate direction of a mental health professional who is on site 8 hours per-day. |

# Appendix B

## Long Term Service and Supports

## Administration, Quality and Service Plan Development

**Please complete this form if you indicated in Section III that the Demonstration will provide long term services and supports (LTSS).**
**Indicate the Population(s) that the following long-term services and support description applies to:**
**Enter Populations Here**: Persons with Serious Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual & Developmental Disabilities (IDD) and Children with Serious Emotional Disturbances (SED).
**Administration of the Long Term Services and Supports Program**
**Will the LTSS component of the Demonstration be operated by one or more State agencies other than the Medicaid agency**? ☐ Yes ☒ No
**If yes, please provide the contact information of the key contacts at those agencies, including name, title, name of agency, address, telephone number, email address and fax number. Also describe the specific sub-population associated with the contact:**
**Do other State agencies, that are not part of the Single State Medicaid Agency, perform Demonstration operational and administrative functions on behalf of the Medicaid agency?**
☐ Yes ☒ No
**Do any contracted entities, including managed care organizations, perform Demonstration operational and administrative functions on behalf of the Medicaid agency or the waiver operating agency (if applicable)?**
☒ Yes ☐ No
**Do any local or regional non-state entities perform Demonstration operational and administrative functions?**
☒ Yes ☐ No
**If yes to any of the questions above, specify the types of State agencies, contracted entities and/or local/regional non-state entities and describe the specific functions that they perform. This includes individual enrollment, management of any enrollment or expenditure limits, level of care evaluation, review of service plans, prior authorization of services, utilization management, provider enrollment and agreements, rate methodologies, rules, policies and procedures, and quality assurance and improvement activities. Please describe how the Single State Agency oversees the performance of these non-State entities**:

Michigan uses a managed care delivery structure including 10 Prepaid Inpatient Health Plans (PIHPs) who contract for service delivery with forty six (46) Community Mental Health Service Programs (CMHSP's) and other non-for profit providers. Through a combination of different PIHP and CMHSP management and service delivery models, CMHSP are normally contracted to directly provide or contract for the majority of direct service including evaluation, service plan development/authorization, and certain quality improvement activities related to clinical service delivery. The State Agency develops rate methodologies for the 10 PIHPs who distribute funds and manage or provide oversight of the provider network including any State Agency delegated functions. By law, the State Agency certifies Community Mental Health Programs every three years, contracts for an External Quality Review and directly completes site reviews of PIHPs/CMHSP's and contract providers every two years. For additional site review protocol, please see the Quality Improvement Strategies section below.

**Consolidation of Existing Waivers or Authorities into the Demonstration**
**Are existing State waivers or programs operating under other authorities are being consolidated into the Demonstration Program?**
[X] Yes [ ] No
**If yes, identify the existing waiver(s) (1915(b),(c),(d),(e) or State Plan authorities (1915(a), (i), (j), (k), 1932) that are being consolidated into the 1115 Demonstration, including the names of the waivers or programs and identifying waiver numbers. Also indicate the current status of these waivers or authorities.**

As outlined in the introduction above, Exhibit 1 outlines the Waivers consolidated under this application. The §1915(b) Managed Specialty Supports and Services Waiver (MI-R06.M02) expires on September 30, 2016, the §1915(b)/(c) Children's Waiver Program and the Habilitation Supports Waiver (MI-16,R01) expires on June 30, 2016. The §1915(b)/(4) Waiver for Children with Serious Emotional Disturbances (MI-17.R01.MO1) expires on June 30, 2016 and the §1915(c) Waiver for Children with Serious Emotional Disturbances (0438.R01.01) expires on September 30, 2018. The §1915(i) SPA for Applied Behavioral Analysis will be discontinued as of 12-31-15 and the services will be included as part of EPSDT benefit under Michigan's Medicaid State Plan.

**Describe how individuals in these programs will be transitioned to the 1115 Demonstration program and assured a comparable level of services, quality and continuity of care.**

All former §1915(b) and §1915(c) Waiver services and eligible populations will be included as part of the Demonstration. Transition and continuity of care will be seamless.

**Level of Care to Qualify for the Program**
**This Demonstration is requested in order to provide LTSS to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which should be reimbursed under the approved Medicaid state plan:**
There is no request for additional LTSS to be reimbursed under this Demonstration**.**
**Indicate and describe the level of care criteria for participants in the Long Term Services and Supports Demonstration program, such as hospital, nursing facility, ICF-MR, IMD-hospital, IMD-nursing facility, or needs-based criteria. Identify which entity performs the initial and subsequent level of care evaluations and the frequency of such reevaluations:**

The level of care criteria for all service and supports (including LTSS) is described in section III of this application. This §1115 Waver will maintain the use of a managed care delivery structure using ten (10) recently procured PIHPs who contract for service delivery with forty-six (46) CMHSP's and other non-for profit providers. Initial and subsequent level of care evaluations are done by the PIHP and/or their CMHSP provider network. Frequency of evaluations is ultimately determined by the Person Centered Plan but done at least annually.

This Demonstration does not cover hospital, nursing facility or ICF-MR facilities for LTSS.

**Individual Cost Limits**

**Do individual cost limits apply when determining whether to deny LTSS or entrance to the Demonstration to an otherwise eligible individual** ☐ Yes ☒ No

**If yes, indicate the type of cost limit that applies and describe any additional requirements pertaining to the indicated limit:**

☐ **Cost Limit in Excess of Institutional Costs. The State refuses entrance to the Demonstration to any otherwise eligible individual when the State reasonably expects that the cost of the LTSS furnished to that individual would exceed the cost of a level of care specified for the Demonstration up to an amount specified by the State.**

☐ **Institutional Cost Limit. The State refuses entrance to the Demonstration to any otherwise eligible individual when the State reasonably expects that the cost of the LTSS furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.**

☐ **Cost Limit Lower Than Institutional Costs. The State refuses entrance to the Demonstration to any otherwise qualified individual when the State reasonably expects that the cost of LTSS furnished to that individual would exceed an amount specified by the State that is less than the cost of a level of care specified for the Demonstration. Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of Demonstration individuals.**

**Long Term Services and Supports – Outreach, Education, Enrollment and Screening**

**Describe the Demonstration program's approach to Outreach, Education, Enrollment and Screening, including any coordination with a Money Follows the Person program. Include a description of the roles of the State and other entities in the processes.**

There is no Money Follows the Person program included in this Demonstration. Medicaid eligibility and enrollment is determined by the State Agency and screening for the eligibility of Specialty Service System supports is determined by the PIHPs and the CMHSP's. Eligibility Criteria for Specialty Services is included in Section III of this application.

**Person-Centered Planning**

**Indicate who is responsible for collaborating with the individual in developing the Demonstration's person-centered service plan and for its final development:**

☒ Case Manager ☒ Social Worker

☐

X Other (please describe, include qualifications)

Staff Qualifications are outlined below:

**<u>Mental Health Professional</u>**

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 (CMHP)**:
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. For the Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) services individuals must be a BCBA or BCaBA or Psychologist working within their scope of practice with extensive knowledge and training on behavior analysis and BCBA certified by 9/30/2020.

**Qualified Intellectual Disability Professional (QIDP)**:
Individual with specialized training 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, registered nurse, registered dietician, therapeutic recreation specialist, a licensed or limited-licensed professional counselor or a human services professional with a bachelor's degree or higher in a human services field (including but not limited to criminal justice, psychology, or sociology) in which the curriculum provided a good understanding of human behavior and the needs of population that they will be serving, as well as training in intervention methods that are useful in the public behavioral health system.

An individual with a bachelor's degree in a human services field who was hired prior to January 1, 2008 and performed in the role of a QMHP prior to January 1, 2008 would also qualify.
**NOTE:** If an individual was hired and performed the role of a QIDP prior to January 1, 2008 and later transfers to a new agency, his/her QIDP status will be grandfathered in to the new agency.
**Qualified Behavioral Health Professional (QBHP)**:
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. Must be BCBA certified by 9/30/2020. 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.

**Social Worker**
Individual who possesses Michigan full or limited licensure as a master's social worker or a bachelor's social worker. Social workers with limited licenses must be supervised by a fully-licensed master's social worker.

**Targeted Case Manager**:
QIDP or QMHP: specified bachelor's degree and one year of experience with the population the targeted case manager will be serving. If targeted case manager has only specified bachelor's degree without specialized training or experience, they must be supervised by a QMHP or QIDP for one year. Services must be provided by a CMHP to any child beneficiary with SED. Services to children ages 7-17 with SED must be provided by a CMHP trained in CAFAS. Services rendered to children ages 4-6 with SED must be provided by a CMHP trained in PECAFAS.

**Supports Coordinator**:
QIDP or QMHP: specified bachelor's degree and one year of experience with the population the supports coordinator will be serving. If the supports coordinator has only the degree without one year of experience, they must be supervised by a QMHP or QIDP for one year. Services must be provided by a CMHP to any child beneficiary with serious emotional disturbance. Services to children ages 7-17 with SED must be provided by a CMHP trained in CAFAS. Services rendered to children ages 4-6 with SED must be provided by a CMHP trained in PECAFAS.

Essential Elements for Person/Family Centered Planning
The Michigan Mental Health Code (the 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). Through the MDHHS/PIHP contract, MDCH delegates the responsibility for development of the IPOS to the PIHP. The PIHP shall implement person-centered planning in accordance with the MDHHS Person-Centered Planning Practice Guideline (P 4.4.1.1). PIHPs and their subcontractors (such as CMHSPs) may provide direct waiver services. The development of the IPOS through the person-centered planning (PCP) process is led by the participant with the involvement of allies chosen by the participant to ensure that the service plan development is conducted in the best interests of the participant.

Each 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 participants about the array of services and supports available and the choice of providers. The participant has the option to choose his or her supports coordinator employed by a PIHP or 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 participant to identify who he or she wants to assist with service plan development that meets the participant's interests and needs.

Michigan law and policy provide guidance as to how PCP is implemented, including Administrative Regulations and the MDCH/PIHP contract attachment entitled "The Person-Centered Planning Policy and Practice Guideline". As described below, there is a separate process and guideline for minor children called the Family-Driven/Youth Guided Policy and Practice Guideline. The following essential elements of the PCP process have been identified to measure the effectiveness of the process in ensuring that participants are directly and actively engaged:

- **Person-Directed.** The individual directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.

- **Family Driven/Youth Guided Practice**. The organization supports a family driven youth-guided approach to service delivery for children and their families. A family driven youth-guided approach recognizes that service and supports impact the entire family; not just the identified youth receiving mental health services. IN the case of minors, the child and the family is the focus of service planning, and family members are integral to a successful planning process.

- **Person-Centered.** The planning process focuses on the individual, not the system or the individual’s family, guardian, or friends. The individual’s goals, interests, desires, and preferences are identified with an optimistic view of the future and plans for a satisfying life. The planning process is used whenever the individual wants or needs it, rather than viewed as an annual event.

- **Outcome-Based.** Outcomes in pursuit of the individual's preferences and goals are identified as well as services and supports that enable the individual to achieve his or her goals, plans, and desires and any training needed for the providers of those services and supports. The way for measuring progress toward achievement of outcomes is identified.

- **Information, Support and Accommodations**. As needed, the individual receives comprehensive and unbiased information on the array of mental health services, community resources, and available providers. Support and accommodations to assist the individual to participate in the process are provided.

- **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process.

- **Pre-Planning**. The purpose of pre-planning is for the individual to gather all of the information and resources (e.g. people, agencies) necessary for effective person-centered planning and set the agenda for the process. Each individual (except for those individuals who receive short-term outpatient therapy only, medication only, or those who are incarcerated) is entitled to use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used.

The following items are addressed through pre-planning with sufficient time to take all necessary/preferred actions (i.e. invite desired participants):

a. When and where the meeting will be held,
b. Who will be invited (including whether the individual has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support),
c. What will be discussed and not discussed,
d. What accommodations the individual may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication),
e. Who will facilitate the meeting,
f. Who will record what is discussed at the meeting.

- **Wellness and Well-Being.** Issues of wellness, well-being, health and primary care coordination or integration, supports needed for an individual to continue to live independently as he or she desires, and other concerns specific to the individual's personal health goals or support needed for the individual to live the way they want to live are discussed and plans to address them are developed. If so desired by the individual, these issues can be addressed outside of the PCP meeting.

- **Participation of Allies.** Through the pre-planning process, the individual selects allies (friends, family members and others) to support him or her through the person-centered planning process. Pre-planning and planning help the individual explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

Independent (External) Facilitation

In Michigan, individuals receiving support through the public mental health system have a right to choose an independent or external facilitator of the person-centered planning process, unless the individual is receiving short-term outpatient therapy or medication only. The PIHP or CMHSP must make available a choice of at least two independent facilitators to individuals interested in using independent facilitation. The facilitator is chosen by the individual and serves as the individual's guide (and for some individuals, their voice) throughout the process, making sure that his or her hopes, interests, desires, preferences and concerns are heard and addressed. The facilitator helps the individual with the pre-planning activities and co-leads any PCP meeting(s) with the individual. The independent facilitator must not have any other role within the CMHSP. The independent facilitator must personally know or get to know the individual who is the focus of the planning including what he or she likes and dislikes as well as personal preferences, goals, modes of communication, and who supports or is important to the individual.

Individual Plan of Service

The Michigan Mental Health Code establishes the right for all individuals to develop individual plans of services (IPOS) through a person-centered planning process regardless of disability or residential setting. However, an IPOS needs to be more than the services and supports authorized by the community mental health system; it must include all of the components described below. The PCP process must be used at any time the individual wants or needs to use the process.

The agenda for each PCP meeting should be set by the individual through the pre-planning process, not by agency or by the fields or categories in a form or an electronic medical record

Once an individual has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the individual's needs, changes in the individual's condition as determined through the PCP process or changes in the individual's preferences for support). Assessment may be used to inform the PCP process, but is not a substitute for the process.

The individual and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. An individual or his/her guardian or authorized representative may request and review the IPOS 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 through the PCP process to review progress toward goals and objectives and to assess beneficiary satisfaction. Reviews will work from the existing plan to amend or update it as circumstances, needs, preferences or goals change or to develop a

completely new plan if so desired by the individual. Use of the PCP process in the review of the plan incorporates all of the Essential Elements as desired by the individual.

The individual decides who will take notes or minutes about what is discussed during the person-centered planning process. In addition, documentation maintained by the CMHSP within the Individual Plan of Service must include:

(1) A description of the individual's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports;
(2) The outcomes identified by the individual and how progress toward achieving those outcomes will be measured;
(3) The services and supports needed by the individual to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports;
(4) The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.
(5) The estimated/prospective cost of services and supports authorized by the community mental health system.
(6) The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.
(7) Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

The individual must be provided with a written copy of his or her plan within 15 business days of conclusion of the PCP process. This timeframe gives the case manager/ supports coordinator a sufficient amount of time to complete the documentation described above.

Organizational Standards

The following characteristics are essential for organizations responsible for providing supports and services through PCP:

- Individual Awareness and Knowledge: The organization provides accessible and easily understood information, support and when necessary, training, to individuals using services and supports and those who assist them so that they are aware of their right to PCP, the essential elements of PCP, the benefits of this approach and the support available to help them succeed (including, but not limited, pre-planning and independent facilitation).
- Person-Centered Culture: The organization provides leadership, policy direction, and activities for implementing person-centered planning at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.

- Training: The organization has a process to identify and train staff at all levels on the philosophy of PCP. Staff who are directly involved in PCP are provided with additional training.
- Roles and Responsibilities: As an individualized process, PCP allows each individual to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.
- Quality Management: The QA/QM System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful person-centered planning. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and standards are in place to assure support the individual directs the PCP process and ensures that PCP is consistently done well.

Dispute Resolution

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to grievance, appeals and recipient rights as set forth in detail in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries. As described in this Contract Attachment, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension or termination of services). Other options are available to all recipients of Michigan mental health services and supports.

Supports Coordinators, Case Managers and Customer Services at PIHP/CMHSPs must be prepared to help people understand and negotiate dispute resolution processes.

**Criminal History and/or Background Investigations**
**Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide Demonstration services:**
**Are criminal history and/or background investigations required**? ☒ Yes ☐ No

**If yes, indicate the types of positions for which such investigations must be conducted:**

☒ Administrative Staff ☒ Transport Staff

☒ Staff, providers and others who have direct contact with the individual

**Others (please describe)**
Indicate the scope of such investigations:

☐ National (FBI) criminal records check ☒ State criminal records check only

☐ Other (please describe)

**Abuse Registry Screening Does the State maintains an abuse registry and requires the screening of individuals through this registry**

Yes ☐
No ☒

**If yes, specify the entity (entities) responsible for maintaining the abuse registry:**

**Indicate the types of positions for which abuse registry screenings must be**

**conducted:**

☐ Administrative Staff ☐ Transport Staff

☐ Staff, providers and others who have direct contact with the individual

☐ Others (please describe)

Allowable Settings

**Are Demonstration services provided in facilities subject to §1616(e) of the Act?**

☐ Yes ☒ No

**If yes, indicate the types of facilities where Demonstration services may be provided, any capacity limits for such facilities, the home and community based services that may be provided in such facilities, and how a home and community character is maintained in these settings.**

**Individual Rights**

**In addition to fair hearings, does the State operate other systems for dispute resolution, grievances or complaints concerning the operation of the Demonstration program's home and community-based services component?**

☐ Yes ☒ No

**Quality Improvement Strategies**

**Provide a description of the quality improvement strategies to be employed in the operation of the Demonstration. In particular describe strategies to ensure the health and welfare of individuals to be served with Home and Community-Based Services, including the prevention of abuse, neglect and exploitation (e.g., critical incident management system, utilization review, case management visits, etc.), the single State Medicaid Agency oversight and involvement. Please also include the self-direction strategy if the Demonstration allows for self-direction.**

The State require***s*** that each specialty Prepaid Inpatient Health Plan (PIHP) to have a quality assessment and performance improvement program (QAPIP). The Guidelines for Internal Quality Assurance Programs as distributed by then Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993; the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358 of 2002.

