STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

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April 30, 2010

TO: Prepaid Inpatient Health Plan Directors

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

SUBJECT: Adult Benefits Waiver Implementation Guidance

As of May 1, 2010, the implementation of the Adult Benefits Waiver (ABW) program of services for eligible individuals in need of mental health or substance abuse services will be initiated through the Prepaid Inpatient Health Plan (PIHP) entities. The current arrangement whereby ABW funds have been prepaid to all Community Mental Health Services Programs (CMHSPs) for mental health services and to Substance Abuse Coordinating Agencies (CAs) for substance use disorders will cease. The purpose of this memorandum is to provide guidance regarding implementation of the Medicaid 1115(a) ABW waiver through the PIHPs, and to provide a response to related questions, as follow-up to the April 5, 2010 implementation meeting with representatives from the PIHPs.

PIHP Responsibility

The PIHP shall implement the ABW program, effective May 2010. The PIHP is responsible for assuring services to all eligible ABW beneficiaries, regardless of MH/DD/SA diagnosis, located in its service area through the ABW program as outlined in the MDCH/PIHP ABW contract. This includes requirements applicable to PIHPs under the Balanced Budget Act (BBA) 1997 regulations that now apply because of the program's move from Title XXI funding to Title XIX funding.

The Use Tax is applicable to the PIHP effective with the May 2010 ABW payments. Given the timing of the ABW payment (generally, the 4th Thursday of the month) it is likely that PIHPs will find it necessary to estimate the associated Use Tax obligation for the ABW revenue in order to be able to make timely payment.

Implementation of the ABW program under Title XIX changes the nature of the program substantially from the past method, where ABW was directly contracted for and managed by CMHSPs for mental health services and by CAs for substance use disorders. With conversion of the program to Medicaid managed care, this option is no longer possible. The PIHP is responsible for procuring, contracting with, and naming a provider network that delivers the

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ABW services array to ABW beneficiaries in the service area. However, it is MDCH's goal that, as much as possible, the opportunity for CMHSPs and CAs to participate as provider networks managing the service benefit in their own area should be maintained, within the overall framework of PIHP accountability for contracted expectations in the PIHP region. The PIHP has the authority to determine how to implement the ABW program across its region. Subcontracting arrangements that the PIHP establishes with its provider networks may include subcapitation arrangements, though these or any other arrangements must meet the requirements of Section 6.4.2 Subcontracting.

Service Benefits

At the April 5 ABW implementation meeting with PIHPs, MDCH described a proposed modified ABW service package with mandatory and optional benefits, and annual limits developed by the work group. However, based on feedback and questions raised at that meeting and examination of the as-yet unclear effect of meeting federal mental health parity regulations, MDCH gave this matter further consideration and decided to delay action to make any policy changes that would affect the current ABW benefits currently described in the Medicaid Provider Manual until at least FY 11.

MDCH is pursuing the revision of the current medical necessity language for specialized services support for the ABW program. Any revisions made would be finalized for the July 2010 Medicaid Provider Manual revision following the standard public comment period.

While these changes have not yet been made in the Medicaid Provider Manual, there are certain points that need to be reiterated about the ABW program.

- No co-payments for mental health or substance abuse services.
- There are no ABW diagnosis-specific eligibility criteria as there are in the Specialty Services Program. Since there is no other mental health or substance abuse benefit available, any ABW beneficiary requesting covered services that are medically necessary – either mental health or substance abuse – must be served. Waiting lists for medically necessary ABW services are not permissible.
- Specific psychotropic injectible drugs administered through the PIHP/CMHSP clinic to an ABW beneficiary are reimbursed by MDCH on a fee-for-service basis if certain criteria are met—see Section 2 of the ABW Chapter of the Medicaid Provider Manual.

Managing Risk

It is required that FY10 ABW revenues be used as the first source of funding for services for ABW beneficiaries, then any ABW reserves resulting from remaining unobligated ABW revenues paid to CMHSPs and CAs prior to the onset of the PIHP-centered contractual arrangement and before use of any other General Fund (GF) or state agreement allocations. Mental health GF appropriations allocated to CMHSPs are reserved for individuals with mental health or developmental disability needs; substance abuse GF appropriations allocated to CAs are reserved for treatment of substance use disorders. Therefore, CMH GF allocation revenues may not be utilized to cover substance abuse services needs for ABW beneficiaries. Likewise,

substance abuse revenues may not be utilized to cover mental health and developmental disability services needs for ABW beneficiaries.

