Pathway to Integration

Michigan's 1115 Waiver Proposal for Persons with Severe Mental Illness, Substance use Disorders, Intellectual and Developmental Disabilities and Children with Severe Emotional Disturbances

To the

Center for Medicare and Medicaid Services

Us Department of Health and Human Services

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State of Michigan

Rick Snyder Governor

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Michigan Department of Health and Human Services

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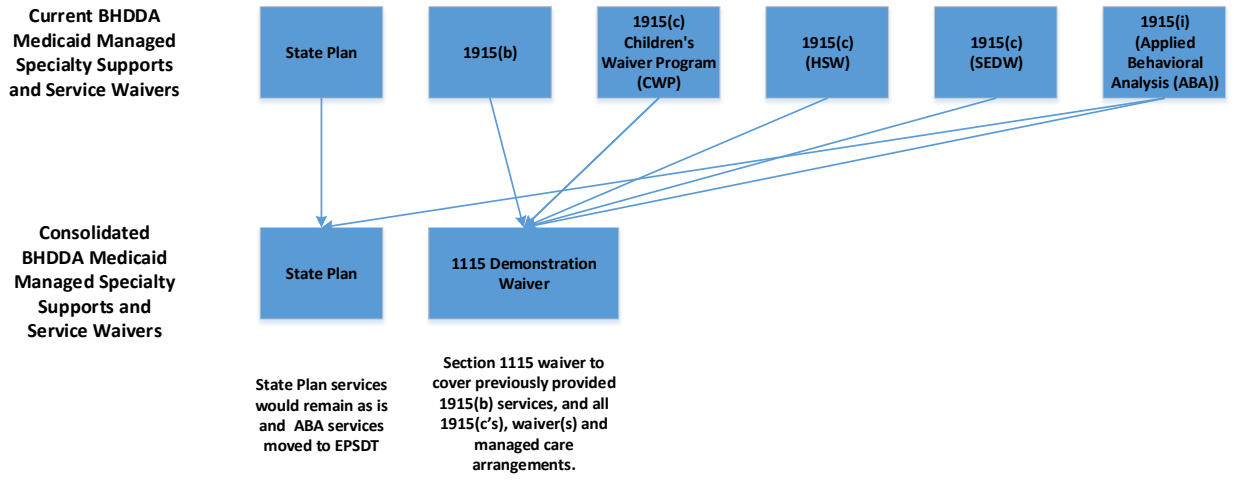
Introduction

Building off of Michigan's long standing commitment to community supports and inclusion and to focus on the capability to function and the opportunity to achieve for persons with Severe Mental Illness (SMI), Substance Use Disorders (SUD), Intellectual/Developmental Disabilities (I/DD) and Children with Severe Emotional Disturbances (SED)[1]. The State of Michigan 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), 1915(i) and its multiple §1915(c) waivers. 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. Exhibit 1 below, describes the current waivers and populations consolidated under this §1115 Waiver application.

Exhibit 1

Pathway to Integration Waiver Consolidation



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

I. 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 by the Centers for Medicare and Medicaid Services (CMS) the 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, 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.

Prompted by the fact that both the Blueprint and HMP identified the need for better care coordination between physical and behavioral healthcare and that a major driver of unnecessary hospital/emergency room utilization is often driven by persons with behavioral health and/or substance use disorders, 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, BHDDA leadership believes that with the broader flexibility allowed through a §1115 Waiver that the Specialty Services System can be incentivized to align better with other healthcare providers and improve the overall population health objectives for this very vulnerable and often underserved population. As outlined in Exhibit 1, this application will allow the consolidation of multiple programs, streamline payment systems and allow the expansion of certain services including the redesign of the SUD delivery system as part of the CMS Innovator Accelerator Program (IAP).

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 but its multiple §1915(c) Waivers have still remained slightly outside the traditional §1915(b) managed care payment structure. Currently, all of Michigan's §1915(c) Waivers include enrollment caps and eligibility requirements based 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-

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

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 (as legislative appropriated and who meet 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 remain.

This consolidated waiver will result in seamless/coordinated care, produce budget neutrality, resolve the current "cost effectiveness" issue related to its current §1915(b) Managed Specialty Service and Supports (MSS&S) Waiver, and move away from the ICF/IID service availability requirements associated with the 1915(c) waivers.

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

Since this proposal is not solely focused on cost savings but rather maintaining Michigan's robust coverage and service array (including the expanded use of peer supports and self-determined arrangements) for Specialty Service Populations, the goal of this demonstration is to actually create a robust evaluation that tests both quality and cost outcomes between traditional Medicaid Health Plans (MHPs) and Michigan's Specialty Services System[3]. These incentives would be specifically targeted for persons with SMI, SUD, IDD and SED. Key indicators would include the joint identification and tracking of high risk/utilizing populations, the prevention of modifiable risk factors[4], access to care incentives, pilot demonstrations through Accountable Systems of Care and the enhancement of co-occurring (SMI/SUD) services and the 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 impact decreased utilization and tracking where savings actually accrues (hospitals, health plans, PIHP's) for this population will be one of the demonstration's major evaluation components.

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

[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.

measured during the demonstration with additional CMS technical assistance (specifically for the enhanced SUD services). Michigan will submit the completed design of the evaluation within 90 days of the application approval.