In addition to the QAPIP, the MDHHS, Quality Management and Planning (QMP) site review team completes on site reviews of PIHPs and their provider networks on a biennial basis assuring the service needs, including the health and welfare are met for the section 1115 population. A more detailed review of the QAPIP standards, critical incident management, the MDHHS site review process and an overview of Michigan's self-determinations strategy is outlined below.

**OAPIP Standards**

I. The PIHP must have a written description of its QAPIP which specifies 1) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2) the components and activities of the QAPIP, including those as required below; 3) the role for recipients of service in the QAPIP; and 4) the mechanisms or procedures to be used for adopting and communicating process and outcome improvement.

II. The QAPIP must be accountable to a Governing Body that is a Community Mental Health Services Program Board of Directors. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

   A. Oversight of QAPIP - There is documentation that the Governing Body has approved the overall QAPIP and an annual QI plan.

   B. QAPIP progress reports - The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions.

   C. Annual QAPIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.

   D. The Governing Body submits the written annual report to MDHHS following its review. The report will include a list of the members of the Governing Body.

III. There is a designated senior official responsible for the QAPIP implementation.

IV. There is active participation of providers and consumers in the QAPIP processes.

V. The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.

   A. PIHP must utilize performance measures established by the department in the areas of access, efficiency and outcome and report data to the state as

established in contract.

B. The PIHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.

VI. The PIHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in the contract and analyzes the causes of negative statistical outliers when they occur.

VII. The PIHP's QAPIP includes affiliation-wide performance improvement projects that achieve through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction.

A. Performance improvement projects must address clinical and non-clinical aspects of care.

1. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.

2. Non-clinical areas would include, but not be limited to, appeals, grievances and trends and patterns of substantiated Recipient Rights complaints; and access to, and availability of, services.

B. Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's consumers; consumer demographic characteristics and health risks; and the interest of consumers in the aspect of service to be addressed.

C. Performance improvement projects may be directed at state or PIHP-established aspects of care. Future state-directed projects will be selected by MDHHS with consultation from the Quality Improvement Council and will address performance issues identified through the external quality review, the Medicaid site reviews, or the performance indicator system.

D. PIHPs may collaborate with other PIHPs on projects, subject to the approval of the department.

E. The PIHP must engage in at least two projects during the waiver renewal period.

VIII. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events and other critical incidents and events that put people at risk of harm.

A. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of the event.

B. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

C. All unexpected* deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:

1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
2. Involvement of medical personnel in the mortality reviews
3. Documentation of the mortality review process, findings, and recommendations
4. Use of mortality information to address quality of care
5. Aggregation of mortality data over time to identify possible trends.

* "Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

D. Following immediate event notification to MDHHS (See Section 6.1 of this contract) the PIHP will submit information on relevant events through the Critical Incident Reporting System described below.

E. Critical Incident Reporting System
The critical incident reporting system collects information on critical incidents that can be linked to specific service recipients.
This critical incident reporting system became fully operational and contractually required October 1, 2011 (see Attachment 7.7.1.1).

The Critical Incident Reporting System captures information on five specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. The population on which these events must be reported differs slightly by type of event.

The QAPIP must describe how the PIHP will analyze at least quarterly the critical incidents, sentinel events, and risk events (see below) to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and

incidents. MDHHS will request documentation of this process when performing site visits.

MDHHS has developed formal procedures for analyzing the event data submitted through this system. This includes criteria and processes for Department follow-up on individual events as well as processes for systemic data aggregation, analysis and follow-up with individual PIHPs.

F. Risk Events Management

The QAPIP has a process for analyzing additional critical events that put individuals (in the same population categories as the critical incidents above) at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. MDHHS will request documentation of this process when performing site visits.

These events minimally include:

- Actions taken by individuals who receive services that cause harm to themselves
- Actions taken by individuals who receive services that cause harm to others
- Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period

Following immediate event notification to MDHHS the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service.

IX. The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have (see F above) been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and that have been approved during person-centered planning by the beneficiary or his/her guardian, may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.

X. The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.

A. The assessments must address the issues of the quality, availability, and

accessibility of care.

B. As a result of the assessments, the organization:
   1. Takes specific action on individual cases as appropriate;
   2. Identifies and investigates sources of dissatisfaction;
   3. Outlines systemic action steps to follow-up on the findings; and
   4. Informs practitioners, providers, recipients of service and the governing body of assessment results.

C. The organization evaluates the effects of the above activities.

D. The organization insures the incorporation of consumers receiving long-term supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

XI. The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the persons served.

XII. The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs. The PIHP must have written policies and procedures for the credentialing process which are in compliance with MDHHS's Credentialing and Re-credentialing Processes, Attachment P.7.1.1, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP are incorporated into this re-credentialing process.

The PIHP must also insure, regardless of funding mechanism (e.g., voucher):

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:

   a. Educational background
   b. Relevant work experience
   c. Cultural competence
   d. Certification, registration, and licensure as required by law

2. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.

3. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

XIII. The written description of the PIHP's QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by affiliates (as applicable***),*** providers and subcontractors.

1. The PIHP must submit to the state for approval its methodology for verification.

2. The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.

XIV. The organization operates a utilization management program.

A. Written Plan - Written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to identify and correct under-utilization as well as over-utilization.

C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:

1. Review decisions are supervised by qualified medical professionals. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.
2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.
3. The reasons for decisions are clearly documented and available to the member.
4. There are well-publicized and readily-available appeals mechanisms for both providers and service recipients. Notification of denial is sent to both the beneficiary and the provider. Notification of a denial includes a description of how to file an appeal.
5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.
7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

XV. The PIHP annually monitors its provider network(s), including any affiliates or sub-contractors to which it has delegated managed care functions, including service and

support provision. The PIHP shall review and follow-up on any provider network monitoring of its subcontractors.

XVI. The PIHPs, shall continually evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes. MDHHS will continue to work with PIHP to develop uniform methods for targeted monitoring of vulnerable people.

The PIHP shall review and approve plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDHHS review.

**MDHHS Quality Management and Planning Site Review Process**

The MDHHS Quality Management and Planning (QMP) Site Review team conducts comprehensive biennial reviews of the 10 PIHPs. This site visit strategy includes rigorous standards for assuring the needs, including health and welfare of the current and proposed waiver populations included under this §1115 Waiver. The comprehensive reviews includes: consistent, uniform, person-centered and medical necessity/needs assessments from clinical record reviews, administrative reviews, consumer/stakeholder meetings and consumer interviews.
In addition to the full biennial site review, the QMP Site Review Team members also conduct a follow-up review approximately 90 days after the issuance of the approved corrective action plan (CAP) to assess the status and effectiveness of the PIHPs implementation of their CAP. Below are the performance measures that the site review team will be focusing on for the combined §1115 Waiver population:

- Number and percent of reviewed participants where the IPOS includes services and supports that align with the individual's assessed needs.

- Number and percent of reviewed participants where the IPOS had adequate strategies to address their assessed health and safety risks.

- Number and percent of reviewed participants where the IPOS reflect their goals and preferences.

- Number and percent of IPOS for reviewed participants in which services and supports are provided as specified in the plan, including type, amount, scope, duration and frequency.

- Number and percent of participants requiring hospitalization due to injury related to the use of physical management.

- How the number of beneficiaries within the PIHP boundaries are identified and tracked including how interventions are addressed in the IPOS including the prevention of modifiable risk factors and access to physical healthcare for individuals considered "High Utilizers".

- Number and percent of participants requiring hospitalization due to medication error.

- Number and percent of participants being reviewed where the BTPRC policy was followed.

- MDHHS is in the process of developing performance measures to assess the settings' status in getting into compliance with the HCBS final rule, person-centered planning process and requirements around conflict free case management.

A standard site review protocol is used at the time of each site visit. The protocol is used to record and document findings during the site review. The findings are sent to the PIHPs which are required to submit a CAP to MDHHS within 30 days. The CAP is reviewed and approved by MDHHS. The PIHP has 90 days after the CAP has been approved to provide evidence to MDHHS that all issues have been remediated. The remediation process continues until all concerns have been appropriately addressed.
If, during a QMP on-site visit, 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.

**MDHHS Self Determination Overview**

In Michigan, we use the term Self-Determination to embrace the concept that the purpose of self-direction opportunities is for individuals to have the support to pursue a meaningful life in the community. The MDHHS BH&DDA Self-Determination Policy and Practice Guideline (SD Guideline) states: "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."

The Self-Determination Policy and Practice Guideline requires that PIHP/CMHSPs "assure that full and complete information about self-determination and the manner in which it may be accessed and applied is available to each consumer. This shall include specific examples of alternative ways that a consumer may use to control and direct an individual budget, and the obligations associated with doing this properly and successfully. (I.C. page 4). Moreover, the policy states: "A CMHSP shall actively support and facilitate a consumer's application of the

principles of self-determination in the accomplishment of his/her plan of services." (I.E.. page 4). Arrangements that support self-determination are developed through the person-centered planning process (see below).

Waiver participants have opportunities for both employer and budget authority. Participants may elect either or both budget authorities and can direct a single service or all of their services for which participant direction is an option. The participant may direct the budget and directly contract with chosen providers. Typically, the individual budget is transferred to a fiscal intermediary (this is the Michigan term for an agency that provides financial management services or FMS) which administers the funds and makes payment upon participant authorization. However, the SD Guideline provides options for use of arrangements that support self-determination without utilizing a fiscal intermediary.

There are two options for participants choosing to exercise employer authority: the direct employment model and Agency with Choice. Through the direct employment model, the participant is the common law employer and delegates' performance of the fiscal/employer agent functions to the fiscal intermediary, which processes payroll and performs other administrative and support functions. The participant directly recruits, hires and manages employees. In the Agency with Choice model, participants may contract with an agency with choice and split the employer duties with the agency. The participant is the managing employer and has the authority to select, hire, supervise and terminate workers. As co-employer, the agency is the common law employer, which handles the administrative and human resources functions and provides other services and supports needed by the participant. The agency may provide assistance in recruiting and hiring workers. A participant may select one or both options. For example, a participant may want to directly employ a good friend to provide support during the week and Agency with Choice to provide support on the weekends.

Through its contract with MDHHS, each PIHP is required to offer information and education to participants on arrangements that support self-determination. MDHHS offers technical guidance, training and prototype documents. Each PIHP also offers support to participants in these arrangements. This support can include offering required training for workers, offering peer-to-peer discussion forums on how to be a better employer, or providing one-on-one assistance when a problem arises. . The participants are given information regarding the responsibilities and benefits of self-determination prior to the PCP process. Participants interested in arrangements that support self-determination start the process by letting their supports coordinator or other chosen qualified provider know of their interest.

PIHPs (and CMHSPs) are the primary entities that support participants who use arrangements that support self-determination. Supports coordinators, supports coordinator assistants, or independent support brokers (or other qualified provider chosen by the participant) are responsible for providing support to participants in arrangements that support self-determination. The supports coordinator, supports coordinator assistant, or independent supports broker is responsible for obtaining authorization of the budget and plan and monitoring the plan, budget and arrangements. Supports coordinators, supports coordinator

assistants, or independent supports brokers (or other qualified provider chosen by the participant) make sure that participants receive the services to which they are entitled and that the arrangements are implemented smoothly. An individual plan of service (IPOS) will be developed through this process with the participant, supports coordinator or other chosen qualified provider, and allies chosen by the participant. The plan will include the waiver services needed by and appropriate for the participant. An individual budget is developed based on the services and supports identified in the IPOS and must be sufficient to implement the IPOS.

Each PIHP is required to contract with fiscal intermediaries to provide financial management services. Fiscal Intermediary Services has been a service in the state's §1915(b) Waiver, which will continue in the 1115 waiver. The fiscal intermediary performs a number of essential tasks to support participant direction while assuring accountability for the public funds allotted to support those arrangements. The fiscal intermediary has four basic areas of performance:

- function as the employer agent for participants directly employing workers to assure compliance with payroll tax and insurance requirements;
- ensure compliance with requirements related to management of public funds, the direct employment of workers by participants, and contracting for other authorized goods and services;
- facilitate successful implementation of the arrangements by monitoring the use of the budget and providing;
- monthly budget status reports to participant and agency.

# Appendix C

## Long Term Services & Supports (LTSS) Benefit Specifications and Provider Qualifications

**For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.**

Notes: These notes apply to the entire document.

1. Prior authorization is required at the PIHP level for all services therefore we have not specifically addressed prior authorizations for each service in the grid. Decisions regarding the authorization of Long Term Service and Supports for individuals who meet the Specialty Service and Supports Eligibility Criteria may take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid populations as further outlined in the Medicaid provider manual.
2. Unless otherwise specified in the grid, the limit on the amount and duration of the service is guided by medical necessity and individual's IPOS.
3. Unless otherwise specified in the grid, agencies must meet the PIHP's provider requirements and assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served.

## Community Living Supports (CLS)

**Service:** Community Living Supports (CLS)
**Scope/Description:**
Community Living Supports 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:
- 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
- Staff assistance 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 or 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 or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

**The following limitation(s) applies to the scope of the service:**
The CLS do not include the costs associated with room and board.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: | Description of allowable providers: |
|---|---|---|---|---|---|---|
| ____ Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>☐ Other, Describe: | ____Day(s)<br>____Week(s)<br><br>Month(s)<br><br>____Other:<br><br>See note No.2 Page 1. | ☒ Individual (list types):<br><br>Personal assistant, CLS aide<br><br>☒ Agency (list types of agencies):<br><br>Home care agency, staffing agency, or other PIHP network provider agency<br><br>licensed children's foster care, licensed adult foster care | ☐ Legally Responsible Person<br><br>☒Relative<br><br>Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. | Provider Type:<br><br>Personal assistant, CLS aide<br><br>License Required:<br>☐ Yes ☒ No<br><br>Certificate Required:<br>☐ Yes ☒ No<br>Describe:<br><br>Other Qualifications Required for this Provider Type (please describe): | Provider Type:<br><br>Home care agency, staffing agency, or other PIHP network provider agency<br><br>License Required:<br>☐ Yes ☐ No<br><br>Certificate Required:<br>☐ Yes ☐ No<br>Describe:<br><br>Other Qualifications Required for this Provider Type (please describe):<br><br>For services delivered in the community, the | Provider Type:<br><br>Licensed children's foster care, licensed adult foster care<br><br>License Required:<br>☒ Yes ☐ No<br><br>Act 116 of 1973 as amended (children), Act 218 of 197 as amended (adults), Administrative Rules R400.4101-.14601, R400.15101-.15411, R400.2231-.2246, R400.1151-.1153, R400.1901-1906 and R400.2101-2475, MCL 722.115-118(a)<br><br>Certificate Required:<br>☐ Yes ☒ No<br>Describe: |

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: | Description of allowable providers: |
|---|---|---|---|---|---|---|
| | | | | Aides must meet criteria specified in the Michigan PIHP/CMHSP Provider Qualification Code Chart: | agency must assure its employees are knowledgeable in the community opportunities available in the area. | **Other Qualifications Required for this Provider Type (please describe):**<br><br>n/a |

## Enhanced Medical Equipment and Supplies

**Service:** Enhanced medical equipment and supplies

**Scope/Description:**

Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances. All enhanced medical equipment and supplies must be specified in the individual plan of service, and must enable the participant to increase his abilities to perform activities of daily living; or to perceive, control, or communicate with the environment. The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the participant will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the participant's need. All items must be ordered on a prescription. An order is valid one year from the date it was signed. This coverage includes:

- Adaptations to vehicles;
- Items necessary for life support;
- Ancillary supplies and equipment necessary for proper functioning of such items;
- Durable and non-durable medical equipment not available under the Medicaid State Plan.

Generators may be covered for an individual who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life sustaining equipment (typically 5,000 watts) and is not intended to provide power for the entire home. The request for approval of a generator must include a documented history of power outages, including frequency and duration.

Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services. 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. The PIHP should have a process in place that gives notice to a medical equipment supplier that purchase of the equipment or supply has been authorized.

Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the individual plan of services that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The PIHP must document 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.

**The following limitation(s) applies to the scope of the service:**
Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the participant are excluded from coverage.

