



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

ANIFER M. GRANHOLM  
GOVERNOR

JANET OLSZEWSKI  
DIRECTOR

March 11, 2004

**TO:** Executive Directors of Michigan's Specialty Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs)

**FROM:** Patrick Barrie<sup>PB</sup>, Deputy Director  
Mental Health and Substance Abuse Administration

**SUBJECT:** Changes Related to the Renewal of the Medicaid Specialty Services Waiver

As you know, on December 9, 2003, the Centers for Medicare and Medicaid Services (CMS) approved the Department of Community Health's (DCH) request to renew the Medicaid specialty services and supports waiver program. However, to ensure compliance with provisions of the Balanced Budget Act (1997) and the federal regulations promulgated pursuant to that Act (42 CFR, Part 438), CMS stipulated that the state make several significant changes in waiver payment method, service taxonomy, and contractual provisions. This memo briefly summarizes these changes, and provides direction on other issues pertinent to PIHP and CMHSP operation.

OVERVIEW OF RENEWAL-RELATED CHANGES

The final federal regulations related to the BBA became effective on August 13, 2003. One requirement set forth in the BBA and the final regulations is the stipulation that capitation rates paid under the waiver program be "actuarially sound."<sup>1</sup> During waiver renewal negotiations, CMS provided additional guidance regarding how the state should structure, calculate, and adjust waiver capitation rates and payment arrangements to ensure compliance with this provision of the BBA and associated regulations.

The application of CMS guidance on actuarial soundness to Michigan's specialty services program has produced major modifications in waiver rate-setting methodology and payment procedures. The most significant changes are as follows:

- Previously, the managed specialty services program was regarded as a "combination" 1915(b)/1915(c) program, and capitation payments for the 1915(b) portion of the waiver were combined (in the developmental disabilities capitation) with payments for 1915(c) waiver beneficiaries and services. Under the waiver renewal, however, capitation payments for the 1915(c) Habilitation Supports Waiver will be made **separately** from the 1915(b) waiver capitation payments, and exclusively for 1915(c) **enrolled beneficiaries** who receive a 1915(c) waiver service within the payment month.

<sup>1</sup> See 42 CFR 438.6(2)

- Under prior waiver conditions, capitation payments reflected separate amounts for Medicaid mental health services, developmental disability services and substance abuse services. Under terms of the renewal, payment for Medicaid mental health services and developmental disability services (minus Habilitation Support Waiver reimbursement, now paid monthly in the separate capitation for enrolled beneficiaries) in the 1915(b) waiver will be **combined** in rate calculations and in the monthly capitation payout. Capitation payment for substance abuse services under the 1915(b) waiver will continue to be separately calculated and identified.
- Previously, while PIHPs received payments in the 1915(b) portion of the program for Medicaid “state plan” services, they could also use capitation funds to provide – under the authority of section 1915(a)(1)(A) of Title XIX of the Social Security Act – certain other “alternative” services to beneficiaries. Under the waiver renewal, the ability to provide such services remains, but the **authority** under which these services are provided has changed from 1915(a)(1)(A) to 1915(b)(3). Situating these services within the 1915(b) waiver means that the coverage responsibilities of the PIHP now include **both state plan and (b)(3) services**. All waiver services are now subject to amount, scope, and duration considerations, medical necessity determination, and notice and appeal requirements.
- PIHP payments under the 1915(b) waiver for mental health/developmental disabilities services and for substance abuse services will be **split** between an amount for state plan services and an amount for (b)(3) services.
- In calculating the payment split amounts, 1915(b) state plan services were estimated at 68% of the adjusted 1915(b) mental health/developmental disabilities aggregate capitation payment, and 84% of the adjusted substance abuse aggregate capitation payment. Hence, (b)(3) services are 32% of the adjusted mental health/developmental disabilities aggregate capitation payment, and are 16% of the adjusted substance abuse aggregate capitation payment.
- Payment under this new structure (i.e., separate 1915(c) payment, split 1915(b) state plan/(b)(3) services payments) will begin with the April 2004 payment. Since CMS certified this methodology and the rate structure as actuarially sound effective January 1, 2004, adjustments for the January 2004 through March 2004 payments (made under the old methodology) will be made in the May 2004 payment.
- The pre-payment for 1915(b) state plan and (b)(3) services is scheduled to be made on the first Wednesday of each month. For those PIHPs opting to receive payment via Electronic Funds Transfer (EFT), the payment will be available on Thursday following the first Wednesday of each month.
- The pre-payment for the 1915(c) Habilitation Supports Waiver is scheduled to be issued on the second Wednesday of each month. For those PIHPs opting to receive payment via EFT, the payment will be available on Thursday following the second Wednesday of each month.