- 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, 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.
- A decrease in hospital admissions for these specific populations (both medical and psychiatric).
- Rate of follow up appointments kept with Specialty Service System providers.

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 4-1-16. Phases for both delivery system innovations and shared savings/risk models will occur in years 2 and 3 to coincide with the enhancement of SUD delivery system, the implementation of the Blueprints Accountable Systems of Care (ACS) and Michigan's desire to be one of the pilot states to develop Certified Behavioral Health Clinics (CCBHCs) and the implementation of a Prospective Payment System (PPS). Demonstration year 1, will include the development of the evaluation, 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.

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 and CHIP programs.

II. 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 eligibility changes will be affected by this demonstration.

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 in section I.3 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).

Not Applicable

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

III. 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:

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. This includes individuals with Autism Spectrum Disorder and individuals eligible for Michigan Special Children's Special Health Insurance Program (aka. MICHILD) and expanded Medicaid Populations. The eligibility criteria described in this section only applies to the additional services previously covered by the §1915(b) Waiver and multiple §1915(c) Waivers. Michigan is NOT reducing or limiting any benefits previously offered and will be expanding through a State Plan Amendment Autism Spectrum Disorders services to children between the ages of 6-21, provide enhanced SUD delivery systems and add coverage for the inclusion of Permanent Supportive Housing.

Specialty Service and Supports Eligibility Criteria and Service Array (Formally known as Section 1915(b)/(3) Supports)

A Medicaid beneficiary with mental illness, serious emotional disturbance, substance use disorder or intellectual/developmental disabilities that are eligible for specialty mental health services and supports when their needs exceed the benefits provided by traditional Medicaid health Plans (MHP).

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient 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	-The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by

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. -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.	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). -The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. 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. -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. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) 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 all Populations
Community Living Supports
Enhanced Medical Equipment Supplies
Enhanced Pharmacy
Environmental Modifications (including vehicle modifications)
Family 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

SUD Eligibly Criteria and Service Array

The SUD eligibility criteria and services described below are based on the readiness and needs of the beneficiary based on medical necessity. Services are also available to all Specialty Service Populations and will be specifically targeted for Beneficiaries identified as High Utilizers with co-occurring SMI and SUD. Individuals who meets these criteria and the medical necessity as described above, will also be afforded access to the Specialty Service and Supports under an integrated system of care. Needs based criteria for SUD services is based on the American Society of Addiction Medicine (ASAM) Criteria.

Outpatient services can include any variety of the covered services (State Plan and Waiver coverages) and are dependent on the individual needs of the beneficiary. The assessment, treatment plan and recovery support preparations are the only components that are consistent throughout the outpatient levels of care as each beneficiary must have these as part of the authorized treatment services. As a beneficiary's needs increase, more services and/or frequency/ duration of services may be utilized if these are medically necessary. The ASAM levels correspond with established hours of services that take place during a week.

Outpatient care may be provided only when:

- The service meets medical necessity criteria.
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression (also known as provisional diagnosis).
- The service is based on individualized determination of need.
- The service is cost effective.
- The ASAM Criteria are used to determine substance abuse treatment placement/admission and/or continued stay needs.

This service is limited to those beneficiaries who will benefit from treatment and have been determined to have:

- an acceptable readiness to change level;
- minimal or manageable medical conditions;
- minimal or manageable withdrawal risks;
- emotional, behavioral and cognitive conditions that will not prevent the beneficiary benefiting from this level of care;
- minimal or manageable relapse potential; and
- a minimally to fully supportive recovery environment

SUD Service Intensity (outpatient and residential)

The medically necessary outpatient and residential services correspond to the frequency and duration of services established by the ASAM levels of care and are referred to as follows:

- Level 0.5 – Early Intervention
- Level 1.0 – Outpatient
- Level 2.1 – Intensive Outpatient
- Level 2.5 – Expanded Intensive Outpatient
- Level 3.1 - Clinically Managed Low-Intensity Residential Services
- Level 3.3 - Clinically Managed Population-Specific High-Intensity Residential Services
- Level 3.5 - Clinically Managed High-Intensity Residential Services

Enhanced Substance Use Disorder Services
Outpatient
Intensive Outpatient
Sub-Acute Detox
Residential Treatment

Intensive Home and Community Based Supports 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 **<u>all</u>** 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 ICF/IID level of care.
   - 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, 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 at least one other community-based Long Term Service and Support each month to maintain eligibility.

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 (including vehicle modifications)
Family Training
Goods and Services
Non Family Training
Out of Home, Non-Vocational Services
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
Enhanced Medical Equipment Supplies
Environmental Modifications (including vehicle modifications)
Family Training
Fiscal Intermediary Services
Non Family Training
Specialty Services/Therapies (Music, Recreational, Art, massage)
Respite
Prevention Services – Direct Model
Enhanced Transportation
Non Family Training

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 Training
Non Family Training
Children's Therapeutic Foster Care
Therapeutic Overnight Camping
Transitional Services
Transportation
Wraparound
Specialty Therapies (Music, Recreational and Art)

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.

There are no limitations of services that differ from Medicaid or CHIP State plan.

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	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.