- "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service.
- "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home;
- Items that are considered family recreational choices;
- Purchase or lease of a vehicle and routine repair and maintenance to the vehicle;
- Educational supplies that are required to be provided by the school as specified in the child's Individualized Education Plan; and
- Eye glasses, hearing aids, and dentures are not covered.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: | Description of allowable providers: |
|---|---|---|---|---|---|---|
| ____ Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>☐ Other, Describe: | Day(s)<br><br>Week(s)<br><br>Month(s)<br><br>Other:<br><br>See note No.2 Page 1. | ☐ Individual (list types):<br><br>☒ Agency (list types of agencies):<br><br>Medicaid Enrolled Durable Medical Equipment and Supplies Provider<br><br>Licensed builder or contractor<br><br>Other vendor as appropriate to the service or supply | ☐ Legally Responsible Person<br><br>☐Relative/Legal Guardian: | **Provider Type:**<br><br>Durable Medical Equipment and Supplies Provider<br><br>**License Required:**<br>☐ Yes ☒ No<br><br>**Certificate Required:**<br>☐ Yes ☒ No<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>The durable medical equipment and supplies (DMES) provider must meet any requirements by | **Provider Type:**<br><br>Licensed builder or contractor<br><br>**License Required:**<br>☒ Yes ☐ No<br><br>Licensed builder or contractor who holds current Michigan license under MCL 339.601(1); MCL 339.601.2401; MCL 339.601.2403(3)<br><br>**Certificate Required:**<br>☐ Yes ☒ No<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):** | **Provider Type:**<br><br>Other vendor as appropriate to the service or supply<br><br>**License Required:**<br>☐ Yes ☒ No<br><br>**Certificate Required:**<br>☐ Yes ☒ No<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):** |

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: | Description of allowable providers: |
|---|---|---|---|---|---|---|
| | | | | private insurance, Medicare or Medicaid as appropriate. | | |

## Enhanced Pharmacy

**Service:** Enhanced Pharmacy
**Scope/Description:**

The intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.
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. Items that are not of direct medical or remedial benefit to the beneficiary are not allowed.

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):

- 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); and
- Special items (i.e., accommodating common disabilities -- longer, wider handles), tweezers and nail clippers.

The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:

- 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 has a diagnosis of dysphagia and either:
    - 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.

**The following limitation(s) applies to the scope of the service:**

Coverage excludes routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products). However, products necessary to ameliorate negative visual impact of serious facial disfigurements (e.g., massive scarring) and/or skin conditions (including exposed area eczema, psoriasis, and/or acne) will be covered.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| **Per**<br>**☐ Day**<br>**☐ Week**<br>**☐ Month**<br>**☐ Year**<br><br>**☐Other, Describe:** | **_____Day(s)**<br>**_____Week(s)**<br>**_____Month(s)**<br><br>**Other:**<br><br>See note No.2 Page 1. | **☐ Individual (list types):**<br><br>**☒ Agency (list types of agencies):**<br><br>Retailers | **☐ Legally Responsible Person**<br><br>**☐Relative/Legal Guardian:** | **Provider Type:**<br><br>Retailers<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>Retailers must sell the enhanced pharmacy items. Participants may freely select the provider based on location or other factors. |

## Environmental Modification

**Service:** Environmental Modification
**Scope/Description:**

The intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.
Physical adaptations to the beneficiary's own home or apartment and/or work place. 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 PIHP case manager/supports coordinator will assist the beneficiary in his 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 be in compliance with 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.

Environmental modifications for licensed settings includes only the remaining balance of previous environmental modification costs that accommodate the specific needs of current waiver beneficiaries, and will be limited to the documented portion being amortized in the mortgage, or the lease cost per bed. Environmental modifications exclude the cost of modifications required for basic foster care licensure or to meet local building codes

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| **Per**<br>**☐ Day**<br>**☐Week**<br>**☐ Month**<br>**☐Year**<br><br>**☐Other, Describe:** | **_____Day(s)**<br>**_____Week(s)**<br><br>**Month(s)**<br><br>**Other:**<br><br>See note No.2 Page 1. | **☐ Individual (list types):**<br><br>**☒ Agency (list types of agencies):**<br><br>Licensed Building Contractor | **☐ Legally Responsible Person**<br><br>**☐Relative/Legal Guardian** | **Provider Type:** Licensed Building Contractor<br><br>**License Required:**<br>**☒ Yes ☐ No**<br><br>MCL 339.601(1); MCL 339.601.2401; MCL 339.601.2403(3)<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>n/a |

## Family and Support Training

**Service:** Family Support and Training
**Scope/Description:**

Family Support and Training is an EPSDT service for persons under age 21. So the grid details apply to persons age 21 and older. For persons 21 and older, the intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.
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:

- performing activities of daily living;
- perceiving, controlling, or communicating with the environment in which he lives; or
- improving his inclusion and participation in the community or productive activity, or opportunities for independent living.

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.
Coverage includes:
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.
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.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Not included are individuals who are employed to provide waiver services for the participant.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | | Description of allowable providers: |
|---|---|---|---|---|---|---|
| **Per**<br>**☐ Day**<br>**☐Week**<br>**☐ Month**<br>**☐Year**<br><br>**☐Other, Describe:** | **Day(s)**<br><br>**Week(s)**<br><br>**Month(s)**<br><br>**Other:**<br><br>See note No.2 Page 1. | **☒ Individual (list types):**<br><br>Clinical professional (psychologist, social worker, family therapist, licensed professional counselor, occupational therapist, physical therapist, speech therapist, nurse), Board Certified Behavioral Analyst (BCBA).<br><br>Trained parent support partner | **☐ Legally Responsible Person**<br><br>**☐Relative/Legal Guardian** | **Provider Type:**<br><br>Clinical professional (psychologist, social worker, family therapist, licensed professional counselor, occupational therapist, physical therapist, speech therapist, nurse, BCBA)<br><br>**License Required:**<br>**☒ Yes ☐ No**<br><br>The provider must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:** | **Provider Type:**<br><br>Trained parent support partner<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):** | **Provider Type:**<br><br>Home care agencies, clinic service agency providers, outpatient clinics<br><br>**License Required:**<br>**☒ Yes ☐ No**<br><br>The provider must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.<br><br>**Certificate Required:**<br>**☒ Yes ☐ No**<br>**Describe:**<br><br>The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978. |

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | | Description of allowable providers: |
|---|---|---|---|---|---|---|
| | | ☒ **Agency (list types of agencies):**<br><br>Home care agencies, clinic service agency providers, outpatient clinics | | **Other Qualifications Required for this Provider Type (please describe):**<br><br>Training must be provided by a professional within the scope of their practice and in good standing with any applicable state and national licensing, certifications, or registrations. | The Trained parent support partner must complete the MDHHS-approved statewide training curriculum and be provided regular supervision and team consultation by the treating professionals. Completion of the training curriculum is documented by a Certificate of Completion which must be maintained in the parent support partner's personnel file. | **Other Qualifications Required for this Provider Type (please describe):**<br><br>Training being provided must fall within the scope of practice of the agency personnel providing the service. |

## Fiscal Intermediary

**Service:** Fiscal Intermediary
The intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

**Scope/Description:**

Fiscal Intermediary Services is 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.

A fiscal intermediary is an independent legal entity – organization or individual – that acts as the fiscal agent of the PIHP for the purpose of assuring fiduciary accountability for the funds authorized to purchase specific services identified in the consumer's individual plan of service (IPOS). The fiscal intermediary acts as an employer agent when the consumer's representative directly employs staff or other service providers.

The fiscal intermediary can be an agency or organization (e.g., financial management services agency, accounting firm, local ARC or other advocacy organization) or individual (e.g., accountant, financial advisor/manager, and attorney). The fiscal intermediary must meet requirements as identified in the MDHHS Managed Mental Health Supports and Services Contract with the PIHP.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

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. Providers of other covered services to the beneficiary, family members, or the beneficiaries' guardians cannot provide fiscal intermediary services to the beneficiary.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: |
|---|---|---|---|---|---|
| _____ Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>☐ Other, Describe: | _____Day(s)<br>_____Week(s)<br>_____Month(s)<br><br>Other:<br><br>See note No.2 Page 1. | ☒ Individual (list types):<br><br>Examples include: accountant, financial advisor/manager, and attorney<br><br>☒ Agency (list types of agencies):<br><br>Examples include: financial management services agency, accounting firm, local ARC, other advocacy organization, other non-profit agencies | ☐ Legally Responsible Person<br><br>☐ Relative/Legal Guardian | Provider Type: Individual<br><br>License Required:<br>☐ Yes ☐ No<br><br>Certificate Required:<br>☐ Yes ☐ No<br>Describe:<br><br>Other Qualifications Required for this Provider Type (please describe):<br><br>The license and certificate requirements depend upon the type of provider. | Provider Type: Agency<br><br>License Required:<br>☐ Yes ☐ No<br><br>Certificate Required:<br>☐ Yes ☐ No<br>Describe:<br><br>Other Qualifications Required for this Provider Type (please describe):<br><br>The license and certificate requirements depend upon the type of agency. |

## Goods and Services

**Service:** Goods and Services

**Scope/Description:**

The purpose of the Goods and Services is to promote individual control over and flexible use of the individual budget by the participant using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must (1) increase independence, facilitate productivity, or promote community inclusion and (2) substitute for human assistance (such as personal care, community living supports, and other one-to-one behavioral health supports) to the extent that individual budget expenditures would otherwise be made for the human assistance.

A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS.

Purchase of a warranty may be included when it is available for the item and is financially reasonable.

**The following limitation(s) applies to the scope of the service:**

This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle. Goods and Services are available only to individuals participating in arrangements of self-determination whose individual budget is lodged with a fiscal intermediary.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| **Per**<br>**☐ Day**<br>**☐Week**<br>**☐ Month**<br>**☐Year**<br><br>**☐Other, Describe:** | **_____Day(s)**<br>**_____Week(s)**<br>**_____Month(s)**<br><br>**Other:**<br><br>See note No.2 Page 1. | **☐ Individual (list types):**<br><br>**☒ Agency (list types of agencies):**<br><br>Goods and services provider | **☐ Legally Responsible Person**<br><br>**☐Relative/Legal Guardian** | **Provider Type:** Goods and services provider<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>Provider must be reputable and able to provide the good or service necessary. |

## Non-Family Training

**Service:** Non-Family Training
**Scope/Description:**

This service provides coaching, training, supervision and monitoring of Community Living Supports (CLS) and respite staff by clinicians working within the scope of their practice. Professional staff work with CLS and respite staff to implement the consumer's IPOS, with focus on all behavioral health services designed to assist the consumer in acquiring, retaining and improving self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. The activities of the professional staff ensure the appropriateness of services delivered by CLS and respite staff and continuity of care. The service provider is selected on the basis of his/her competency in the aspect of the IPOS on which training is conducted.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: |
|---|---|---|---|---|---|
| **4 sessions**<br>**Per**<br>**☒ Day**<br>**☐ Week**<br>**☐ Month**<br>**☐ Year**<br><br>**☒ Other, Describe:**<br>12 sessions per 90 days;<br><br>Reportable encounter must be at least 45 minutes<br>. | **____Day(s)**<br>**____Week(s)**<br><br>**Month(s)**<br><br>**____Other:**<br><br>See note No.2 Page 1. | **☒ Individual (list types):**<br><br>Clinicians: licensed psychologist, Master's level social worker, nurse, occupational therapist, physical therapist, speech therapist, Child Mental Health Professional, Qualified Mental Health Professional, Qualified Intellectual Disability Professional, Board Certified Behavior Analyst (BCBA). | **☐ Legally Responsible Person**<br><br>**☐Relative/Legal Guardian:** | **Provider Type:** Individual Clinician<br><br>**License Required:**<br>**☒ Yes ☐ No**<br><br>As applicable to the clinician, and as detailed in the Michigan PIHP/CMHSP Provider Qualification Code Chart, must hold a current Michigan license<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>Child Mental Health Professional, Qualified Mental Health Professional, Qualified Intellectual Disability Professional: must meet criteria specified in the Michigan PIHP/CMHSP Provider Qualification Code Chart<br><br>All clinicians must provide non-family training within the scope of their professional practice | **Provider Type:** Agency<br><br>**License Required:**<br>**☐ Yes ☐ No**<br><br>**Certificate Required:**<br>**☐ Yes ☐ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>Agency qualifications are dependent on the type of agency and are not specific to this service.<br><br>The individual hands-on clinical provider must meet professional credentialing requirements as specified in this section and must provide services within the scope of their professional practice. |

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: |
|---|---|---|---|---|---|
| | | ☒ **Agency (list types of agencies):**<br><br>Staffing agency, home care agency, clinical service agency, out-patient clinic, other PIHP network provider agency | | | |

## Out-of-Home Non-Vocational Habilitation

**Service:** Out-of-Home Non-Vocational Habilitation
**Scope/Description:**

Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the participant resides. Examples of incidental support include:

- Aides helping the participant with his mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community.
- When necessary, helping the participant to engage in the habilitation activities (e.g., interpreting).

**The following limitation(s) applies to the scope of the service:**

Payments for Out-of-Home Non-Vocational Habilitation may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: | Description of allowable providers: |
|---|---|---|---|---|---|---|
| **4 or more hours Per**<br>**☒ Day**<br>**☐Week**<br>**☐ Month**<br>**☐Year**<br><br>**☒Other, Describe:**<br><br>Service must be provided on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the participant's plan of service. | **Day(s)**<br><br>**Week(s)**<br><br>**Month(s)**<br><br>**Other:**<br><br>See note No.2 Page 1. | **☒ Individual (list types):**<br><br>Aide<br><br>**☒ Agency (list types of agencies):**<br><br>Staffing agency, home care agency or other subcontractor<br><br>Community-based non-residential settings operated by CMHSP or other subcontractor | **☐ Legally Responsible Person**<br><br>**Relative**<br><br>Payments for Out-of-Home Non-Vocational Habilitation may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. | **Provider Type:**<br><br>Aide<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>Aides must meet criteria specified in the Michigan PIHP/CMHSP Provider Qualification Code Chart. | **Provider Type:**<br><br>Staffing agency, home care agency or other subcontractor<br><br>**License Required:**<br>**☐ Yes ☐ No**<br><br>**Certificate Required:**<br>**☐ Yes ☐No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area. | **Provider Type:**<br><br>Community-based non-residential settings operated by CMHSP or other subcontractor<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area. |

## Personal Emergency Response System (PERS)

**Service:** Personal Emergency Response System (PERS)
**Scope/Description:**

PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service includes a one-time installation and up to twelve monthly monitoring services per year.

**The following limitation(s) applies to the scope of the service:**

PERS services are limited to those participants who live alone (or living with a roommate who does not provide supports), or who are alone for significant parts of the day, and have no regular caregiver support/service provider for extended periods of time, and who would otherwise require extensive routine supervision and guidance.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| **Per**<br>**☐ Day**<br>**☐ Week**<br>**☐ Month**<br>**☐ Year**<br><br>**☐Other, Describe:** | **_____Day(s)**<br>**_____Week(s)**<br>**_____Month(s)**<br><br>**Other:**<br><br>See note No.2 Page 1. | **☐ Individual (list types):**<br><br>**☒ Agency (list types of agencies):**<br><br>PERS provider | **☐ Legally Responsible Person**<br><br>**☐Relative/Legal Guardian** | **Provider Type:**<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>a. The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.<br>b. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency.<br>c. The response center must maintain the monitoring capacity to respond to all incoming emergency signals.<br>d. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis. |

## Prevocational Services

**Service:** Prevocational Services
**Scope/Description:**

Prevocational services involve the provision of learning and work experiences where a participant can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome, as determined by the participant and his/her care planning team in the ongoing person-centered planning process. Services are expected to specifically involve strategies that enhance a participant's employability in integrated, community settings. Competitive employment or supported employment are considered successful outcomes of prevocational services. However, participation in prevocational services is not a required pre-requisite for competitive employment or receiving supported employment services.

Prevocational services should enable each participant to attain the highest possible wage and work which is in the most integrated setting and matched to the participant's interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to 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.

Support of employment outcomes is a part of the person-centered planning process, and emphasizes informed consumer choice. This process specifies the participant's personal outcomes toward a goal of productivity, identifies the services and items, including prevocational services and other employment-related services that advance achievement of the participant's outcomes, and addresses the alternatives that are effective in supporting his or her outcomes. From the alternatives, the participant selects the most cost-effective approach that will help him or her achieve the outcome.

Participants who receive prevocational services during some days or parts of days may also receive other waiver services, such as supported employment, out-of-home non-vocational habilitation, or community living supports at other times. Participants who are still attending school may receive prevocational training and other work related transition services through the school system and may also participate in prevocational services designed to complement and reinforce the skills being learned in the school program during portions of their day that are not the educational system's responsibility, e.g., after school or on weekends and school vacations. Prevocational services may be provided in a variety of community locations.

Participants participating in prevocational service may be compensated in accordance with applicable Federal laws and regulations, but the provision of prevocational services is intended to lead to a permanent integrated employment situation.