As you will note, these changes in payment arrangements and service coverage are substantial. With payments being made for different purposes and benefits, PIHPs have inquired regarding how they might manage these different funding “buckets” and responsibilities. After consultation with CMS we can provide the following guidance:

- On a month-to-month basis, the PIHP can have flexibility and interchangeably expend capitation payments received through the three sources or “buckets.” That is, once capitation payments are received, the PIHP may spend any funds received on 1915(b) state plan services, (b)(3) services, or 1915(c) waiver services (with the caveat that the money is spent on Medicaid beneficiaries for Medicaid services).
- However, while there is flexibility in month-to-month expenditures and service utilization related to the three “buckets,” the PIHP must keep in mind three important considerations:
  - The PIHP must submit encounter data on service utilization – with procedure codes that identify the service as 1915(b) state plan, (b)(3) services, or 1915(c) services (the latter should always be accompanied by an HK modifier). This encounter data (including cost information) will serve as the basis for future 1915(b) state plan, (b)(3) services, and 1915(c) waiver capitation rate development.
  - The PIHP has certain coverage obligations to Medicaid beneficiaries under the 1915(b) waiver (both state plan and (b)(3) services), and to enrollees under the 1915(c) waiver (such as provision of a Habilitation Supports Waiver service each month to each enrollee). It must use capitation payments to address these obligations.
  - The PIHP must monitor and track expenditures on 1915(b) state plan services, (b)(3) services, and 1915(c) services, and the PIHP and DCH must work together to assure that aggregate expenditures for (b)(3) services **do not grow or rise faster** than the respective aggregate expenditures for 1915(b) state plan and 1915(c) services. The requirements for tracking expenditures will be included in the contract amendment between DCH and the PIHPs (Note: PIHPs must include these requirements in their Medicaid-related contracts with CMHSP affiliates).

Beyond alterations in rate calculations, payment methodology, reporting requirements, expenditure tracking and coverage obligations, the renewal of the waiver also entails changes in the risk corridor arrangement, the method for determining and settling Medicaid specialty services “savings,” and the conditions regarding subsequent use of Medicaid savings.

- The risk corridor (savings/losses) is now “symmetrical.” The PIHP will now be able to carry forward a maximum of 7.5% of aggregate Medicaid capitation payments (all three Medicaid sources) made by the state to the PIHP. Savings related to payments for 1915(b) state plan and (b)(3) **substance abuse services** are now **included** in the calculation of the maximum 7.5% savings on aggregate capitation payments (i.e., funds paid to the Coordinating Agencies subcontracted to manage Medicaid substance abuse benefits are **no longer** settled separately).
- Medicaid savings – within the corridor – claimed by the PIHP **must** be spent in the next fiscal year according to a community reinvestment plan that has received prior approval from both the Department of Community Health (DCH) and the Centers for Medicare and Medicaid Services (CMS). DCH and CMS **jointly retain an exclusive right** to determine the acceptability and approval of the community reinvestment plan.
- Medicaid savings may only be used to provide approved services to Medicaid beneficiaries, as specified in the approved community reinvestment plan.

- The new risk corridor arrangement and the community reinvestment plan approval requirement will be specified in an amendment to the current DCH-PIHP contract, and will be included in the master DCH-PIHP contract in subsequent contract years.

#### CHANGES IN THE 1915(C) HABILITATION SUPPORTS WAIVER

The renewal of the 1915(b) waiver has precipitated (due to constraints imposed by the BBA and federal regulations) significant changes in the way the 1915(c) Habilitation Supports Waiver is funded and managed, within the 1915(b)/1915(c) concurrent waiver program framework. Below is a list of some of the prominent changes. A more complete description of changes in the operation of the 1915(c) waiver will be forwarded to you in a separate correspondence.

- The separation of 1915(c) waiver and 1915(b) waiver capitation payments created some difficulties for DCH in estimating aggregate fiscal year Medicaid capitation payments under the two waivers, and in projecting cumulative expenditures against the amount appropriated for the managed specialty services program (see P.A. 159 of the Public Acts of 2003).
- To maintain aggregate program payments within the limits of state appropriations (and consistent with actuarial soundness requirements), DCH requested (and was granted) an amendment to the 1915(c) waiver. The amendment caps waiver enrollment (the "c-value" or unduplicated yearly count) at the number of active waiver certificates/enrollees (as of September 30, 2003), plus a small number of certificates reserved for "targeted" enrollment of individuals who will age-out of the Children's Waiver, and for those individuals with a developmental disability who will exit the state's ICF/MR center (Mt. Pleasant) before September 30, 2004. The total number of 1915(c) waiver certificates for this fiscal year (FY 03-04) is 7,900.
- DCH requires central office authorization of new 1915(c) waiver enrollments and approval of annual recertifications (beginning October 1, 2003). DCH personnel will review PIHP enrollment and/or recertification information, and approve (within the constraint of the total yearly number of available waiver certificates and targeted populations) those that are in compliance with waiver enrollment qualifications and requirements.
- DCH continues discussions with CMS regarding an attrition replacement plan and methodology, and there are some hopeful signs emerging from these deliberations. However, PIHPs **should plan on some loss of 1915(c) waiver funds** (related to attrition) over the first 3 to 6 months of the new payment process.
- DCH will work with PIHPs that request to redirect a portion of their current state general funds allocation to support (i.e., provide the state match share) additional waiver certificates. Adding waiver certificates will require an amendment of our 1915(c) waiver (to increase the c-value).