IV. 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 enhanced SUD provider systems and provide or partner with traditional health plans to ensure access for persons with mild and moderate behavioral health disorders. These linkages are directly intended to identify and provide education, prevention and treatment and of modifiable health risk factors, provide Screening Brief Intervention Referral and Treatment (SBIRT) for persons with SUD, provide housing first initiatives and provide incentives for increased access to primary care and the coordinated tracking of High Utilizers of emergency department usage and hospital admissions/readmissions.

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 Waver 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 Exhibit 2, seven (7) of the PIHPs are formed by multiple CMHSP's (aka. Regional Entities) and three (3) are stand-alone PIHPs/CMHSPs

Exhibit 2

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) Centra Wellness Network (Manistee, Benzie) **North Country CMH** (Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, Otsego) **Northern Lakes CMH** (Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, Wexford)	**PIHP**	**Northern Michigan Regional Entity**

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

Northeast CMH (Alcona, Alpena, Montmorency, Presque Isle)		
Allegan CMH **Muskegon CMH** **Network 180** (Kent) Ottawa CMH West MI CMH (Lake, Mason, Oceana)	**PIHP**	**Lake Shore Regional Entity**
Barry CMH **Berrien CMH** **Kalamazoo CMH** **Pines CMH** (Branch) **St. Joseph CMH** **Summit Pointe CMH** (Calhoun) **Van Buren CMH** **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** **LifeWays CMH** (Jackson, Hillsdale) **Montcalm CMH** **Newaygo CMH** **Saginaw CMH** **Shiawassee CMH** **Tuscola CMH**	**PIHP**	**Mid State Health Network**
Washtenaw CMH **Lenawee CMH** **Livingston CMH** **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 **Lapeer CMH** **Sanilac CMH**	**PIHP**	**Region 10 PIHP**

St. Clair CMH		

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. The participant may direct the budget and directly contract with chosen providers.

If chosen, 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. There are two options for participants choosing to directly employ workers, the Choice Voucher System and/or Agency with Choice. In the first option, the participant is the common law employer and delegate's performance of the fiscal/employer agent functions to the Fiscal Intermediary (FI). 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 Choice Voucher System 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 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. Detailed guidance to PIHP entities is provided in the Agency with Choice Technical Advisory. A participant may select one or both options.

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 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. Participants are provided many options for Independent Advocacy, through involvement of a network of participant allies and independent supports brokerage. 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 individual plan of service and individual budget. The primary roles of the independent supports broker are to assist the participant in making informed decisions about what will work best for him/her, are consistent with his/her needs and reflect the participant's circumstances. 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 individual advocate 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 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. Each PIHP is required to contract with one or more fiscal intermediaries to provide financial management services. 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
- 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 implantation of complex care management, joint PIHP and MHP performances 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.

V. 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, the MDHHS proposes a start date on 4-1-16. Phase 1 of the demonstration will include the development of the evaluation, collection of bassline data, the further implementation and development of policy and statewide system reediness for a reformed SUD delivery system and the consolidation of the existing §1915(b) and §1915(c)

Waivers. Phase 2 (which may span demonstration years 2 and 3) may 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. Beginning on or before 1-1-17, both traditional 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 between traditional health plans, PIHP's and their respective provider networks.

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

As indicated above, Michigan's Pathway to Integration Waiver will not affect Medicaid eligibility or enrollment into the Specialty Service System. All current Medicaid beneficiaries who meet the medical necessity for the Specialty Service System will have a seamless transition. Participant notification will occur upon demonstration approval.

2) 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. As part of the demonstration, the state does hold the ability to change or modify the managed care payment and service delivery structure as described in section V.1 above.

VI. 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 C.

VII. 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.

1) Provide a list of proposed waivers and 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)
  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.

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

- 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.

VIII. Public Notice

Tribal notice was done on: 12-18-15
Public notice was done on: 12-18-15
Press release was done on: 12-18-15
Stakeholder notice was done on: 12-18-15
An electronic mailing list was used to notify the Tribes and stakeholders.
Tribal consultation was done on: TBD

Two Public hearings were held on the 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

Appendix A

Long Term Service and Supports

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?

☒ 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 March 31, 2016, the §1915(b)/(c) Children's Waiver Program and the Habilitation Supports Waiver (MI-16,R01) expires on March 28, 2016. The §1915(b)/(4) Waiver for Children with Serious Emotional Disturbances (MI-17.R01.MO1) expires on March 31, 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:

Mental Health Professional
An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following: a physician, psychologist, registered professional nurse licensed or otherwise authorized to engage in the practice of nursing under part 172 of the public health code (1978 PA 368, MCL 333.17201 to 333.17242),

licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code (1978 PA 368, MCL 333.18501 to 333.18518), licensed professional counselor licensed or otherwise authorized to engage in the practice of counseling under part 181 of the public health code (1978 PA 368, MCL 333.18101 to 333.18177), or a marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the public health code (1978 PA 368, MCL 333.16901 to 333.16915).

NOTE: The approved licensures for disciplines identified as a Mental Health Professional include the full, limited and temporary limited categories.

Qualified Intellectual Disability Professional (QIDP)
Individual with specialized training or one 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, or a licensed or limited-licensed professional counselor. 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 QIDP 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.