**The following limitation(s) applies to the scope of the service:**

Prevocational services furnished under the waiver are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17).
Prevocational services may be provided to supplement, but may not duplicate, services provided under supported employment or out-of-home non-vocational habilitation services. Coordination with the participant's school is necessary to assure that prevocational services provided in the waiver do not duplicate or supplant transition services that are the responsibility of the educational program.
Transportation provided between the beneficiary's place of residence and the site of the prevocational services, or between habilitation sites, is included as part of the prevocational and/or habilitation services.
Assistance with personal care or other activities of daily living that are provided to a participant during the receipt of prevocational services may be included as part of prevocational services, or may be provided as a separate State Plan Home Help service or community living supports service under the waiver, but the same activity cannot be reported as being provided to more than one service.
Only activities that contribute to the participant's work experience, work skills, or work-related knowledge can be included in prevocational services.
Payments for Prevocational Services may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: |
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| **Per**<br>**☐ Day**<br>**☐Week**<br>**☐ Month**<br>**☐Year**<br><br>**☐Other, Describe:**<br><br>. | **_____Day(s)**<br>**_____Week(s)**<br>**_____Month(s)**<br><br>**Other:**<br>See note No.2 Page 1. | **☒ Individual (list types):**<br><br>Prevocational support staff<br><br>**☒ Agency (list types of agencies):**<br><br>Community-based prevocational program operated by CMHSP or other subcontractor | **☐ Legally Responsible Person**<br><br>**Relative**<br><br>Payments for Prevocational Services may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. | **Provider Type:**<br><br>Prevocational support staff<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>The support staff must, at a minimum, meet provider qualifications for an aide as specified in the PIHP/CMHSP Provider Qualification Code Chart. Additionally, the support staff must be knowledgeable about the unique abilities, preferences, and needs of the individual(s) served and be able to provide services directed toward the outcome of achieving competitive employment. | **Provider Type:**<br><br>Community -based prevocational program operated by CMHSP or other subcontractor<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area. |

## Skill Building Assistance

**Service:** Skill Building Assistance
**Scope/Description:**

Skill-building assistance consists of activities identified in the individual plan of services and designed by a professional within his/her scope of practice that assist a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the beneficiary's residence or in community settings.

Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for sheltered work services provided by Michigan Rehabilitation Services (MRS).

Information must be updated when the beneficiary's MRS eligibility conditions change.
Coverage includes:

- Out-of-home adaptive skills training: Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and supports services incidental to the provision of that assistance, including:
- Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where adaptive skills training is provided in the community.
- When necessary, helping the person to engage in the adaptive skills training activities (e.g., interpreting).

Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services and should be coordinated with any physical, occupational, or speech therapies listed in the plan of supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

- Work preparatory services are aimed at preparing a beneficiary for paid or unpaid employment, but are not job task-oriented. They include teaching such concepts as attendance, task completion, problem solving, and safety. Work preparatory services are provided to people not able to join the general workforce, or are unable to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Activities included in these services are directed primarily at reaching habilitative goals (e.g., improving attention span and motor skills), not at teaching specific job skills. These services must be reflected in the beneficiary's person-centered plan and directed to habilitative or rehabilitative objectives rather than employment objectives.

- Transportation from the beneficiary's place of residence to the skill building assistance training, between skills training sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

Services that would otherwise be available to the beneficiary.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: |
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| **Per**<br>**☐ Day**<br>**☐Week**<br>**☐ Month**<br>**☐Year**<br><br>**☐Other, Describe:**<br><br>. | **_____Day(s)**<br>**_____Week(s)**<br>**_____Month(s)**<br><br>**Other:**<br>See note No.2 Page 1. | **☒ Individual (list types):**<br><br>Skill Building support staff<br><br>**☒ Agency (list types of agencies):**<br><br>Community-based Skill Building Services/ program operated by CMHSP or other subcontractor | **☐ Legally Responsible Person**<br><br>**Relative**<br><br>Payments for Skill Building Services may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. | **Provider Type:**<br><br>Skill Building support staff<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>The support staff must, at a minimum, meet provider qualifications for an aide as specified in the PIHP/CMHSP Provider Qualification Code Chart. Additionally, the support staff must be knowledgeable about the unique abilities, preferences, and needs of the individual(s) served and be able to provide services directed toward the outcome of achieving competitive employment. | **Provider Type:**<br><br>Community –Skill Building Services/programs operated by CMHSP or other subcontractor<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area. |

## Specialty Services / Therapies

**Service:** Specialty Services/Therapies

**Scope/Description:**

Specialty Services are: Music Therapy, Recreation Therapy, Art Therapy and Massage Therapy and may include the following activities: Child and family training; coaching and supervision of staff; monitoring of progress related to goals and objectives; and recommending changes in the plan. These therapies may be used in addition to the traditional professional therapy model included in Medicaid. Services must be directly related to an identified goal in the individual plan of service and approved by the physician. Service providers must meet the applicable licensure/certification requirements.

**The following limitation(s) applies to the scope of the service:**

Massage therapy is not available to people under age 21 who meet the clinical needs based criteria for psychiatric hospital level of care. Music Therapy, Recreational Therapy and Art Therapy are only available to children under 18.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: |
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| **4 sessions Per**<br>☐ **Day**<br>☐ **Week**<br>☒ **Month**<br>☐ **Year**<br><br>☒ **Other, Describe:** | **Day(s)**<br><br>**Week(s)**<br><br>**Month(s)**<br><br>**____Other:**<br><br>See note No.2 Page 1. | ☒ **Individual (list types):**<br><br>Massage Therapist, Therapeutic Recreation Specialist, Music Therapist, Art Therapist<br><br>☒ **Agency (list types of agencies):**<br><br>Home care agency, clinical service agency, out-patient clinic, other PIHP network provider agency | ☐ **Legally Responsible Person**<br><br>☐ **Relative/Legal Guardian:** | **Provider Type:** Individual Therapist<br><br>**License Required:**<br>☒ **Yes** ☐ **No**<br><br>Massage Therapists must hold a current Michigan license, issued pursuant to the Public Health Code as amended by Public Act 471 of 2008.<br><br>**Certificate Required:**<br>☒ **Yes** ☐ **No**<br>**Describe:**<br><br>Therapeutic Recreation Specialist must be certified by the National Council for Therapeutic Recreation (NCTRC); Music Therapist must be Board Certified (MT-BC) National Music Therapy Registry (NMTR); Art Therapist must be a Registered Art Therapist (ATR); Massage Therapist must be Nationally Certified in Therapeutic Massage and Bodywork (NCBTMB). | **Provider Type:** Agency<br><br>**License Required:**<br>☐ **Yes** ☐ **No**<br><br>**Certificate Required:**<br>☐ **Yes** ☐ **No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>Agency qualifications are dependent on the type of agency and are not specific to this service. |

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: |
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| | | | | **Other Qualifications Required for this Provider Type (please describe):** | The hands-on Massage Therapist, Therapeutic Recreation Specialist, Music Therapist, Art Therapist must meet licensure or certification requirements as specified in this section and must provide services within the scope of their professional practice. |

## Supports and Service Coordination

**Service:** Supports and Service Coordination

**Scope/Description:**

Supports and Service Coordination is an EPSDT service for persons under age 21. So the grid details apply to persons age 21 and older. For persons 21 and older, the intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

Functions performed by a supports coordinator, supports coordinator assistant, services and supports broker, or otherwise designated representative of the PIHP that include assessing the need for support and service coordination, and assurance of the following:

- Planning and/or facilitating planning using person-centered principles
- Developing an individual plan of service using the person-centered planning process
- Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports.
- Brokering of providers of services/supports
- Assistance with access to entitlements and/or legal representation
- Coordination with the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers

The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, in lieu of a supports coordinator or case manager. A beneficiary would have only one of the three possible options: targeted case manager, supports coordinator, or supports coordinator assistant. When a supports coordinator assistant is used, a qualified supports coordinator or targeted case manager must supervise the assistant. The role and qualifications of the targeted case manager are described in the Targeted Case Management section of this chapter.

A services and supports broker is used to explore the availability of community services and supports, housing, and employment and then to make the necessary arrangement to link the beneficiary with those supports. The role of the supports coordinator or supports coordinator assistant when a services and supports broker is used is to perform the remainder of the functions listed above as they are needed, and to assure that brokering of providers of services and supports is performed.

Whenever services and supports brokers provide any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or case manager, or their assistant, employed by the PIHP or its provider network who assures that the other functions above are in place.

If a beneficiary has both a supports coordinator or supports coordinator assistant AND a services and supports broker, the individual plan of service must clearly identify the staff who is responsible for each function. The PIHP must assure that it is not paying for the

supports coordinator (or supports coordinator assistant) and the services and supports broker to perform service brokering. Likewise, when a supports coordinator (or supports coordinator assistant) facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any services and supports broker who also attends. During its annual on-site visits, the MDHHS will review individual plans of service to verify that there is no duplication of service provision when both a supports coordinator assistant and a services and supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Supports coordinators will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports Coordination is reported only when there is face-to-face contact with the beneficiary. Related activities, such as telephone calls to schedule appointments or arrange supports, are functions that are performed by a supports coordinator but not reported separately. Supports coordination functions must assure:

- The desires and needs of the beneficiary are determined
- The supports and services desired and needed by the beneficiary are identified and implemented
- Housing and employment issues are addressed
- Social networks are developed
- Appointments and meetings are scheduled
- Person-centered planning is provided, and independent facilitation of person-centered planning is made available
- Natural and community supports are used
- The quality of the supports and services, as well as the health and safety of the beneficiary, are monitored
- Income/benefits are maximized
- Activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverage and/or short-term provision of supports, it shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Supports coordinators are prohibited from exercising the agency's authority to authorize or deny the provision of services. Supports coordination may not duplicate services that are the responsibility of another program.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The beneficiary's record must contain sufficient information to document the provision of supports coordination, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of supports coordination contacts must take into consideration the health and safety needs of the individual.

**The following limitation(s) applies to the scope of the service:**
The participant cannot receive supports broker services provided by parents (of a minor-aged child) or spouse or legal guardian (of an adult participant). Independent supports broker services may be provided by other relatives of the participant that are not excluded in the preceding sentence.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: | Description of allowable providers: | Description of allowable providers: |
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| **Per**<br>**☐ Day**<br>**☐ Week**<br>**☐ Month**<br>**☐ Year**<br><br>**☐Other, Describe:** | **_____Day(s)**<br>**_____Week(s)**<br><br>**Month(s)**<br><br>**Other:**<br>See note No.2 Page 1. | **☒ Individual (list types):**<br><br>Services and Supports Broker<br><br>Supports Coordinator Assistant<br><br>Supports Coordinator<br><br>**☒ Agency (list types of agencies):**<br><br>Supports Coordination Agency | **☐ Legally Responsible Person**<br><br>**Relative**<br><br>The participant cannot receive supports broker services provided by parents (of a minor-aged child) or spouse or legal guardian (of an adult participant). Independent supports | **Provider Type:**<br><br>Service and Supports Broker<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:** | **Provider Type:**<br><br>Supports Coordinator Assistant<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:** | **Provider Type:**<br><br>Supports Coordinator<br><br>**License Required:**<br>**☒ Yes ☐ No**<br><br>The supports coordinator must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan.<br><br>**Certificate Required:** | **Provider Type:**<br><br>Supports Coordination Agency<br><br>**License Required:**<br>**☐ Yes ☒ No**<br><br>**Certificate Required:**<br>**☐ Yes ☒ No** |

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| | | | broker services may be provided by other relatives of the participant that are not excluded in the preceding sentence. | **Other Qualifications Required for this Provider Type (please describe):**<br><br>1. Chosen by the participant.<br>2. Minimum of a high school diploma and demonstrated skills and knowledge to perform the functions.<br>3. Functions under the supervision of a supports coordinator. | **Other Qualifications Required for this Provider Type (please describe):**<br><br>1. Chosen by the participant.<br>2. Minimum of a high school diploma and one year of experience working directly with people who have developmental disabilities.<br>3. Functions under the supervision of a supports coordinator. | ☐ **Yes** ☒ **No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>1. Chosen by the participant.<br><br>The independent supports coordinator must be a QIDP or QMHP: specified bachelor's degree and one year of experience with the population the supports coordinator will be serving. If the supports coordinator has only the degree without one year of experience, they must be supervised by a QMHP or QIDP for one year. Services must be | **Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>The agency must meet provider requirements for the PIHP. The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served.<br><br>In addition, the agency must maintain a pool of qualified supports coordinators from which the participant can choose. The supports |

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| | | | | | | provided by a CMHP to any child beneficiary with serious emotional disturbance. Services to children ages 7-17 with SED must be provided by a CMHP trained in CAFAS. Services rendered to children ages 4-6 with SED must be provided by a CMHP trained in PECAFAS.<br><br>Assistants or brokers: high school diploma and one year experience, and supervised by a qualified supports coordinator or case manager.<br>2. | coordinator employed by an agency must be a QIDP as defined in the Michigan PIHP/CMHSP Provider Qualification Code Chart and maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan. |

## Respite

**Service:** Respite

**Scope/Description:**

The intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

Respite care services are provided to a waiver eligible participant on a short-term, intermittent basis to relieve the participant's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. "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 periods in between. "Primary" caregivers are typically the same people day after day who provide at least some unpaid supports. "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 participant 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). Since adult participants 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.

**The following limitation(s) applies to the scope of the service:**

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 full-time. In those cases, community living supports, or other services of paid support or training staff, should be used. The participant's record must clearly differentiate respite hours from community living support services. Decisions about the methods and amounts of respite are decided during the person-centered planning process and are specified in the individual plan of service.

Respite care may not be provided by a parent of a minor participant, the spouse of the participant, the participant's legal guardian, or the primary unpaid caregiver. Respite services may be provided in the following settings that are approved by the participant and identified in the individual plan of services:

- Participant's home
- Home of a friend or relative (not the parent of a minor or the spouse of the participant or the legal guardian)
- Licensed foster care home or respite care facility

- Licensed camp
- In community settings accompanied by a respite worker
- Facility approved by the State that is not a private residence, such as group home or licensed respite care facility

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. Respite is not covered if the care is being provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDHHS approved day program site.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: | Description of allowable providers: | Description of allowable providers: | Description of allowable providers: |
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| ____ **Per**<br>☐ **Day**<br>☐ **Week**<br>☐ **Month**<br>☐ **Year**<br><br>☐ **Other, Describe:** | ____**Day(s)**<br><br>**Week(s)**<br><br>**Month(s)**<br><br>____**Other:**<br><br>See note No.2 Page 1. | ☒ **Individual (list types):**<br><br>Independent Nurse (RN or LPN)<br><br>Individual aide level respite provider<br><br>☒ **Agency (list types of agencies):**<br><br>Licensed Camp<br><br>Staffing agency, home care agency, other PIHP network provider agency<br><br>Licensed children's foster care, licensed | ☐ **Legally Responsible Person**<br><br>☐**Relative**<br><br>Respite care may not be provided by a parent of a minor participant, the spouse of the participant, the participant's legal guardian, or the primary unpaid caregiver. | **Provider Type:**<br><br>Independent Nurse (RN or LPN)<br><br>**License Required:**<br>☒ **Yes** ☐ **No**<br><br>This service must be provided by either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under the supervision of an RN. The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211<br><br>**Certificate Required:** | **Provider Type:**<br><br>Individual aide level respite provider<br><br>**License Required:**<br>☐ **Yes** ☒ **No**<br><br>**Certificate Required:**<br>☐ **Yes** ☒ **No**<br>**Describe:**<br><br>**Other Qualifications** | **Provider Type:**<br><br>Licensed Camp<br><br>**License Required:**<br>☒ **Yes** ☐ **No**<br><br>Children's Camps: MCL 722.111, MCL 330.1153, Act 116 of 1973, Act 218 of 1978 as amended, Administrative Rule 400.11101-.11413<br>Adult's Camps: MCL 400.703, Act 218 of 1979 as amended, Administrative Rule 400.11101-.11413<br><br>**Certificate Required:**<br>☐ **Yes** ☒ **No** | **Provider Type:**<br><br>Staffing agency, home care agency, other PIHP network provider agency<br><br>**License Required:**<br>☒ **Yes** ☐ **No**<br><br>Hands-on provider must meet RN.LPN or aide level eligibility requirement specified in this section.<br><br>**Certificate Required:**<br>☐ **Yes** ☒ **No** | **Provider Type:**<br><br>Licensed children's foster care, licensed adult foster care.<br><br>**License Required:**<br>☒ **Yes** ☐ **No**<br><br>Act 116 of 1973 as amended (children), Act 218 of 197 as amended (adults), Administrative Rules R400.4101-.9506 and R400.1401-.15411 and R400.1901-1906, MCL 722.115-118(a)<br><br>**Certificate Required:**<br>☒ **Yes** ☒ **No** |

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| | | adult foster care | | ☐ **Yes** ☐ **No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>Nurses may provide respite only in situations where the participant's medical needs are such that a trained respite aide cannot care for the participant during times where the unpaid caregiver is requesting respite. | **Required for this Provider Type (please describe):**<br><br>Aides must meet criteria specified in the Michigan PIHP/CMHSP Provider Qualification Code Chart: | **Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>The camp must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) | **Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>The agency must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s) being served. For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area. | **Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>n/a |

## Private Duty Nursing (PDN)

**Service**: Private Duty Nursing (PDN)

**Scope/Description:**

PDN services are skilled nursing interventions provided to individuals age 21 and older, up to a maximum of 16 hours per day, to meet health needs that are directly related to the individual's developmental disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's individual plan of services (IPOS). PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health. The individual receiving PDN must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver.