The MDCH/PIHP contract for the ABW program is a full risk contract and the PIHP has flexibility in terms of how risk is covered. Under this full risk arrangement any remaining funds convert in the subsequent year to local revenue. No other Medicaid revenue or Medicaid savings accruing from the MDCH/PIHP Specialty Services Waiver program may be used to meet ABW risk or for services for ABW beneficiaries.

It is permissible for CMHSP GF allocations and CA-SA state agreement allocations to be used to manage risk, with the following constraints:

- Risk must be covered by existing/remaining allocations to the CMHSP and the CA—allocations will not be redistributed to PIHPs for this purpose.
- CMHSP funds cannot be used to cover substance abuse services risk, and substance abuse funds cannot be used to cover mental health services risk.
- The priority population and other state agreement contractual requirements of the CA must continue to be covered irrespective of use of these state agreement funds for ABW risk. Correspondingly, CMHSP priority population needs must also continue to be met.

Examples of risk management tools include pooling mental health ABW revenue across affiliates or CAs, sharing risk across a PIHP affiliation, establishing a single risk pool across multiple PIHPs, and/or the designation of local funds. Correspondingly, while savings will convert to local funds in the subsequent year, "where" these funds are held would be a local matter. After conversion to local funds, there are no state restrictions regarding the use of these local funds.
For the FY10 transition year, any FY10 ABW revenue (SCHIP, ABW Medicaid prior to May 2010 and ABW Medicaid from May forward) can be used to provide ABW covered services to ABW beneficiaries during FY10 so long as the ABW revenue provided to the PIHP under the new contract has been used first. However, substance abuse ABW revenue cannot be used for mental health services and mental health ABW revenue cannot be used for substance abuse services.

For those individuals with co-occurring mental health and substance use disorders, integrated treatment can be funded through either benefit.

Rates and Payments

May 2010 payments will be made to the PIHPs subject to a signed MDCH/PIHP ABW contract. The April 16, 2010 Milliman rate correspondence sent under Irene Kazieczko's signature on April 20, 2010 will be an attachment to this contract.

Also note:

- Unspent funds convert to local revenue in the subsequent year and could then be used to cover risk on either the mental health side or the substance abuse side.
- Mental health and substance abuse revenue and expenditures will be cost settled separately.

The certified ABW rates for FY10 incorporate consideration for administrative costs. The substance abuse benefit includes an 8% administrative load for the substance abuse benefit and 7.5% for the mental health benefit.

The ABW rate development recognizes the cost experience for ABW services and the additional BBA compliance related administrative costs. Rate setting methodology for future years will attempt to build in factors that can include recognition of morbidity and other variables, to the extent these can be ascertained.

Enrollment

Enrollment will remain frozen throughout FY10; enrollment will periodically re-open in FY11 depending on the availability of state match funds. Statewide, enrollment is declining by about 6% each month.

Transition

BBA requires that notification be made to ABW beneficiaries when changes are made that impact their ABW services. Each PIHP will be implementing this ABW program and needs to determine whether the way it will implement the ABW program will necessitate providing notice to ABW beneficiaries.

Financial Reporting and Settlement

DCH will require transparency in ABW financial reporting and, in general, will follow the FSR Medicaid reporting format. Cost settlement will take place separately for the October-December 2009 period, January through April 2010, and May through September 2010 due to the differences in fund source and administration of the ABW waiver. Revised FY10 FSR reporting and settlement forms will be issued separately as soon as these are available.

For FY10, there will NOT be any FY10 MUNC reporting for ABW expenditures or services. This will change for FY11. ABW federal reporting requirements are based on date of service, not date of payment. This is different from the Specialty Services and Supports Waiver.

Budget

In general, the CMHSP ABW spending pattern is below the appropriated $40 million gross. However, CMHSPs should not expect redistribution of unpaid ABW GF dollars at year end due to the change in SCHIP federal match. In FY11, due to the loss of the SCHIP enhanced federal match rate, the Executive Budget reflects a reduction of about $8 million.

QI and Encounter Reporting

Current information suggests that not all CMHSPs and CAs have been correctly identifying and reporting ABW beneficiaries and/or spending. Since encounters will be used for subsequent year rate setting, it is important that ABW beneficiary IDs be reported.

Questions

Questions regarding the ABW service benefit and notice requirements should be directed to Judy Webb at webb@michigan.gov; regarding the DCH/PIHP ABW contract to John Duvendeck at duvendeck@michigan.gov; and questions regarding general administrative matters to Doris Gellert at gellert@michigan.gov.

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