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 Autism Benefit, must have minimum of master's degree and one year of experience in the evaluation and treatment of children with autism spectrum disorder (ASD).

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: if case manager has only bachelor's degree without specialized training or experience, they must be supervised by a QMHP or QIDP. 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

Supports Coordinator: bachelor's degree in a human services field and one year of experience with population the supports coordinator will be serving. 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. Assistants or brokers: high school diploma and one year experience, and supervised by a qualified supports coordinator or case manager.

Supporting the Participant in Service Plan Development

Specify: (a) the supports and information that are made available to the individual (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the individual's authority to determine who is included in the process.

Essential Elements for Person-Centered Planning and Service Plan Development

The following characteristics are essential to the successful use of the PCP process with an individual and his/her allies.

1. **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.

2. **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.

3. **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.

4. **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.

5. **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process. See Section III below

6. **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.

7. **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.

8. **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 community 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 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. The Medicaid Provider Manual (MPM) permits independent facilitation to be provided to Medicaid beneficiaries as one aspect of the coverage called "Treatment Planning" MPM MH&SAA Chapter, Section 3.25. If the independent facilitator is paid for the provision of these activities, the PIHP may report the service under the code H0032. It is advisable that the CMHSP support independent facilitators in obtaining training in PCP, regardless of whether the independent facilitator is paid or unpaid.

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? [X] Yes [ ] No

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

[X] Administrative Staff [X] Transport Staff

[X] 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 [X] 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 [X]

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 (See Section 6.1 of this contract) 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

Self-determination is the value that people served by the public mental health system must be supported to have a meaningful life in the community. The components of a meaningful life include: work or volunteer activities that are chosen by and meaningful to person, reciprocal relationships with other people in the community, and daily activities that are chosen by the individual and support the individual to connect with others and contribute to his or her community. With arrangements that support self-determination, individuals have control over an individual budget for their mental health services and supports to live the lives they want in the community. The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported.

Person-centered planning (PCP) is a central element of self-determination. PCP is the crucial medium for expressing and transmitting personal needs, wishes, goals and aspirations. As the PCP process unfolds, the appropriate mix of paid/non-paid services and supports to assist the individual in realizing/achieving these personally defined goals and aspirations are identified.

The principles of self-determination recognize the rights of people supported by the mental health system to have a life with freedom, and to access and direct needed supports that assist in the pursuit of their life, with responsible citizenship. These supports function best when they build upon natural community experiences and opportunities. The person determines and manages needed supports in close association with chosen friends, family, neighbors, and co-workers as a part of an ordinary community life.

Person-centered planning and self-determination underscore a commitment in Michigan to move away from traditional service approaches for people receiving services from the public mental health system. In Michigan, the flexibility provided through its historical LTSS within its Specialty Service System, together with the Mental Health Code requirements of PCP, have reoriented organizations to respond in new and more meaningful ways.

Recognition has increased among providers and professionals that many individuals may not need, want, or benefit from a clinical regimen, especially when imposed without clear choice.

Many provider agencies are learning ways to better support the individual to choose, participate in, and accomplish a life with personal meaning. This has meant, for example, reconstitution of segregated programs into non-segregated options that connect better with community life.

Self-determination builds upon the choice already available within the public mental health system. In Michigan, all Medicaid beneficiaries who services through the public mental health system have a right under the Balanced Budget Act (BBA) to choose the providers of the services and supports that are identified in their individual plan of service "to the extent possible and appropriate." Qualified providers chosen by the beneficiary, but who are not currently in the network or on the provider panel, should be placed on the provider panel. Within the PIHP, choice of providers must be maintained at the provider level. The individual must be able to choose from at least two providers of each covered support and service and must be able to choose an out-of-network provider under certain circumstances. Provider choice, while critically important, must be distinguished from arrangements that support self- determination. The latter arrangements extend individual choice to his/her control and management over providers (i.e., directly employs or contracts with providers), service delivery, and budget development and implementation.

In addition to choice of provider, individuals using mental health services and supports have access to a full-range of approaches for receiving those services and supports. Agencies and providers have obligations and underlying values that affirm the principles of choice and control. Yet, they also have long-standing investments in existing programs and services, including their investments in capital and personnel resources. Some program approaches are not amenable to the use of arrangements that support self-determination because the funding and hiring of staff are controlled by the provider (for example, day programs and group homes) and thus, preclude individual employer or budget authority.

It is not anticipated that every person will choose arrangements that support self-determination. Traditional approaches are offered by the system and used very successfully by many people. An arrangement that supports self-determination is one method for moving away from predefined programmatic approaches and professionally managed models. The goals of arrangements that support self-determination, on an individual basis, are to dissolve the isolation of people with disabilities, reduce segregation, promote participation in community life and realize full citizenship rights.

The MDHHS supports the desire of people to control and direct their specialty mental health services and supports to have a full and meaningful life. At the same time, the Department knows that the system change requirements, as outlined in this policy and practice guideline, are not simple in their application. The Department is committed to continuing dialogue with stakeholders; to the provision of support, direction and technical assistance so the system may make successful progress to resolve technical difficulties and apparent barriers; and to achieve real, measurable progress in the implementation of this policy. This policy is intended to clarify the essential aspects of arrangements that promote opportunity for self-determination and define required elements of these arrangements.