- Community living supports
- Out-of-home non-vocational habilitation
- Prevocational or supported employment

To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I or Medical Criteria II **AND** Medical Criteria III as defined by the MDHHS. (Note: Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III.)

The amount of PDN hours authorized represents a monthly total determined by calculating an average amount of PDN per day multiplied by the number of days in the month. The beneficiary has the flexibility to use the hours as needed during the month, not to exceed the total monthly authorized amount.

The amount of PDN (i.e., the number of hours that can be authorized for a beneficiary) is determined through the person-centered planning process to address the individual's unique needs and circumstances. Factors to be considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances (e.g., the availability of natural supports); and other resources for daily care (e.g., private health insurance, trusts, bequests). Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day.

The nurse may provide personal care only when incidental to the delivery of PDN, e.g. diaper changes, but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a state plan service. If the beneficiary

receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to assure no duplication of services.

Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.

These services should be provided to a beneficiary at home or in the community. A physician's prescription is required.

The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champus, Worker's Compensation, an indemnity policy, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

If a beneficiary is attending school and the Individualized Educational Plan (IEP) identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant services provided in school or other settings or to be provided during the times when the beneficiary would typically be in school but for the parent's choice to home-school.

An exception process to ensure the beneficiary's health, safety and welfare is available if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the beneficiary's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.

Exceptions must be based on the increased identified medical needs of the beneficiary or the impact on the beneficiary's needs due to the unavailability of the primary unpaid caregiver. Consideration for an exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

- A temporary alteration in the beneficiary's care needs, resulting in one or both of the following:

- A temporary increase in the intensity of required assessments, judgments, and interventions.
- A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.

- The temporary inability of the primary unpaid caregiver(s) to provide the required care, as the result of one of the following:
  - In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.
  - The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP.
  - The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.

"Inability" is defined as the caregiver is either unable to provide care, or is prevented from providing care.

"Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.

"Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or Community Living Supports staff.

This exception is not available if the beneficiary resides in a licensed setting or in a home where all care is provided by paid caregivers.

In the event that a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and assuring a smooth transition. In those cases, the transition plan, including amount,

scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide.

**The following limitation(s) applies to the scope of the service:**

Payments for PDN may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: |
|---|---|---|---|---|---|
| **16 hours**<br>**Per**<br>**☒ Day**<br>**☐ Week**<br>**☐ Month**<br>**☐ Year**<br><br>**☐ Other, Describe:**<br><br>. | **____Day(s)**<br>**____Week(s)**<br>**____Month(s)**<br><br>**____Other:**<br><br>See note No.2 Page 1. | **☒ Individual (list types):**<br><br>Private Duty Nurse (RN or LPN)<br><br>**☒ Agency (list types of agencies):**<br><br>Private duty nursing agency, home care agency | **☐ Legally Responsible Person**<br><br>**☐ Relative**<br><br>Payments for PDN may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. | **Provider Type:**<br><br>Private Duty Nurse (RN or LPN)<br><br>**License Required:**<br>**☒ Yes ☐ No**<br><br>The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>A Licensed Practical Nurse (LPN) must be working under the supervision of an RN. | **Provider Type:**<br><br>Home care agency, staffing agency, private duty nursing agency, or other PIHP network provider agency<br><br>**License Required:**<br>**☐ Yes ☐ No**<br><br>**Certificate Required:**<br>**☐ Yes ☐ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>The agency should assure that personnel providing this service are knowledgeable in the unique abilities, preferences and needs of the individual(s) receiving the service. |

## Supported / Integrated Employment Services

**Service**: Supported/Integrated Employment Services

**Scope/Description:**

Supported/Integrated Employment Services is an EPSDT service for persons under age 21. So the grid details apply to persons age 21 and older. For persons 21 and older, the intent of this service is to fund medically necessary supports that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

Provide job development, initial and ongoing support services, and activities as identified in the individual plan of services that assist beneficiaries to obtain and maintain paid employment that would otherwise be unachievable without such supports. Support services are provided continuously, intermittently, or on a diminishing basis as needed throughout the period of employment. Capacity to intervene to provide assistance to the individual and/or employer in episodic occurrences of need is included in this service.

Supported/ integrated employment must be provided in community-based, integrated work settings where the beneficiary works alongside people who do not have disabilities.

**The following limitation(s) applies to the scope of the service:**

Coverage includes:

- Job development, job placement, job coaching, and long-term follow-along services required to maintain employment.
- Consumer-run businesses (e.g., vocational components of Fairweather Lodges, supported self-employment)
- Transportation provided from the beneficiary's place of residence to the site of the supported employment service, among the supported employment sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Employment preparation.
- Services otherwise available to the beneficiary under the Individuals with Disabilities Education Act (IDEA).

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| _____ **Per**<br>☐ **Day**<br>☐**Week**<br>☐ **Month**<br>☐**Year**<br><br>☐ **Other, Describe:**<br><br>. | _____**Day(s)**<br>_____**Week(s)**<br>_____**Month(s)**<br><br>_____**Other:**<br><br>See note No.2 Page 1. | ☒ **Individual (list types):**<br>Employment specialist, Personal assistant, Individual job coach<br><br>☐ **Agency (list types of agencies):** | ☐ **Legally Responsible Person**<br><br>☐**Relative** | **Provider Type:**<br><br>Employment specialist, Personal assistant, Individual job coach<br><br>**License Required:**<br>☐ **Yes** ☒ **No**<br><br>**Certificate Required:**<br>☐ **Yes** ☒ **No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>Qualifications of providers depend upon the service |

## Child Therapeutic Foster Care

**Service:** Child Therapeutic Foster Care
**Scope/Description:**

This service is only available to people under age 21 who meet the clinical needs based criteria for psychiatric hospital level of care.

Child Therapeutic Foster Care (CTFC) is an evidence-based practice. It provides an intensive therapeutic living environment for a child with challenging behaviors. Important components of CTFC include:

- intensive parental supervision,
- positive adult-youth relationships,
- reduced contact with children with challenging behaviors, and
- family behavior treatment skills.

CTFC seeks to change the negative trajectory of a child's behavior by improving his social adjustment, family adjustment and peer group. CTFC attempts to decrease negative behavior, increase appropriate behavior, and build pro-social skills. Foster parents, teachers, therapists and other adults act as change agents for the child. The change agents contribute to the treatment of the child and the preparation of his family for the child's return to the home and community. Foster parents are specially recruited, trained and supervised. The total number of individuals (including beneficiaries served in the waiver) living in the home who are unrelated to the primary caregiver may not exceed one.

CTFC must be billed as a 'per diem' service. The per diem rate for Therapeutic Foster Care rate is comprised of 3 components, 2 of which earn FFP; one of which does not.

1. The daily rate covers $75.00 per day for the enhanced therapeutic rate to be paid to foster parents. This rate includes respite care (purchased by the foster parent), participation in wraparound team meetings, training and other treatment-oriented appointments for the youth and family, data collection required as part of implementing the POS (including a daily/weekly log and 24 hour supervision).
2. A portion of the daily rate is to be paid to the provider agency. This part of the daily rate includes recruitment, pre-service training and licensing of the foster parents for this specialized service; on-going support, monitoring, training and oversight of the foster home; as well as closely supervised home visits throughout the youth's placement in the foster home.

3. Room and Board rate paid to Foster Parents is separate from the enhanced therapeutic foster care rate and paid from a different funding source (e.g., Title IV-E); Medicaid cannot be used to pay this component. The room and board rate includes basic needs, including clothing, shelter, food and daily essentials.

**The following limitation(s) applies to the scope of the service:**

In addition to being licensed:

- All CTFC programs under this waiver are to be pre-enrolled by MDHHS to ensure they meet the requirements set forth in this policy.
- Separate payment will not be made for homemaker or chore services, for community living services provided by the foster parents, or for respite care furnished for the foster care parents to a child receiving CTFC services since these services are integral to, and inherent in, the provision of CTFC.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| ____ Per<br>☐ Day<br>☐ Week<br>☐ Month<br>☐ Year<br><br>☐ Other, Describe: | ____Day(s)<br>____Week(s)<br>____Month(s)<br><br>____Other:<br><br>See note No.2 Page 1. | ☐ Individual (list types):<br><br>☒ Agency (list types of agencies):<br><br>A licensed family foster home contracted to the PIHP | ☐ Legally Responsible Person<br><br>☐Relative/Legal Guardian: | **Provider Type:**<br><br>A licensed family foster home contracted to the PIHP<br><br>**License Required:**<br>☒ Yes ☐ No<br><br>Child Therapeutic Foster Care (CTFC) providers are licensed by the Michigan Department of Licensing and Regulatory Affairs under MCL 722.122<br><br>**Certificate Required:**<br>☒ Yes ☐ No<br>**Describe:**<br><br>CTFC providers must be certified by MDHHS.<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>The child foster care home must be contracted by the PIHP to provide child therapeutic foster care services. |

## Therapeutic Overnight Camping

**Service:** Therapeutic Overnight Camping
**Scope/Description:**

This service is only available to people under age 21 who meet the clinical needs based criteria for psychiatric hospital level of care.

A group recreational and skill building service in a camp setting aimed at meeting the goal(s) detailed in the beneficiary's IPOS. A session can be multiple days and must include at least one night.

Additional criteria:

- Camps are licensed by Michigan Department of Licensing and Regulatory Affairs; and
- Camp staff is trained in working with children with SED.

Coverage includes:

- Camp fees, including enrollment and other fees;
- Transportation to and from the camp; and
- Additional costs for staff with specialized training with this population.

**The following limitation(s) applies to the scope of the service:**

Coverage excludes: Room and board for the camp.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: |
|---|---|---|---|---|
| **3 sessions**<br>**Per**<br>**☐ Day**<br>**☐Week**<br>**☐ Month**<br>**☒Year**<br><br>**☐ Other, Describe:**<br>A session can be multiple days but must include at least one night. | **____Day(s)**<br>**____Week(s)**<br>**____Month(s)**<br><br>**____Other:**<br><br>See note No.2 Page 1. | **☐ Individual (list types):**<br><br>**☒ Agency (list types of agencies):**<br>Camps | **☐ Legally Responsible Person**<br><br>**☐Relative/Legal Guardian:** | **Provider Type:**<br>Camps<br><br>**License Required:**<br>**☒ Yes ☐ No**<br><br>Camps are licensed by Michigan Department of Licensing and Regulatory Affairs<br><br>**Certificate Required:**<br>**☐ Yes ☒ No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):**<br><br>Camp staff is trained in working with children with SED. |

## Transitional Services

**Service:** Transitional Services
**Scope/Description:**
This service is only available to people under age 21 who meet the clinical needs based criteria for psychiatric hospital level of care.

Transitional services is a one-time-only expense to assist beneficiaries returning to their family home and community while the family is in the process of securing other benefits (e.g., SSI) or resources (e.g., governmental rental assistance and/or home ownership programs) that may be available to assume these obligations and provide needed assistance.

Additional criteria for using Transitional Services:

- The beneficiary must have in his/her IPOS a goal to return to his/her home and community; and
- Documentation of the family's control (i.e., signed lease, rental agreement, deed) of their living arrangement in the family-centered plan of service; and
- Documentation of efforts (e.g., the family is on a waiting list) under way to secure other benefits (such as SSI) or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these benefits become available, they will assume the obligation and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to the beneficiary's family home;
- Interim assistance with utilities, insurance, or living expenses when the beneficiary's family, already living in an independent setting, experiences a temporary reduction or termination of their own or other community resources; and
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the beneficiary would be unable to move there or, if already living there, would be forced to leave for health and safety reasons.

All services provided must be in accordance with applicable state or local building codes. Standards of value purchasing must be followed. The home maintenance must be the most reasonable alternative, based on the results of a review of all options. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved must be in compliance with any applicable local codes. The home maintenance involved shall exclude costs for improvements required exclusively to meet local building codes. The home maintenance must incorporate reasonable and necessary construction

standards, excluding cosmetic improvements. The home maintenance or repair cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

**The following limitation(s) applies to the scope of the service:**
Coverage excludes those home maintenance or repairs to the home that are:

- Of general utility or are cosmetic;
- Considered to be standard housing obligations of the beneficiary's family;
- Not of direct medical or remedial benefit to the child;
- On-going housing costs; and
- Costs for room and board that are not directly associated with transition arrangements while securing other benefits.

| Limitations on the amount of service | Limitations on the duration of the service | Provider Category(s): | The service may be provided by a: | Description of allowable providers: | Description of allowable providers: |
|---|---|---|---|---|---|
| ____ **Per**<br>☐ **Day**<br>☐ **Week**<br>☐ **Month**<br>☐ **Year**<br><br>☒ **Other, Describe:**<br>Once per consumer | ____**Day(s)**<br><br>**Week(s)**<br><br>**Month(s)**<br><br>**Other:**<br><br>See note No.2 Page 1. | ☒ **Individual (list types):**<br><br>As appropriate to the service, an individual contracted by the PIHP.<br><br>☒ **Agency (list types of agencies):**<br><br>As appropriate to the service, an agency contracted by the PIHP. | ☐ **Legally Responsible Person**<br><br>☐**Relative/Legal Guardian:** | **Provider Type:**<br>As appropriate to the service, an individual contracted by the PIHP.<br><br>**License Required:**<br>☒ **Yes** ☐ **No**<br><br>When appropriate to the service must be a licensed builder MCL 339.601 (1), MCL 339.601.2401, or MCL 339.601.2404 or a licensed utility company.<br><br>**Certificate Required:**<br>☐ **Yes** ☒ **No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):** | **Provider Type:**<br>As appropriate to the service, an agency contracted by the PIHP.<br><br>**License Required:**<br>☒ **Yes** ☐ **No**<br><br>When appropriate to the service must be a licensed builder MCL 339.601 (1), MCL 339.601.2401, or MCL 339.601.2404 or a licensed utility company.<br><br>**Certificate Required:**<br>☐ **Yes** ☒ **No**<br>**Describe:**<br><br>**Other Qualifications Required for this Provider Type (please describe):** |

# Appendix D

# Milliman Client Report

# SECTION 1115 MEDICAID DEMONSTRATION WAIVER APPLICATION – BUDGET NEUTRALITY FORM RESPONSE

## State of Michigan

## Department of Health and Human Services

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# I. BACKGROUND

Milliman, Inc. (Milliman) was retained by the State of Michigan, Department of Health and Human Services (MDHHS) to develop the response to the Budget Neutrality Form for the Section 1115 Medicaid Demonstration Waiver Application (1115 Waiver). The Centers for Medicare and Medicaid Services (CMS) requires all 1115 Waivers to demonstrate budget neutrality.
MDHHS is transitioning the following programs currently covered under the Specialty Services and Supports 1915 (b/c) waiver and other 1915(c) home and community-based waivers to the 1115 Waiver beginning on April 1, 2016.

- Aged, Blind, and Disabled (DAB) population
- TANF population
- 1915 (c) home and community-based services habilitation supports waiver, referred to as Waiver (c)
- 1915 (i) state plan home and community-based services Autism Benefit, which includes Medicaid and MIChild eligible members
- MIChild population
- 1915 (c) home and community-based services children's waiver program, referred to as Child Waiver
- 1915 (c) home and community-based services waiver for children with serious emotional disturbances, referred to as SED Waiver

The Healthy Michigan specialty services managed care program, currently covered under a separate 1115 Waiver, has also been included in this budget neutrality form for completeness.
This letter documents the narrative for the *"Interim Section 1115 Demonstration Application BN Table Shell.xlsx"* Excel Workbook, which provides supporting data demonstrating budget neutrality for the 1115 Waiver. It is our understanding that this letter will be incorporated into an overall response to CMS regarding the 1115 Waiver application.

# II. BUDGET NEUTRALITY NARRATIVE

Milliman was asked to develop the response to the Budget Neutrality section of Michigan's Pathway to Integration Section 1115 Waiver. This narrative and budget neutrality expenditure projections follow CMS guidance. It should be noted that this Section 1115 application does not include new populations and disproportionate share hospital expenditure offsets.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual Data

We have provided the actual historic data for the last five years (state fiscal year (SFY) 2011 to SFY 2015) pertaining to each of the Medicaid Populations included in the 1115 Demonstration.

DAB, TANF, and HSW populations

For the DAB, TANF, and Waiver (c) populations, we have summarized historical capitation payment data paid by MDHHS to the PIHPs from October 1, 2010 through September 30, 2015. The capitation payments are inclusive of all mental health, substance abuse, and developmental disabilities service cost, administrative cost, taxes (claims and use), and the hospital reimbursement adjustment (HRA). These expenditures are consistent with amounts reported on the CMS-64.