Appendix B

Long Term Services 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.

Service: Community Living Supports (CLS)

Scope/Description:

The intent of CLS services 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.

CLS facilitate an individual's independence, productivity, and promote community inclusion and participation. The supports can be provided in the participant's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.) CLS services may not supplant State Plan services, such as Home Help or Expanded Home Help (assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living (ADLs) and shopping in the participant's or family's own unlicensed home) and Personal Care (assistance with ADLs in a certified specialized residential setting). Coverage for Community Living Supports includes:

Assisting, reminding, observing, guiding or training the participant with:

- Meal preparation;
- Laundry;
- Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these activities);
- Activities of Daily Living (ADLs), such as bathing, eating, dressing, personal hygiene;
- Shopping for food and other necessities of daily living.

In addition. CLS Coverage includes: Assisting, supporting and/or training the participant with:

- Money management;
- Non-medical care (not requiring nurse or physician intervention);
- Socialization and relationship building;

- Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through local DHHS or Medicaid health plan) from the participant's residence to community activities, among community activities, and from the community activities back to the participant's residence;
- Leisure choice and participation in regular community activities;
- Attendance at medical appointments; and
- Acquiring goods and services other than those listed under shopping
- 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.

If participants living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs and/or shopping, the participant must request Home Help, and if necessary Expanded Home Help, from local MDHHS. For these participants, CLS assistance for these activities 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 DHHS's allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

CLS may be used for those activities while the participant awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the participant requests it, the PIHP must assist with applying for Home Help or filling out and submitting a request for a Fair Hearing when the participant believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs based on the findings of the local DHHS assessment. CLS may also be used for those activities while the participant awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.

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.

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 ☐ Day ☐Week ☐ Month ☐Year ☐ Other, Describe:	____Day(s) ____Week(s) Month(s) ____Other: See note No.2 Page 1.	☒ Individual (list types): Personal assistant, CLS aide ☒ Agency (list types of agencies): Home care agency, staffing agency, or other PIHP network provider agency licensed children's foster care, licensed adult foster care	☐ Legally Responsible Person ☒Relative 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: Personal assistant, CLS aide License Required: ☐ Yes ☒ No Certificate Required: ☐ Yes ☒ No Describe: Other Qualifications Required for this Provider Type (please describe):	Provider Type: Home care agency, staffing agency, or other PIHP network provider agency License Required: ☐ Yes ☐ No Certificate Required: ☐ Yes ☐ No Describe: Other Qualifications Required for this Provider Type (please describe):	Provider Type: Licensed children's foster care, licensed adult foster care License Required: ☒ Yes ☐ No 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) Certificate Required: ☐ Yes ☒ No Describe:

				Aides must meet criteria specified in the Michigan PIHP/CMHSP Provider Qualification Code Chart:	For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.	**Other Qualifications Required for this Provider Type (please describe):** n/a

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 ☐ Day ☐ Week ☐ Month ☐ Year ☐ Other, Describe:	Day(s) Week(s) Month(s) Other: See note No.2 Page 1.	☐ Individual (list types): ☒ Agency (list types of agencies): Medicaid Enrolled Durable Medical Equipment and Supplies Provider Licensed builder or contractor Other vendor as appropriate to the service or supply	☐ Legally Responsible Person ☐Relative/Legal Guardian:	**Provider Type:** Durable Medical Equipment and Supplies Provider **License Required:** ☐ Yes ☒ No **Certificate Required:** ☐ Yes ☒ No **Describe:** **Other Qualifications Required for this Provider Type (please describe):** The durable medical equipment and supplies (DMES) provider must meet any requirements by private insurance, Medicare or Medicaid as appropriate.	**Provider Type:** Licensed builder or contractor **License Required:** ☒ Yes ☐ No Licensed builder or contractor who holds current Michigan license under MCL 339.601(1); MCL 339.601.2401; MCL 339.601.2403(3) **Certificate Required:** ☐ Yes ☒ No **Describe:** **Other Qualifications Required for this Provider Type (please describe):**	**Provider Type:** Other vendor as appropriate to the service or supply **License Required:** ☐ Yes ☒ No **Certificate Required:** ☐ Yes ☒ No **Describe:** **Other Qualifications Required for this Provider Type (please describe):**

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 **☐ Day** **☐ Week** **☐ Month** **☐ Year** **☐Other, Describe:**	**_____Day(s)** **_____Week(s)** **_____Month(s)** **Other:** See note No.2 Page 1.	**☐ Individual (list types):** **☒ Agency (list types of agencies):** Retailers	**☐ Legally Responsible Person** **☐Relative/Legal Guardian:**	**Provider Type:** Retailers **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Retailers must sell the enhanced pharmacy items. Participants may freely select the provider based on location or other factors.