In SFY 2015, the TANF population capitation payment to eligibility month ratio was lower than recent historical experience. As a result, the number of capitation payments processed during the SFY 2015 was materially lower than in prior fiscal years. MDHHS is currently making retroactive TANF payments that increase the PMPM rate in a budget neutral manner to account for the capitation payment to eligibility month ratio decrease. The first and second quarter SFY 2015 TANF population capitation rate amendment methodology is documented in our correspondence to MDHHS on October 5, 2015 entitled *Capitation Certification – SFY 2015 Q1-Q2 TANF Amendment.* We are currently assuming that the payment issues in SFY 2015 will be resolved in SFY 2016.

Autism Benefit

MDHHS began its 1915(i) State plan HCBS benefit for applied behavior analysis (ABA) services on April 1, 2013. This program includes both Medicaid and MI Child autism spectrum disorder (ASD) beneficiaries. We utilized PIHP submitted expenditures from the financial status report (FSR) from SFY 2013 and SFY 2014. This program only includes expenditures for applied behavioral analysis (ABA) and other Autism related services. These expenditures were included in the CMS-64.

To estimate the number of individuals being provided ASD related services in SFY 2013, we utilized the SFY 2014 PMPM (adjusted for trend) due to non-credible encounter data. We have estimated SFY 2015 member months using emerging encounter data through March 31, 2015. We have estimated the SFY 2015 PMPM cost based on trended SFY 2014 PMPM cost (using the composite DAB and TANF population trend).

Healthy Michigan (HMP) population

For the HMP population, we have summarized historical capitation payment data paid by MDHHS to the PIHPs from April 1, 2014 (program inception) through September 30, 2015. The capitation payments are inclusive of all mental health and substance abuse service

cost, as well as administrative cost and taxes (claims and use). These expenditures are consistent with what has been reported on the CMS-64.

MIChild, SED Waiver, and Child Waiver populations

For the remaining populations included in the 1115 Demonstration (the MI Child, SED Waiver, and Child Waiver populations), we utilized PIHP submitted expenditures from the FSR from SFY 2011 to SFY 2014. These expenditures were included in the CMS-64. The expenditures for these populations include mental health services, substance abuse services, support services for beneficiaries with developmental disabilities, and administrative cost. We have not included taxes or costs that are funded only by MDHHS (without federal match). These costs are included in the 'Demonstration with Waiver' and 'Demonstration Without Waiver' sections for the Child and SED Waiver populations as program changes. MDHHS plans to modify the structure of these programs to pull down the federal match on all expenditures.

We have estimated SFY 2015 expenditures for the Child and SED Waiver programs by trending the SFY 2014 expenditures at the composite DAB and TANF population trend. We estimated SFY 2015 membership to be consistent with SFY 2014 figures.

Beginning on October 1, 2014, Milliman began certifying actuarially sound capitation rates that MDHHS paid to the PIHPs for the MI Child population. The capitation rates included all historical expenditures incurred for services delivered to the MI Child population, including expenditures incurred for costs over the fee schedule. The capitation rates also included both claims and use tax. For the MI Child population in SFY 2015, we have summarized revenue and capitation payments from actual experience through July 2015. We have assumed no growth in the number of capitation payments in August and September of 2015.

B. Bridge Period

The bridge period is October 1, 2015 to March 31, 2015 (6 months).

C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification

DAB, TANF, and HSW Populations

Beginning on October 1, 2015, MDHHS modified its capitation payment system process to make one-month retroactive payments for individuals who become Medicaid eligible during the month. As a result, MDHHS will make October capitation payments (in the month of November) for individuals who become eligible during the month of October. We have reflected this change in our demonstration year projections. This is a budget neutral change from a revenue standpoint, as the policy increases the estimated number of capitation payments, while reducing the PMPM capitation rate. This change impacted the DAB, TANF, and Healthy Michigan populations. As a result of this change, we utilized capitation payment and PMPM costs consistent with the SFY 2016 certification estimates instead of historical experience for the "Base Year DY 00" figures.

As mentioned in section A. above, the DAB, TANF, and Waiver (c) historical expenditures includes both claims and use taxes. Over the historical period, the level of claims and use taxes has varied.

- Use tax 5.98%: effective 10/1/2010 – 7/1/2012, 4/1/2014 – present.
- Claims tax 1%: effective 10/1/2012 – 7/1/2014.
- Claims tax 0.75%: effective 7/1/2014 – present.

As a result of the varying tax scenarios, we have developed trend rates using only the service cost used to develop the capitation rates. We have also provided different enrollment trend rates than what is reflected in the historical data for the TANF and Waiver (c) populations. We have reflected no growth in the Waiver (c) population because it has a cap on enrollment. We have also modified the PMPM cost for the DAB and TANF populations to reflect the cost estimate associated with the expansion of the EPSDT benefit for ASD individuals.

Autism Benefit

In the historic experience, the 1915(i) HCBS Waiver for ABA services covered beneficiaries from 18 months up to age 6. We have not relied on the member months, PMPM cost, or trends from the historic experience to use in the With- and Without-Waiver sections of the Budget Neutrality form for the following reasons:

- MDHHS is expanding this benefit to include children up to age 21 by filing a state plan amendment (SPA).
- The network is not fully developed.
- The settlement process between MDHHS and the PIHPs is expected to change from settling on cost to settling on utilization and a fixed fee schedule.
- Utilization per recipient is immature and is expected to vary by age group.

We have included the build-up of the average monthly cost for the Autism Benefit by age group and diagnosis, as well as the projection of member months for the five year demonstration period by age group and diagnosis as part of the 1115 Demonstration Application. The build-up of the average monthly cost by age group and diagnosis is consistent with the SPA filed with CMS. We have trended the PMPM cost over the five year demonstration at the composite DAB and TANF population trend.

SED Waiver, and Child Waiver populations

We utilized different trend assumptions than the historic experience would suggest for these populations because there are a relatively small number of beneficiaries driving the cost from year to year. For the PMPM cost trend, we utilized a weighted average of the DAB and TANF population PMPM cost trends. For the Child Waiver population, we utilized no membership trend because the program enrollment has a cap. For the SED Waiver population, we utilized a 1% membership trend based on internal expectations of the future enrollment in the population.

We have also included the following program adjustments:

- We have included costs from the FSR that did not have a corresponding federal match. MDHHS intends to restructure the payments made for these populations to pull down the federal match on what is currently covered using state only funds. This will affect the SED Waiver, and Child Waiver populations.
- We have included claims and use tax in the demonstration years.
- In 2016, the SED Waiver population will be statewide. Historically, it has been limited to 85% of the State. The list of counties currently included in the SED Waiver can be found on the tab "Estimated Future SED Kids".

MI Child population

We utilized different trend assumptions than the historic experience would suggest for these populations because there are a relatively small number of beneficiaries driving the cost from year to year. For the PMPM cost trend, we utilized a weighted average of the DAB and TANF population PMPM cost trends.

We have also included a program adjustment for the PIHP system will no longer serve mild to moderately disabled children in the MI Child population. These children will be served by the Medicaid health plans (MHP). MDHHS estimates 66 kids will move to the MHPs.

Healthy Michigan (HMP) population

As mentioned in section A. above, HMP historical expenditures includes both claims and use taxes. We have developed trend rates using only the service cost used to develop the capitation rates.

D. Risk

E. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

The With-Waiver PMPM cost and member month projections are consistent with the Without-Waiver projections with the following exception. The With-Waiver projections for the DAB and TANF populations include the addition of Complex Case Managers into the provider system. We are assuming that the Complex Case Managers will manage the top 50% of high cost DD individuals who have an inpatient stay and the top 3% of all SMI individuals. We have estimated that the Complex Case Managers will save the system $1.3 million per year. .

F. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

Please see section E above.

# III. LIMITATIONS

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved June 30, 2015.
The information contained in this report, including the appendices, has been prepared for the State of Michigan, Department of Health and Human Services and their consultants and advisors. It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this report is provided to third parties, the report should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for MDHHS by us that would result in the creation of any duty or liability under any theory of law by us or its employees to third parties.

Other parties receiving this report must rely upon their own experts in drawing conclusions about the MDHHSs capitation rates, assumptions, and trends. In performing this analysis, we relied on data and other information provided by MDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.
Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.
Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

# IV. BUDGET NEUTRALITY FORMS

**5 YEARS OF HISTORIC DATA**

**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**

| DAB | FY11 | FY12 | FY13 | FY14 | FY15 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES (MH + SA) | $ 1,548,051,935 | $ 1,543,737,822 | $ 1,550,779,963 | $ 1,572,585,937 | $ 1,677,779,613 | $ 7,892,935,270 |
| ELIGIBLE MEMBER MONTHS(Capitation Payments) | 5,611,026 | 5,738,870 | 5,836,436 | 5,856,485 | 5,953,093 | |
| PMPM COST | $ 275.89 | $ 269.00 | $ 265.71 | $ 268.52 | $ 281.83 | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | -0.28% | 0.46% | 1.41% | | 2.03% |
| ELIGIBLE MEMBER MONTHS | | 2.28% | 1.70% | 0.34% | | 1.49% |
| PMPM COST | | -2.50% | -1.22% | 1.06% | | 0.53% |

| TANF (including Healthy Kids) | FY11 | FY12 | FY13 | FY14 | FY15 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES (MH + SA) | $ 203,254,206 | $ 193,531,783 | $ 187,968,689 | $ 195,361,698 | $ 203,649,138 | $ 983,765,514 |
| ELIGIBLE MEMBER MONTHS(Capitation Payments) | 13,707,932 | 13,584,362 | 13,476,439 | 13,482,446 | 11,872,630 | |
| PMPM COST | $ 14.83 | $ 14.25 | $ 13.95 | $ 14.49 | $ 17.15 | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | -4.78% | -2.87% | 3.93% | | -0.99% |
| ELIGIBLE MEMBER MONTHS | | -0.90% | -0.79% | 0.04% | | -0.41% |
| PMPM COST | | -3.92% | -2.10% | 3.89% | | -0.57% |

| 1915(c) Habilitation Supports Waiv | FY11 | FY12 | FY13 | FY14 | FY15 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES (MH + SA) | $ 421,659,510 | $ 431,562,315 | $ 418,413,184 | $ 441,662,525 | $ 448,724,360 | $ 2,162,021,894 |
| ELIGIBLE MEMBER MONTHS(Capitation Payments) | 91,788 | 92,357 | 91,585 | 91,883 | 92,675 | |
| PMPM COST | $ 4,593.84 | $ 4,672.76 | $ 4,568.58 | $ 4,806.79 | $ 4,841.91 | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | 2.35% | -3.05% | 5.56% | | 1.17% |
| ELIGIBLE MEMBER MONTHS | | 0.62% | -0.84% | 0.33% | | 0.03% |
| PMPM COST | | 1.72% | -2.23% | 5.21% | | 1.14% |

| Autism | FY11 | FY12 | FY13 | FY14 | FY15 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES (MH + SA) | | | $ 2,185,439 | $ 15,318,187 | $ 25,719,628 | $ 43,223,254 |
| ELIGIBLE MEMBER MONTHS(Capitation Payments) | | | 883 | 6,067 | 9,991 | |
| PMPM COST | | | $ 2,476.52 | $ 2,524.84 | $ 2,574.10 | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | | | | | 1.00% |
| ELIGIBLE MEMBER MONTHS | | | | | | 1.00% |
| PMPM COST | | | | | | 1.00% |

| Child Waiver | FY11 | FY12 | FY13 | FY14 | FY15 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES (MH + SA) | $ 18,812,416 | $ 16,564,078 | $ 15,752,224 | $ 14,100,068 | $ 14,376,095 | $ 79,604,882 |
| ELIGIBLE MEMBER MONTHS(Capitation Payments) | 4,657 | 4,859 | 4,603 | 4,868 | 4,868 | |
| PMPM COST | $ 4,039.60 | $ 3,408.95 | $ 3,422.16 | $ 2,896.48 | $ 2,953.18 | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | -11.95% | -4.90% | -10.49% | 1.96% | -6.95% |
| ELIGIBLE MEMBER MONTHS | | 4.34% | -5.27% | 5.76% | 0.00% | 1.11% |
| PMPM COST | | -15.61% | 0.39% | -15.36% | 1.96% | -7.98% |

| SED Waiver | FY11 | FY12 | FY13 | FY14 | FY15 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES (MH + SA) | $ 3,858,363 | $ 5,064,808 | $ 5,875,800 | $ 5,858,356 | $ 5,973,041 | $ 26,630,368 |
| ELIGIBLE MEMBER MONTHS(Capitation Payments) | 2,039 | 2,910 | 3,438 | 3,684 | 3,684 | |
| PMPM COST | $ 1,892.28 | $ 1,740.48 | $ 1,709.08 | $ 1,590.22 | $ 1,621.35 | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | 31.27% | 16.01% | -0.30% | 1.96% | 11.01% |
| ELIGIBLE MEMBER MONTHS | | 42.72% | 18.14% | 7.16% | 0.00% | 15.94% |
| PMPM COST | | -8.02% | -1.80% | -6.95% | 1.96% | -4.25% |

| MIChild | FY11 | FY12 | FY13 | FY14 | FY15 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES (MH + SA) | $ 3,745,114 | $ 4,106,897 | $ 4,111,794 | $ 3,787,031 | $ 7,916,418 | $ 23,667,255 |
| ELIGIBLE MEMBER MONTHS(Capitation Payments) | 414,664 | 452,612 | 452,519 | 423,239 | 486,884 | |
| PMPM COST | $ 9.03 | $ 9.07 | $ 9.09 | $ 8.95 | $ 16.26 | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | 9.66% | 0.12% | -7.90% | 109.04% | 0.28% |
| ELIGIBLE MEMBER MONTHS | | 9.15% | -0.02% | -6.47% | 15.04% | 0.51% |
| PMPM COST | | 0.47% | 0.14% | -1.53% | 81.71% | -0.23% |

| HMP | FY11 | FY12 | FY13 | FY14 | FY15 | 5-YEARS |
|---|---|---|---|---|---|---|
| TOTAL EXPENDITURES (MH + SA) | | | | $ 125,340,454 | $ 325,958,392 | $ 451,298,847 |
| ELIGIBLE MEMBER MONTHS(Capitation Payments) | | | | 1,788,286 | 6,216,251 | |
| PMPM COST | | | | $ 70.09 | $ 52.44 | |
| TREND RATES | | | ANNUAL CHANGE | | | 5-YEAR AVERAGE |
| TOTAL EXPENDITURE | | | | | 160.06% | 1.00% |
| ELIGIBLE MEMBER MONTHS | | | | | 247.61% | 1.00% |
| PMPM COST | | | | | -25.19% | 1.00% |

**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**

| ELIGIBILITY GROUP | TREND RATE 1 | MONTHS OF AGING | BASE YEAR DY 00 | TREND RATE 2 | DEMONSTRATION YEARS (DY) DY 01 | DY 02 | DY 03 | DY 04 | DY 05 | TOTAL WOW |
|---|---|---|---|---|---|---|---|---|---|---|
| **DAB** | | | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | | | |
| Eligible Member Months | 1.5% | 6 | 6,057,012 | 1.5% | 6,101,970 | 6,192,889 | 6,285,163 | 6,378,812 | 6,473,857 | |
| PMPM Cost | 1.5% | 6 | $ 281.91 | 1.5% | $ 286.55 | $ 290.85 | $ 295.21 | $ 299.64 | $ 304.13 | |
| Total Expenditure | | | | | $ 1,748,519,472 | $ 1,801,201,836 | $ 1,855,443,055 | $ 1,911,347,295 | $ 1,968,893,985 | $9,285,405,643 |
| **TANF (including Healthy Kids)** | | | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | | | |
| Eligible Member Months | 0.5% | 6 | 12,820,200 | 0.5% | 12,852,211 | 12,916,472 | 12,981,054 | 13,045,959 | 13,111,189 | |
| PMPM Cost | 5.0% | 6 | $ 17.99 | 5.0% | $ 19.14 | $ 20.10 | $ 21.11 | $ 22.17 | $ 23.28 | |
| Total Expenditure | | | | | $ 245,991,310 | $ 259,621,079 | $ 274,030,049 | $ 289,228,916 | $ 305,228,480 | $1,374,099,834 |
| **1915(c) Habilitation Supports Waiver** | | | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | | | |
| Eligible Member Months | 0.0% | 6 | 92,400 | 0.0% | 92,400 | 92,400 | 92,400 | 92,400 | 92,400 | |
| PMPM Cost | 2.3% | 6 | $4,855.92 | 2.3% | $4,910.24 | $ 5,020.72 | $ 5,133.69 | $ 5,249.20 | $ 5,367.31 | |
| Total Expenditure | | | | | $ 453,706,176 | $ 463,914,528 | $ 474,352,956 | $ 485,026,080 | $ 495,939,444 | $2,372,939,184 |
| **Autism** | | | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | | | |
| Eligible Member Months | 1.0% | 6 | 10,041 | 1.0% | 15,750 | 24,614 | 31,975 | 32,825 | 32,825 | |
| PMPM Cost | 2.0% | 6 | $ 2,599.17 | 2.0% | $ 3,156.69 | $ 2,991.58 | $ 2,955.51 | $ 3,005.01 | $ 3,063.84 | |
| Total Expenditure | | | | | $ 49,717,404 | $ 73,633,908 | $ 94,502,529 | $ 98,638,584 | $ 100,569,562 | $ 417,061,987 |
| **Child Waiver** | | | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | | | |
| Eligible Member Months | 0.0% | 6 | 4,868 | 0.0% | 4,868 | 4,868 | 4,868 | 4,868 | 4,868 | |
| PMPM Cost | 2.0% | 6 | $ 2,981.95 | 2.0% | $ 4,089.57 | $ 4,169.63 | $ 4,251.26 | $ 4,334.48 | $ 4,419.33 | |
| Total Expenditure | | | | | $ 19,908,027 | $ 20,297,759 | $ 20,695,134 | $ 21,100,249 | $ 21,513,298 | $ 103,514,466 |
| **SED Waiver** | | | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | | | |
| Eligible Member Months | 1.0% | 6 | 3,702 | 1.0% | 4,343 | 4,386 | 4,430 | 4,474 | 4,519 | |
| PMPM Cost | 2.0% | 6 | $ 1,637.14 | 2.0% | $ 1,850.28 | $ 1,886.50 | $ 1,923.43 | $ 1,961.08 | $ 1,999.47 | |
| Total Expenditure | | | | | $ 8,035,416 | $ 8,274,640 | $ 8,520,990 | $ 8,774,661 | $ 9,035,897 | $ 42,641,603 |
| **MIChild** | | | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | | | |
| Eligible Member Months | 0.5% | 6 | 488,123 | 0.5% | 489,821 | 492,319 | 494,830 | 497,353 | 499,890 | |
| PMPM Cost | 2.0% | 6 | $ 16.42 | 2.0% | $ 16.74 | $ 17.07 | $ 17.40 | $ 17.74 | $ 18.09 | |
| Total Expenditure | | | | | $ 8,199,602 | $ 8,403,885 | $ 8,610,039 | $ 8,823,050 | $ 9,043,009 | $ 43,079,585 |
| **HMP** | | | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | | | |
| Eligible Member Months | 1.0% | 6 | 6,962,400 | 1.0% | 6,997,125 | 7,067,097 | 7,137,768 | 7,209,145 | 7,281,237 | |
| PMPM Cost | 2.0% | 6 | $ 37.03 | 2.0% | $ 37.39 | $ 38.12 | $ 38.87 | $ 39.63 | $ 40.41 | |
| Total Expenditure | | | | | $ 261,622,519 | $ 269,397,724 | $ 277,445,027 | $ 285,698,428 | $ 294,234,777 | $1,388,398,476 |

| ELIGIBILITY GROUP | DY 00 | DEMO TREND RATE | DEMONSTRATION YEARS (DY) DY 01 | DY 02 | DY 03 | DY 04 | DY 05 | TOTAL WW |
|---|---|---|---|---|---|---|---|---|
| **DAB** | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | |
| Eligible Member Months | 6,057,012 | 1.5% | 6,101,970 | 6,192,889 | 6,285,163 | 6,378,812 | 6,473,857 | |
| PMPM Cost | $ 281.91 | 1.5% | $ 286.23 | $ 290.52 | $ 294.88 | $ 299.30 | $ 303.79 | |
| Total Expenditure | | | $ 1,746,566,842 | $ 1,799,158,182 | $ 1,853,368,951 | $ 1,909,178,499 | $ 1,966,692,874 | $ 9,274,965,348 |
| **TANF (including Healthy Kids)** | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | |
| Eligible Member Months | 12,820,200 | 0.5% | 12,852,211 | 12,916,472 | 12,981,054 | 13,045,959 | 13,111,189 | |
| PMPM Cost | $ 17.99 | 5.0% | $ 19.08 | $ 20.03 | $ 21.03 | $ 22.08 | $ 23.18 | |
| Total Expenditure | | | $ 245,220,177 | $ 258,716,926 | $ 272,991,565 | $ 288,054,780 | $ 303,917,361 | $ 1,368,900,809 |
| **1915(c) Habilitation Supports Waiver** | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | |
| Eligible Member Months | 92,400 | 0.0% | 92,400 | 92,400 | 92,400 | 92,400 | 92,400 | |
| PMPM Cost | $ 4,855.92 | 2.3% | $ 4,910.24 | $ 5,020.72 | $ 5,133.69 | $ 5,249.20 | $ 5,367.31 | |
| Total Expenditure | | | $ 453,706,176 | $ 463,914,528 | $ 474,352,956 | $ 485,026,080 | $ 495,939,444 | $ 2,372,939,184 |
| **Autism** | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | |
| Eligible Member Months | 10,041 | 1.0% | 15,750 | 24,614 | 31,975 | 32,825 | 32,825 | |
| PMPM Cost | $ 2,599.17 | 2.0% | $ 3,156.69 | $ 2,991.58 | $ 2,955.51 | $ 3,005.01 | $ 3,063.84 | |
| Total Expenditure | | | $ 49,717,404 | $ 73,633,908 | $ 94,502,529 | $ 98,638,584 | $ 100,569,562 | $ 417,061,987 |
| **Child Waiver** | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | |
| Eligible Member Months | 4,868 | 0.0% | 4,868 | 4,868 | 4,868 | 4,868 | 4,868 | |
| PMPM Cost | $ 2,981.95 | 2.0% | $ 4,089.57 | $ 4,169.63 | $ 4,251.26 | $ 4,334.48 | $ 4,419.33 | |
| Total Expenditure | | | $ 19,908,027 | $ 20,297,759 | $ 20,695,134 | $ 21,100,249 | $ 21,513,298 | $ 103,514,466 |
| **SED Waiver** | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | |
| Eligible Member Months | 3,702 | 1.0% | 4,343 | 4,386 | 4,430 | 4,474 | 4,519 | |
| PMPM Cost | $ 1,637.14 | 2.0% | $ 1,850.28 | $ 1,886.50 | $ 1,923.43 | $ 1,961.08 | $ 1,999.47 | |
| Total Expenditure | | | $ 8,035,416 | $ 8,274,640 | $ 8,520,990 | $ 8,774,661 | $ 9,035,897 | $ 42,641,603 |
| **MIChild** | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | |
| Eligible Member Months | 488,123 | 0.5% | 489,821 | 492,319 | 494,830 | 497,353 | 499,890 | |
| PMPM Cost | $ 16.42 | 2.0% | $ 16.74 | $ 17.07 | $ 17.40 | $ 17.74 | $ 18.09 | |
| Total Expenditure | | | $ 8,199,602 | $ 8,403,885 | $ 8,610,039 | $ 8,823,050 | $ 9,043,009 | $ 43,079,585 |
| **HMP** | | | | | | | | |
| **Pop Type:** | **Medicaid** | | | | | | | |
| Eligible Member Months | 6,962,400 | 1.0% | 6,997,125 | 7,067,097 | 7,137,768 | 7,209,145 | 7,281,237 | |
| PMPM Cost | $ 37.03 | 2.0% | $ 37.39 | $ 38.12 | $ 38.87 | $ 39.63 | $ 40.41 | |
| Total Expenditure | | | $ 261,622,519 | $ 269,397,724 | $ 277,445,027 | $ 285,698,428 | $ 294,234,777 | $ 1,388,398,476 |

**Budget Neutrality Summary**

**Without-Waiver Total Expenditures**

| | DEMONSTRATION YEARS (DY) | | | | | TOTAL |
|---|---|---|---|---|---|---|
| | DY 01 | DY 02 | DY 03 | DY 04 | DY 05 | |
| **Medicaid Populations** | | | | | | |
| DAB | $ 1,748,519,472 | $ 1,801,201,836 | $ 1,855,443,055 | $ 1,911,347,295 | $ 1,968,893,985 | $ 9,285,405,643 |
| TANF (including Healthy Kids) | $ 245,991,310 | $ 259,621,079 | $ 274,030,049 | $ 289,228,916 | $ 305,228,480 | $ 1,374,099,834 |
| 1915(c) Habilitation Supports Waiver | $ 453,706,176 | $ 463,914,528 | $ 474,352,956 | $ 485,026,080 | $ 495,939,444 | $ 2,372,939,184 |
| Autism | $ 49,717,404 | $ 73,633,908 | $ 94,502,529 | $ 98,638,584 | $ 100,569,562 | $ 417,061,987 |
| Child Waiver | $ 19,908,027 | $ 20,297,759 | $ 20,695,134 | $ 21,100,249 | $ 21,513,298 | $ 103,514,466 |
| SED Waiver | $ 8,035,416 | $ 8,274,640 | $ 8,520,990 | $ 8,774,661 | $ 9,035,897 | $ 42,641,603 |
| MIChild | $ 8,199,602 | $ 8,403,885 | $ 8,610,039 | $ 8,823,050 | $ 9,043,009 | $ 43,079,585 |
| HMP | $ 261,622,519 | $ 269,397,724 | $ 277,445,027 | $ 285,698,428 | $ 294,234,777 | $ 1,388,398,476 |
| **DSH Allotment Diverted** | $ - | $ - | $ - | $ - | $ - | $ - |
| **Other WOW Categories** | | | | | | |
| Category 1 | | | | | | $ - |
| Category 2 | | | | | | $ - |
| **TOTAL** | $ 2,795,699,925 | $ 2,904,745,358 | $ 3,013,599,779 | $ 3,108,637,262 | $ 3,204,458,454 | $ 15,027,140,778 |

**With-Waiver Total Expenditures**

| | DEMONSTRATION YEARS (DY) | | | | | TOTAL |
|---|---|---|---|---|---|---|
| | DY 01 | DY 02 | DY 03 | DY 04 | DY 05 | |
| **Medicaid Populations** | | | | | | |
| DAB | $ 1,746,566,842 | $ 1,799,158,182 | $ 1,853,368,951 | $ 1,909,178,499 | $ 1,966,692,874 | $ 9,274,965,348 |
| TANF (including Healthy Kids) | $ 245,220,177 | $ 258,716,926 | $ 272,991,565 | $ 288,054,780 | $ 303,917,361 | $ 1,368,900,809 |
| 1915(c) Habilitation Supports Waiver | $ 453,706,176 | $ 463,914,528 | $ 474,352,956 | $ 485,026,080 | $ 495,939,444 | $ 2,372,939,184 |
| Autism | $ 49,717,404 | $ 73,633,908 | $ 94,502,529 | $ 98,638,584 | $ 100,569,562 | $ 417,061,987 |
| Child Waiver | $ 19,908,027 | $ 20,297,759 | $ 20,695,134 | $ 21,100,249 | $ 21,513,298 | $ 103,514,466 |
| SED Waiver | $ 8,035,416 | $ 8,274,640 | $ 8,520,990 | $ 8,774,661 | $ 9,035,897 | $ 42,641,603 |
| MIChild | $ 8,199,602 | $ 8,403,885 | $ 8,610,039 | $ 8,823,050 | $ 9,043,009 | $ 43,079,585 |
| HMP | $ 261,622,519 | $ 269,397,724 | $ 277,445,027 | $ 285,698,428 | $ 294,234,777 | $ 1,388,398,476 |
| **Expansion Populations** | | | | | | |
| **Excess Spending From Hypotheticals** | | | | | | $ - |
| **Other WW Categories** | | | | | | |
| Category 3 | | | | | | $ - |
| Category 4 | | | | | | $ - |
| **TOTAL** | $ 2,792,976,162 | $ 2,901,797,552 | $ 3,010,487,190 | $ 3,105,294,330 | $ 3,200,946,224 | $ 15,011,501,458 |
| **VARIANCE** | $ 2,723,763 | $ 2,947,806 | $ 3,112,588 | $ 3,342,932 | $ 3,512,230 | $ 15,639,320 |

**HYPOTHETICALS ANALYSIS**

**Without-Waiver Total Expenditures**

| | DEMONSTRATION YEARS (DY) | | | | | TOTAL |
|---|---|---|---|---|---|---|
| | DY 01 | DY 02 | DY 03 | DY 04 | DY 05 | |
| **TOTAL** | $ - | $ - | $ - | $ - | $ - | $ - |

**With-Waiver Total Expenditures**

| | DEMONSTRATION YEARS (DY) | | | | | TOTAL |
|---|---|---|---|---|---|---|
| | DY 01 | DY 02 | DY 03 | DY 04 | DY 05 | |
| **TOTAL** | $ - | $ - | $ - | $ - | $ - | $ - |
| **HYPOTHETICALS VARIANCE** | $ - | $ - | $ - | $ - | $ - | $ - |

# Appendix E

# Public Notice Update with Attachments

The MDHHS developed multiple opportunities for public input and dialog during the waiver development process and prior to the submission of Michigan's §1115 Pathway to Integration Waiver application. The input and public notice process is consistent with the requirements outlined in 42 CFR Part 431 Subpart G.

**Public Notice of Waiver Application**

The MDHHS, BHDDA began discussions on the proposed §1115 waiver application to the Medical Care Advisory Council (MCAC) on 2/19/15. BHDDA staff, as regular members of the MCAC, continued to provide updates and receive input through their quarterly meetings in 2015 and 2016. BHDDA staff met with Tribal Health Centers as part of the Behavioral Health Communication Network on 4/15/15, 6-26-15, 7-16-15, 8-17-15, 10-14-15 and most recently 4-13-16. Although the §1115 Pathway to Integration Waiver application does not change the current relationship between the state and the Tribal Health Centers, as a result of these meetings the state has requested attendance from the regional PIHPs to assure proper service coordination and access to specialty services as needed. From September, 2015 through November, 2015, the BHDDA held four Sounding Board Workgroups with the Michigan Association of Community Mental Health Boards (MACMHB), the Michigan ARC and the Behavioral Health Advisory Council (BHAC). Membership included PIHPs, CMHSPs, invited advocates and family members. These sounding board workgroups allowed open discussion regarding Michigan's current behavioral health system and the planned initiatives to be included in Michigan's §1115 demonstration waiver application.

On 12-18-15, the MDHHS published the Pathway to Integration §1115 waiver proposal on its Behavioral Health and Developmental Disabilities Administrations (BHDDA) website http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868---,00.html. The web page included a complete copy of the §1115 waiver proposal, a waiver summary, stakeholder notice, and an email address for questions and comments and where to receive a hard copy of the waiver proposal. The website also included the dates and locations of the two public hearings. MDHHS also began its formal public notice process on 12-18-16 including a 45 day comment period for all interested parties. Notice was published in select newspapers throughout the state on or around 12-18-15. This notice included a brief summary of the proposal, the dates and times of public hearings, instructions on how to submit comments and questions including the link to where the application could be requested in hard copy or downloaded. A copy of the web posting, stake holder letter, and the public hearing power point is included as Appendix E, Attachment 1.

Michigan held two public hearings on the waiver application, one by webinar on 1-13-16 and one in person on 1-28-16 in Lansing Michigan. Combined attendance included over 150 participants from trade associations, family members' advocates, consumers and other

interested individuals. Common themes and responses along with all written comments and responses received is included as Appendix E, Attachment 2.

# Attachment 1

# Stakeholder Notice and Public Hearing

December 18, 2015

Dear Stakeholders and Interested Parties:

**RE:** Section 1115 Waiver - Pathway to Integration Proposal

The Michigan Department of Health and Human Services (MDHHS) is seeking approval from the Centers for Medicare and Medicaid Services (CMS) for a §1115 Demonstration Waiver to combine under a single waiver authority all services and eligible populations served through its §1915(b) and its multiple §1915(c) waivers for persons with Serious Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual & Developmental Disabilities (IDD) and Children with Serious Emotional Disturbances (SED). Under this consolidated waiver authority, Michigan is seeking broad flexibility to develop quality, financing and integrated care (physical and behavioral health care) initiatives for all Specialty Service Populations on a statewide basis.

In addition to aligning and expanding MDHHS integrated care initiatives for all Specialty Service Populations, the services covered under this §1115 Waver include the full array of mandatory and optional State Plan services for persons who meet the eligibility criteria for the Specialty Services System. Michigan is NOT reducing for limiting any benefits outlined in this waiver application.

The anticipated effective date of this waiver is April 1, 2016.

A copy of the complete §1115 waiver, stakeholder notice and waiver summary is available online at http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868---,00.html. You may request a hard copy of the complete §1115 waiver, stakeholder notice and waiver summary by contacting Teri Baker at the address below. You may also submit questions or comments regarding the waiver to the address below or by email at MDHHS-Pathway1115@Michigan.gov. All comments on this topic should include a "Section 1115 – Pathway to Integration reference somewhere in the written submission or the subject line if by email.

Michigan Department of Health and Human Services
Bureau of Community Health Behavioral Health and Developmental Disabilities Administration
320 S. Walnut Street, Lewis Cass Building, 5th Floor
Lansing MI 48913

Two public hearings have been scheduled for following dates, times and locations:

- January 13th, 2016 1-2:30 pm Webinar:

https://connectpro14871085.adobeconnect.com/dualel/
U.S. Toll-Free Access Number: (877) 366-0711
Participant Passcode: 39535358

- January 28th Lansing Center, 10-11:30am
  333 Michigan Avenue
  Lansing MI 48933

Any questions regarding this letter should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, phone number so you may be contacted if necessary. Providers may phone toll-free at 1-800-292-2550.

We thank you in advance for your participation.