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 **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:**	**_____Day(s)** **_____Week(s)** **Month(s)** **Other:** See note No.2 Page 1.	**☐ Individual (list types):** **☒ Agency (list types of agencies):** Licensed Building Contractor	**☐ Legally Responsible Person** **☐Relative/Legal Guardian**	**Provider Type:** Licensed Building Contractor **License Required:** **☒ Yes ☐ No** MCL 339.601(1); MCL 339.601.2401; MCL 339.601.2403(3) **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** n/a

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 **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:**	**Day(s)** **Week(s)** **Month(s)** **Other:** See note No.2 Page 1.	**☒ Individual (list types):** Clinical professional (psychologist, social worker, family therapist, licensed professional counselor, occupational	**☐ Legally Responsible Person** **☐Relative/Legal Guardian**	**Provider Type:** Clinical professional (psychologist, social worker, family therapist, licensed professional counselor, occupational therapist, physical therapist, speech therapist, nurse, BCBA) **License Required:** **☒ Yes ☐ No**	**Provider Type:** Trained parent support partner **License Required:** **☐ Yes ☒ No**	**Provider Type:** Home care agencies, clinic service agency providers, outpatient clinics **License Required:** **☒ Yes ☐ No** The provider must maintain any current registration, license, certification or

		therapist, physical therapist, speech therapist, nurse), Board Certified Behavioral Analyst (BCBA). Trained parent support partner **☒ Agency (list types of agencies):** Home care agencies, clinic service agency providers, outpatient clinics		The provider must maintain any current registration, license, certification or credentialing required by his or her profession to practice in the State of Michigan. **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** 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.	**Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** 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.	credentialing required by his or her profession to practice in the State of Michigan. **Certificate Required:** **☒ Yes ☐ No** **Describe:** The social worker credential must be a "licensed master's social worker" as defined by Section 18509 of PA 368 of 1978. **Other Qualifications Required for this Provider Type (please describe):** Training being provided must fall within the scope of practice of the agency personnel providing the service.

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 **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:**	**_____Day(s)** **_____Week(s)** **_____Month(s)** **Other:** See note No.2 Page 1.	**☒Individual (list types):** Examples include: accountant, financial advisor/manager, and attorney **☒ Agency (list types of agencies):** Examples include: financial management services agency, accounting firm, local ARC, other advocacy organization, other non-profit agencies	**☐ Legally Responsible Person** **☐Relative/Legal Guardian**	**Provider Type: Individual** **License Required:** **☐ Yes ☐ No** **Certificate Required:** **☐ Yes ☐No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** The license and certificate requirements depend upon the type of provider.	**Provider Type: Agency** **License Required:** **☐ Yes ☐ No** **Certificate Required:** **☐ Yes ☐No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** The license and certificate requirements depend upon the type of agency.

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 **☐ Day** **☐ Week** **☐ Month** **☐ Year** **☐ Other, Describe:**	**_____Day(s)** **_____Week(s)** **_____Month(s)** **Other:** See note No.2 Page 1.	**☐ Individual (list types):** **☒ Agency (list types of agencies):** Goods and services provider	**☐ Legally Responsible Person** **☐ Relative/Legal Guardian**	**Provider Type:** Goods and services provider **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Provider must be reputable and able to provide the good or service necessary.

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 **Per** **☒ Day** **☐Week** **☐ Month** **☐Year** **☒ Other, Describe:** 12 sessions per 90 days; Reportable encounter must be at least 45 minutes .	**____Day(s)** **____Week(s)** **Month(s)** **____Other:** See note No.2 Page 1.	**☒ Individual (list types):** 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). **☒ Agency (list types of agencies):**	**☐ Legally Responsible Person** **☐Relative/Legal Guardian:**	**Provider Type:** Individual Clinician **License Required:** **☒ Yes ☐ No** As applicable to the clinician, and as detailed in the Michigan PIHP/CMHSP Provider Qualification Code Chart, must hold a current Michigan license **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** 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 All clinicians must provide non-family training within the scope of their professional practice	**Provider Type:** Agency **License Required:** **☐ Yes ☐ No** **Certificate Required:** **☐ Yes ☐ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Agency qualifications are dependent on the type of agency and are not specific to this service. 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.

		Staffing agency, home care agency, clinical service agency, out-patient clinic, other PIHP network provider agency			

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 **☒ Day** **☐ Week** **☐ Month** **☐ Year** **☒Other, Describe:** 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)** **Week(s)** **Month(s)** **Other:** See note No.2 Page 1.	**☒ Individual (list types):** Aide **☒ Agency (list types of agencies):** Staffing agency, home care agency or other subcontractor Community-based non-residential settings operated by CMHSP or other subcontractor	**☐ Legally Responsible Person** **Relative** 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:** Aide **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Aides must meet criteria specified in the Michigan PIHP/CMHSP Provider Qualification Code Chart.	**Provider Type:** Staffing agency, home care agency or other subcontractor **License Required:** **☐ Yes ☐ No** **Certificate Required:** **☐ Yes ☐No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.	**Provider Type:** Community-based non-residential settings operated by CMHSP or other subcontractor **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

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 **☐ Day** **☐Week** **☐ Month** **☐Year** **☐Other, Describe:**	**_____Day(s)** **_____Week(s)** **_____Month(s)** **Other:** See note No.2 Page 1.	**☐ Individual (list types):** **☒ Agency (list types of agencies):** PERS provider	**☐ Legally Responsible Person** **☐Relative/Legal Guardian**	**Provider Type:** **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** 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. 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. c. The response center must maintain the monitoring capacity to respond to all incoming emergency signals. 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.

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:
Per **☐ Day** **☐ Week** **☐ Month** **☐ Year** **☐Other, Describe:** .	**_____Day(s)** **_____Week(s)** **_____Month(s)** **Other:** See note No.2 Page 1.	**☒ Individual (list types):** Prevocational support staff **☒ Agency (list types of agencies):** Community-based prevocational program operated by CMHSP or other subcontractor	**☐ Legally Responsible Person** **Relative** 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:** Prevocational support staff **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** 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	**Provider Type:** Community -based prevocational program operated by CMHSP or other subcontractor **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

				outcome of achieving competitive employment.	

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:
Per **☐ Day** **☐ Week** **☐ Month** **☐ Year** **☐Other, Describe:** .	**_____Day(s)** **_____Week(s)** **_____Month(s)** **Other:** See note No.2 Page 1.	**☒ Individual (list types):** Skill Building support staff **☒ Agency (list types of agencies):** Community-based Skill Building Servcies/ program operated by CMHSP or other subcontractor	**☐ Legally Responsible Person** **Relative** 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:** Skill Building support staff **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** The support staff must, at a minimum, meet provider qualifications for an aide	**Provider Type:** Community –Skill Building Services/programs operated by CMHSP or other subcontractor **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):**

				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.	For services delivered in the community, the agency must assure its employees are knowledgeable in the community opportunities available in the area.

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:
4 sessions **Per** ☐ **Day** ☐ **Week** ☒ **Month** ☐ **Year** ☒ **Other, Describe:**	**Day(s)** **Week(s)** **Month(s)** **Other:** See note No.2 Page 1.	☒ **Individual (list types):** Massage Therapist, Therapeutic Recreation Specialist, Music Therapist, Art Therapist ☒ **Agency (list types of agencies):** Home care agency, clinical service agency, out-patient clinic, other PIHP network provider agency	☐ **Legally Responsible Person** ☐ **Relative/Legal Guardian:**	**Provider Type:** Individual Therapist **License Required:** ☒ **Yes** ☐ **No** Massage Therapists must hold a current Michigan license, issued pursuant to the Public Health Code as amended by Public Act 471 of 2008. **Certificate Required:** ☒ **Yes** ☐ **No** **Describe:** 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	**Provider Type:** Agency **License Required:** ☐ **Yes** ☐ **No** **Certificate Required:** ☐ **Yes** ☐ **No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Agency qualifications are dependent on the type of

				Massage and Bodywork (NCBTMB). **Other Qualifications Required for this Provider Type (please describe):**	agency and are not specific to this service. 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.

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:
Per **☐ Day** **☐ Week** **☐ Month** **☐ Year** **☐Other, Describe:**	**_____Day(s)** **Week(s)** **Month(s)** **Other:** See note No.2 Page 1.	**☒ Individual (list types):** Services and Supports Broker Supports Coordinator Assistant Supports Coordinator **☒ Agency (list types of agencies):** Supports Coordination Agency	**☐ Legally Responsible Person** **Relative** 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	**Provider Type:** Service and Supports Broker **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):**	**Provider Type:** Supports Coordinator Assistant **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):**	**Provider Type:** Supports Coordinator **License Required:** **☒ Yes ☐ No** 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. **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** 1. Chosen by the participant. 2. The independent supports coordinator must be a	**Provider Type:** Supports Coordination Agency **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider**

			the participant that are not excluded in the preceding sentence.	1. Chosen by the participant. 2. Minimum of a high school diploma and demonstrated skills and knowledge to perform the functions. 3. Functions under the supervision of a supports coordinator.	1. Chosen by the participant. 2. Minimum of a high school diploma and one year of experience working directly with people who have developmental disabilities. 3. Functions under the supervision of a supports coordinator.	QIDP, QMHP, MHP, CMHP, as defined in the Michigan PIHP/CMHSP Provider Qualification Code Chart: An individual who meets the qualifications under 42 CFR 483.430. A QIDP is a person who has specialized training or one year of experience in treating or working with a person who has intellectual/developmental disabilities; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QIDP prior to January 1, 2008.	**Type (please describe):** 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. In addition, the agency must maintain a pool of qualified supports coordinators from which the participant can choose. The supports 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.

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:
_____ Per **☐ Day** **☐ Week** **☐ Month** **☐ Year** **☐ Other, Describe:**	**_____Day(s)** **Week(s)** **Month(s)** **_____Other:** See note No.2 Page 1.	**☒ Individual (list types):** Independent Nurse (RN or LPN) Individual aide level respite provider **☒ Agency (list types of agencies):** Licensed Camp Staffing agency, home care agency, other PIHP network provider agency Licensed children's foster care, licensed adult foster care	**☐ Legally Responsible Person** **☐Relative** 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:** Independent Nurse (RN or LPN) **License Required:** **☒ Yes ☐ No** 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 **Certificate Required:** **☐ Yes ☐ No** **Describe:**	**Provider Type:** Individual aide level respite provider **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type**	**Provider Type:** Licensed Camp **License Required:** **☒ Yes ☐ No** Children's Camps: MCL 722.111, MCL 330.1153, Act 116 of 1973, Act 218 of 1978 as amended, Administrative Rule 400.11101-.11413 Adult's Camps: MCL 400.703, Act 218 of 1979 as amended, Administrative Rule 400.11101-.11413 **Certificate Required:** **☐ Yes ☒ No** **Describe:**	**Provider Type:** Staffing agency, home care agency, other PIHP network provider agency **License Required:** **☒ Yes ☐ No** Hands-on provider must meet RN.LPN or aide level eligibility requirement specified in this section. **Certificate Required:** **☐ Yes ☒ No** **Describe:**	**Provider Type:** Licensed children's foster care, licensed adult foster care. **License Required:** **☒ Yes ☐ No** 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) **Certificate Required:** **☒ Yes ☒ No** **Describe:**