Sincerely,

Chris Priest, Acting Director
Medical Service Administration
Administration

Lynda Zeller, Director
Behavioral Health and Developmental Disabilities

Public Hearing PPT

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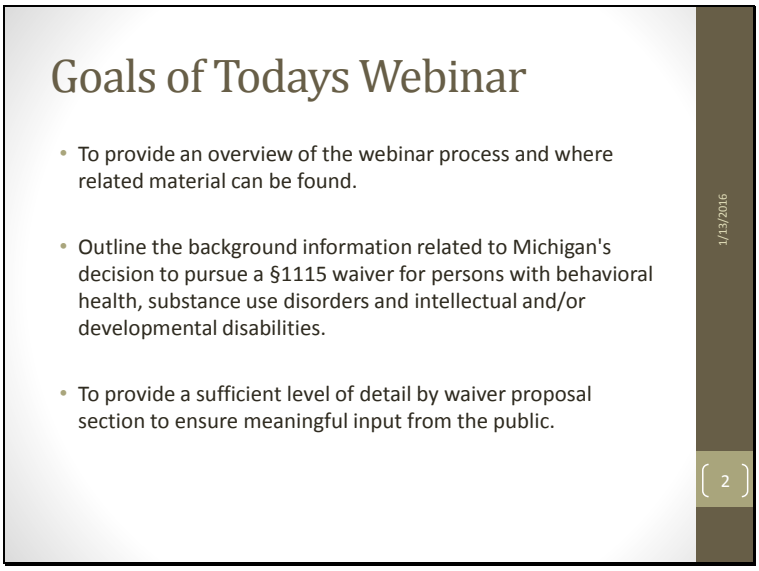


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# Webinar Overview

- This webinar is the first of two public hearings to be held on Michigan's Pathway to Integration §1115 waiver proposal.
- The second hearing will be on 1-28-16 at the Lansing Center, from 10-11:30am at 333 Michigan Avenue, Lansing Michigan.
- The webinar today will be muted by the host. Session participants will be able to type in questions on Adobe Connect. During three intervals, the host will respond to posted questions.
- While not all questions will be responded to today, all questions and answers will be posted on the MDHHS website after the comment period has ended.
- Hard copies of the comments, questions and answers will be made available upon request at the email or address provided on page 4 of this slide deck. The slide deck will also be available on the same site shortly after today's webinar.

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# Webinar Overview

A copy of the complete §1115 waiver, stakeholder notice and waiver summary is available online at www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health & Developmental Disability >> Mental Health.

You may request a hard copy of the complete §1115 waiver, stakeholder notice and waiver summary by contacting Teri Baker at the address below. You may also submit questions or comments regarding the waiver to the address below or by email at MDHHS-Pathway1115@Michigan.gov. All comments on this topic should include a "Section 1115 – Pathway to Integration" reference somewhere in the written submission or the subject line if by email.

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration
Bureau of Community Health
320 S. Walnut Street, Lewis Cass Building, 5th Floor
Lansing, MI 48913

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## Pathway to Integration Background

- Over the past the past 18 years, Michigan has operated under a Managed Specialty Service & Supports Waiver (MSS&SW) through a §1915(b) Managed Care Waiver.
- The MSS&SW has been the vehicle used to waive "Freedom of Choice" requirements and to mandate managed care enrollment (basically creating the structure of Prepaid Inpatient Health Plans).
- Connected to the MSS&SW are the §1915(b(4) Children's waiver Program (CWP), the §1915(b(4) waiver for Children with Severe Emotional Disturbances (SEDW) (both Fee for Service (FFS) programs) and the § 1915(c) Habilitation Supports Waiver (HSW) and all applicable State Plan services.

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## The Desire and Need for Change

- With each §1915(b) waiver renewal and/or amendments over the past several years, Michigan has struggled to meet the *cost effectiveness* requirements of its §1915(b) waiver services.
- *Cost effectiveness* for the purposes of this proposal means the rate of increases in the costs of the §1915(b) waiver services cannot exceed the rate of increase in of other state plan services over the term of the waiver.
- Because Michigan provides one of the most robust set of community based supports in the country, the requirements for the §1915(b) waiver to be considered cost effective without limiting or moving benefit options has became difficult, if not impossible.
- Additionally, and building off of multiple statewide integrated physical and behavioral health care initiatives, Michigan desires to test integrated care initiatives specifically targeting the populations covered by this waiver proposal.

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# Questions so far?

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# Pathway to Integration Waiver Proposal

- Michigan has a long standing commitment to community supports and inclusion for persons with Severe Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual and/or Developmental Disabilities (I/DD), and Children with Severe Emotional Disturbances (SED).
- The Pathway to Integration Waiver is intended to combine under a single waiver authority all services and eligible populations served through its current §1915(b), State Plan and its multiple §1915(c) waivers (aka. Specialty Service System/Populations).

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# Waiver Rationale

- The §1115 waiver allows broad flexibility to combine existing waivers with differing eligibility and service arrays.
- The §1115 waiver is one of the only waiver models that did NOT require reducing current Medicaid eligible populations without adding additional waivers.
- The §1115 waiver allows the state to develop quality financing and integrated care initiatives specifically for the Specialty Service Populations.
- The §1115 waiver enhances the prospect of streamlining multiple payment and reporting requirements as we bring new populations into managed care arrangements.
- The §1115 waiver allows options for integrated service and delivery options for person with SUD.

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# Hypotheses/Goal of Demonstration

- The goal of this Demonstration is to create a robust evaluation that tests both quality and cost outcomes between traditional Medicaid Health Plans (MHPs) and Michigan's Specialty Service System.
- Proposed Key indicators include:
  - Joint identification and tracking of High Utilizers.
  - Access to care incentives.
  - Pilot Demonstrations through the State Innovation Model (SIM) and Accountable Systems of Care (ASC).
  - Enhancement of co-occurring (SMI/SUD) services.
  - The use of Specialized Complex Care Managers for individuals considered High Utilizers.

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# Medicaid Eligibility

- There are no eligibility changes proposed under this waiver that do not currently exist. These also Include eligible MI CHILD and Healthy Michigan Plan beneficiaries.
- Michigan intends to maintain the current service array and, where possible and explore the expansion of enrollment caps for certain services previously provided through its §1915(c) CWP and SEDW programs (as legislatively approved).
- All current HSW enrollees and services (including HSW enhanced payments) will be covered under this §1115 waiver authority.
- Anticipated beneficiaries served under this waiver and current enrolment caps are outlined below:
  - §1915(c) HSW = 8268
  - §1915(c) SEDW = 969
  - §1915(c) CWP = 469
  - Estimated Demonstration populations Including §1915(b)/(c) Populations = 230,000

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# Demonstration Benefits

- The services covered under this §1115 waiver include the full array of mandatory and optional State Plan services for persons ***"who meet the eligibility and the needs assessment criteria for the Specialty Services System" (see pages 9-17 of the waiver proposal).***
- This includes individuals with Autism Spectrum Disorder, individuals eligible for Michigan's Special Health Insurance Program (aka MI CHILD) and expanded Medicaid Populations.
- Michigan is ***NOT reducing or limiting any benefits*** previously offered.
- Michigan will also be providing integrated SUD delivery systems and services and adding coverage for the inclusion of Permanent Supportive Housing for all eligible populations.

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# Questions so far?

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# Delivery Systems and Reforms

- Enrollment into the Michigan's Specialty Service System will continue to be mandatory based on the criteria described in Section II of the waiver proposal.
- Michigan will continue to use a single Specialty Service System (on a statewide basis) for State Plan and the former §1915(b) and §1915(c) waiver beneficiaries who meet Specialty Service Criteria. This includes persons previously enrolled in the MI CHILD program and expansion populations.
- The former CWP and SEDW programs will move from FFS delivery system to managed care.
- The alignment of quality and financial incentives between Medicaid Health Plans and Michigan's Specialty Service System.

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## Delivery Systems and Reforms (cont.)

- The proposed delivery system changes will require PIHPs and their CMHSP providers to meet quality reporting requirements, develop enhanced SUD provider systems and provide or partner with Medicaid Health plans to improve access for persons with mild and moderate behavioral health disorders.
- These linkages are intended to:
  - Identify and provide education, prevention and treatment of modifiable health risk factors.
  - Provide Screening Brief Intervention Referral and Treatment (SBIRT) services for persons with SUD.
  - Provide housing first initiatives/models through permanent supportive housing models.
  - Provide incentives for increased access to primary care and the coordinated tracking of High Utilizers of emergency department usage and hospital admissions/readmissions.

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## Long Term Service and Supports & Self Direction

- The Demonstration will provide personal care and Long Term Services and Supports (LTSS) including options for both self-direction/determination models, including the use of fiscal intermediaries.
- Waiver participants will have opportunities for both employer and budget authority.
- Participants may elect to control their individual budget for all services or can direct a single service for which participant direction is an option.
- The participant may direct the budget and directly contract with chosen providers.

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## Payments to Managed Care Entities

- Capitation rates will include all State Plan, §1915(b) and §1915(c) waivers as outlined in Exhibit 1 of the proposal.
- Capitation rate values will be developed using PIHP submitted encounter data and Medicaid Utilization Net Cost Reports (MUNC) and will vary by benefit type and program code.
- Rate adjustment factors will be developed to reflect age, gender and geographic region for each benefit category.
- As with the current §1915(b) and §1915(c) waivers, PIHPs are responsible for all Medicaid beneficiaries within a geographic catchment area who meet criteria for the Specialty Service System.
- Questions regarding budget neutrality estimates outside of those outlined in Appendix C, will be answered and posted on the MDHHS website after the comment period has closed.

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## Quality Based Supplemental Payments

- MDHHS intends to hold back up to 1.0% of capitation payments to be redistributed based on meeting the Demonstration expectations and/or other shared metrics.
- Current Quality based incentives include:
  - The implementation of complex care management.
  - joint PIHP and MHP performances incentives.
  - Incentives to PIHP regions who service foster children and children in Child Protective Services (CPS) with Serious Emotional Disturbances.

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## Implementation of the Demonstration

- Phase 1 (Upon submission and anticipated approval):
  - The consolidation of the existing §1915(b) and §1915(c) Waivers.
  - The development of the demonstration evaluation and collection of baseline data.
  - The statewide evaluation and system readiness for a reformed SUD delivery system. Based on system readiness may be phased approach and include Demonstration years 2 and 3.
- Phase 2 (may span Demonstration years 2 and 3):
  - The development of bundled funding and other quality incentives for Accountable Systems of Care.
  - Medicaid Health Plans and PIHP will be contractually required to monitor certain quality and integrated care outcomes that lead toward the tracking and implementation of potential shared savings models.

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## List of Proposed Waiver & Expenditure Authorities

- Proper and Efficient Administration §1902(a)(4)

  Rationale for Authority: Mandate beneficiaries into a single Prepaid Inpatient Health Plan
- Comparability §1902(a)(17)

  This waiver program includes benefits specific to eligibility criteria as described in Section II that will not be available to other Medicaid beneficiaries.
- Amount, Duration, and Scope §1902(a)(10)(B)

  To enable the State to offer a different benefit package to the Demonstration participants that varies in amount, duration, and scope from the benefits offered under the State Plan.

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## List of Proposed Waiver & Expenditure Authorities

- Freedom of Choice §1902(a)(23)(A)
  - To enable the State to restrict Demonstration participants to receive benefits through PIHPs and CMHSPs.
  - Rationale for Authority – beneficiaries enrolled in the program must receive services through a PIHP.
- Choice of Coverage §1932(a)(3)
  - To enable the State to assign Demonstration participants to PIHPs based on geography and to permit participant choice of provider, but not plan.
- Reasonable Promptness Section §1902(a)(8)
  - To enable the State to limit enrollment for Demonstration eligible population in order to remain under the annual budget neutrality limits under the Demonstration.

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## List of Proposed Waiver & Expenditure Authorities

- Methods of Administration: Transportation §1902(a)(4), insofar as it incorporates 42 CFR 431.53
  - To enable the State to assure transportation to and from providers for the Demonstration participants.
- Eligibility Standards §1902(a)(17)
  - To enable the State to apply different eligibility methodologies and standards to the Demonstration eligible population than are applied under the State Plan.
- Retroactive Eligibility Section §1902(a)(34)
  - To enable the State to not provide coverage for the Demonstration eligible population for any time prior to the first day of the month in which the application was received by the State.

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# Appendix A LTSS

- As outlined in Section II, item 6, Michigan will be including LTSS that were previously provided through its §1915(b) and its multiple §1915(c) waivers.
- Appendix A outlines the MDHHS Quality Assessment and Performance Improvement Program (QAPIP) including the current risk management and critical incident reporting.
- Appendix A, also outlines MDHHS site review process and will include all §1115 waiver populations.

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# Appendix B LTSS

- Appendix B provides a service description and provides a grid of all LTSS service descriptions and provider qualifications.
- Appendix B services mimic those included in the current §1915(b)/(c) and multiple 1915(c) waivers included in this proposal.

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# Questions?

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# Attachment 2

# Common Themes and Written Comments Received

## Common Themes and State Responses

**Implementation of Conflict Free Case Management (CFCSM).**
Conflict Free Case Management (CFCSM) went into immediate effect with the HCBS final rule in January, 2014. Policy and procedures related to rural counties along with the state's overall policy considerations are being developed and promulgated as part of a state sponsored CFCSM workgroup including both consumer, advocates and key stakeholders.

**Persons directed supports, medical necessity and provider networks.**
As outlined in Appendix B, Michigan has a long history of person directed supports through the person centered planning process (PCP). The PCP process is outlined in the Michigan Mental Health Code, the managed specialty services and supports contracts as well as numerous PCP and self –determination guidelines. The interplay with published medical necessity guidelines and the use of independent facilitation for planning and fiscal intermediary services, does not change with the Pathway to Integration Waiver application. The balance between consumer choice and reasonableness of service request and location of service should always be balanced based on the individual consumer needs, provider ethics and medical necessity for the services delivered. This process should always take into consideration of the living arrangements the wellbeing of the consumer and ultimately the health and safety of the individual beneficiary.

**Pathway to Integration Waiver, quality of services and current delivery system and the potential to contract with other entities based on quality of performance.**
The Pathway to Integration Waiver does not intend to undue the current managed care delivery system. The potential to contract outside of the current PIHP and CMHSP managed care structure is only intended if the current managed care entity cannot meet the service delivery, quality, financial and reporting requirements to serve the beneficiaries within a given region. This waiver application acknowledges the current efforts to consolidate managed care functions and will continue to support the current managed care arrangements and efforts to meet the waiver requirements.

**Definition of Permanent Supportive Housing (PSH).**
Permanent supportive Housing (PSH) is a service MDHHS plans to add as an additional benefit during the waiver demonstration. PSH, is a set of service and supports provided by a team that combines housing development and the support services for individual with SMI, SUD, or I/DD that require assistance to maintain consistent and permanent housing. Individuals targeted for this service are often frequent or high users of hospital emergency departments and inpatient and/or chronic homelessness.

Services to support housing retention include: Case management, service planning, nurse care coordination (physical and behavioral health), peer supports, counseling and supported employment. Targeted supports should include dispute resolution between landlord and tenant, assistance with transportation, legal assistance and benefit management.

**Removal of enrollment caps and separate rates by person with Intellectual/Developmental Disabilities (I/DD).**
MDHHS received a number of questions related to the consolidation of the multiple section 1915(c) waivers and the continued use of enrollment caps for the former Habilitation Supports Waiver (HSW), the Waiver for Children with Serious Emotional Disturbances (SEDW) and the Children's Waiver Program (CWP). Although MDHHS is desirous to potentially remove enrollment caps in the future, the SEDW and the CWP both waive parental income for individuals who meet specific eligibility requirements and Michigan must also continue to meet budget neutrality under the proposed demonstration. MDHHS also received questions related to development of a separate rate category for adult individuals with I/DD, which could eliminate the need for HSW enrollment caps. This is something MDHHS may consider in the future.

**Inclusion of services to person with mild and moderate behavioral health disorders within the specialty services system.**
MDHHS received numerous questions related to moving the benefit for persons with mild and/or moderate behavioral health disorders from the Medicaid Health Plans (MHPs) to the Prepaid Inpatient Health Plans (PIHPs). Although the coordination of care and access to needed behavioral health services for this population has been an ongoing concern, licensing and mental health parity require MHPs to provide certain behavioral health services.

**Increase use of peer supports, recovery coaches and peer crisis services.**
MDHHS covers and encourages the expanded use of peer supports within its specialty service system. In addition to the current coverages, MDHHS intends to have peer supports as part of permanent supportive housing teams as well as their expanded use for persons with substance use disorders. Specific peer support crisis models may be considered in the future, but MDHHS does currently encourage the use of peer supports within existing crisis teams.

**Will the final waiver application reflect the New Service Delivery Opportunities for Individuals with Substance Use Disorder and the use of IMDs as outlined in the State Medicaid Director Letter # 15-003?**
Yes, Michigan was one of the early states as part of the CMS Innovation Accelerator Program (IAP) and in conjunction with these ongoing efforts, the final application will include the goals of a transformed system including a comprehensive evidence based benefit design and the use of ASM to establish appropriate levels of care. Michigan will be specifically asking for expenditure authority for the use of IMDs.

Written Comments Received

**(Please see separate PDF)**