				Other Qualifications Required for this Provider Type (please describe): 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.	**(please describe):** Aides must meet criteria specified in the Michigan PIHP/CMHSP Provider Qualification Code Chart:	**Other Qualifications Required for this Provider Type (please describe):** The camp must assure its employees are knowledgeable in the unique abilities, preferences and needs of the individual(s)	**Other Qualifications Required for this Provider Type (please describe):** 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.	**Other Qualifications Required for this Provider Type (please describe):** n/a

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:
<u>16 hours</u> **Per** **☒ Day** **☐ Week** **☐ Month** **☐ Year** **☐ Other, Describe:** .	**____Day(s)** **____Week(s)** **____Month(s)** **____Other:** See note No.2 Page 1.	**☒ Individual (list types):** Private Duty Nurse (RN or LPN) **☒ Agency (list types of agencies):** Private duty nursing agency, home care agency	**☐ Legally Responsible Person** **☐ Relative** 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:** Private Duty Nurse (RN or LPN) **License Required:** **☒ Yes ☐ No** The nurse (RN or LPN) must have a current license in good standing with the State of Michigan under MCL 333.17211 **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** A Licensed Practical Nurse (LPN) must be working under the supervision of an RN.	**Provider Type:** Home care agency, staffing agency, private duty nursing agency, or other PIHP network provider agency **License Required:** **☐ Yes ☐ No** **Certificate Required:** **☐ Yes ☐ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** 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.

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:
10 hours Per **☒ Day** **☐ Week** **☐ Month** **☐ Year** **☐ Other, Describe:** .	**____Day(s)** **____Week(s)** **____Month(s)** **____Other:** See note No.2 Page 1.	**☒ Individual (list types):** Employment specialist, Personal assistant, Individual job coach **☐ Agency (list types of agencies):**	**☐ Legally Responsible Person** **☐Relative**	**Provider Type:** Employment specialist, Personal assistant, Individual job coach **License Required:** **☐ Yes ☒ No** **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Qualifications of providers depend upon the service

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** ☐ **Day** ☐ **Week** ☐ **Month** ☐ **Year** ☐ **Other, Describe:**	____**Day(s)** ____**Week(s)** ____**Month(s)** ____**Other:** See note No.2 Page 1.	☐ **Individual (list types):** ☒ **Agency (list types of agencies):** A licensed family foster home contracted to the PIHP	☐ **Legally Responsible Person** ☐**Relative/Legal Guardian:**	**Provider Type:** A licensed family foster home contracted to the PIHP **License Required:** ☒ **Yes** ☐ **No** Child Therapeutic Foster Care (CTFC) providers are licensed by the Michigan Department of Licensing and Regulatory Affairs under MCL 722.122 **Certificate Required:** ☒ **Yes** ☐ **No** **Describe:** CTFC providers must be certified by MDHHS. **Other Qualifications Required for this Provider Type (please describe):** The child foster care home must be contracted by the PIHP to provide child therapeutic foster care services.

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 **Per** **☐ Day** **☐ Week** **☐ Month** **☒ Year** **☐ Other, Describe:** A session can be multiple days but must include at least one night.	**____Day(s)** **____Week(s)** **____Month(s)** **____Other:** See note No.2 Page 1.	**☐ Individual (list types):** **☒ Agency (list types of agencies):** Camps	**☐ Legally Responsible Person** **☐Relative/Legal Guardian:**	**Provider Type:** Camps **License Required:** **☒ Yes ☐ No** Camps are licensed by Michigan Department of Licensing and Regulatory Affairs **Certificate Required:** **☐ Yes ☒ No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):** Camp staff is trained in working with children with SED.

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 ☐ Day ☐ Week ☐ Month ☐ Year ☒ **Other, Describe:** Once per consumer	_____Day(s) Week(s) Month(s) Other: See note No.2 Page 1.	☒ **Individual (list types):** As appropriate to the service, an individual contracted by the PIHP. ☒ **Agency (list types of agencies):** As appropriate to the service, an agency contracted by the PIHP.	☐ **Legally Responsible Person** ☐**Relative/Legal Guardian:**	**Provider Type:** As appropriate to the service, an individual contracted by the PIHP. **License Required:** ☒ **Yes** ☐ **No** 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. **Certificate Required:** ☐ **Yes** ☒ **No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):**	**Provider Type:** As appropriate to the service, an agency contracted by the PIHP. **License Required:** ☒ **Yes** ☐ **No** 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. **Certificate Required:** ☐ **Yes** ☒ **No** **Describe:** **Other Qualifications Required for this Provider Type (please describe):**

Appendix C

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.

<u>DAB, TANF, and HSW populations</u>

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.

<u>Autism Benefit</u>

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	$ -	$ -	$ -	$ -	$ -	$ -