#### DATA CERTIFICATION AND OTHER REPORTING CONSIDERATIONS

The managed care regulations promulgated pursuant to the BBA require that all PIHP Chief Executive Officers (CEOs) or their designees must sign an attestation regarding data integrity (see 42 CFR 438, Subpart H). A form for CEOs to use for this attestation/certification is included with this letter as **Attachment A**. Completed forms must be submitted to MDCH by March 31, 2004.

Recently, the department indicated that there would be some changes related to reporting services in a specialized residential setting. Effective April 1, 2004, services delivered in a specialized residential setting must be "unbundled" and reported as personal care and community living supports, and as applicable, any other Medicaid state plan, (b)(3) service, or waiver service previously included (bundled) in the specialized residential per diem. Each PIHP-purchased day of specialized residential service will typically be reported as a day of personal care (T1020) and a day of community living supports (H2016). Technical information regarding this new requirement is included with this letter as **Attachment B**.

Please note that all Medicaid 1915(c) Habilitation Supports Waiver services provided to a waiver enrollee must be reported using the **HK** modifier.

#### FAMILY FRIEND RESPITE CLARIFICATION

The department has received numerous questions recently regarding family friend respite. Technical information regarding the use of Medicaid funds for this service is included with this letter as **Attachment C**.

#### ADULT BENEFIT WAIVER

As you are aware, the Adult Benefit Waiver was approved by CMS in early January 2004. The Adult Benefit Waiver is an insurance program with a limited range of specified benefits available to enrollees, subject to medical necessity determination and coverage parameters. A treatment protocol for the mental health benefit included under the ABW is included as **Attachment D** to this letter.

#### MISCELLANEOUS ITEM

DCH will be modifying/correcting the "Grievance and Appeal Technical Requirement" to remove the state level appeal for the Family Support Subsidy. This will be included in the next contract amendment.

This letter has provided an overview and summary of changes related to the renewal of the 1915(b) waiver, and has touched on a few other pertinent issues affecting the public mental health system. DCH will provide additional information on other important topics (e.g., definitions of the (b)(3) services, detailed directions for the 1915(c) waiver, etc.) in an upcoming correspondence to the field.

Attachments

**PRE-PAID INPATIENT HEALTH PLAN DATA CERTIFICATION**  
**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
**MENTAL HEALTH & SUBSTANCE ABUSE ADMINISTRATION**  
**ANNUAL ATTESTATION**

Reports Period From: _____ To: _____	Report Year FY03-04
--	------------------------

*Please Type or Print Clearly*

Name of Pre-Paid Inpatient Health Plan	Payer ID Number
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**Data Certification Statement:**

On behalf of the above named PIHP, I attest, based on best knowledge, information and belief, that all data submitted to the State is accurate, complete, and true. This statement applies to all documents and data submitted by the PIHP to the State, including, but not limited to the following information: encounter data, Habilitation Supports Waiver information, performance indicator data, recipient rights data, sentinel events data, sub-element cost data, annual budget planning documents, and financial information. I further attest that no material fact has been omitted from the form and acknowledge that the information described above may directly affect the payments made to the Pre-Paid Inpatient Health Plan that I represent. I understand that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact.

**Signatures:** *(Enter names as applicable)*

The certification must be signed by the Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to the Chief Executive Office or Chief Financial Officer.

CEO Name (Type/Print)	
CEO Signature	
CFO Name (Type/Print)	
CFO Signature	
Authorized Representative Name (Type/Print)	Authorized Representative Title
Authorized Representative Signature	
Date Certification is Signed	

**AUTHORITY:** PIHP Contract: Section 6.5.1 as amended August  
**COMPLETION:** 13, 2003. Failure to file this report may result in sanctions permitted under Mental Health Code 330.1232b or under the PIHP Contract.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

Submit form to: Mark Kielhorn  
 Division of Program Development, Consultation and Contracts

Michigan Department of Community Health  
 320 S. Walnut,

Lansing, MI 48913

**REPORTING MEDICAID SERVICES DELIVERED IN  
LICENSED SPECIALIZED RESIDENTIAL SETTINGS**

The procedure codes for reporting services in a licensed, certified specialized residential setting, S5140 and S5145, will be retired for reporting services delivered after April 1, 2004. PIHPs may hold reporting for specialized residential services delivered between 10/1/03 and 3/31/04 until after April 1, 2004 and convert to, then report as personal care and community living supports using the codes listed below. Services delivered in a specialized residential setting after 4/1/04 must be unbundled and reported as personal care and community living supports; and as applicable, any other Medicaid state plan, waiver or additional (1915(b)(3) service that was previously included in the specialized residential per diem. Each PIPH-purchased day of specialized residential service will typically be reported as **a day** of personal care (T1020) and **a day** of community living support (H2016) using modifiers according to the formula below. The unit type for both of these procedure codes is "day." Modifiers TG and TF allow distinctions by level of and cost of service provided. The modifier HK must always be added to any Habilitation Supports Waiver community living supports service provided to an enrolled HSW beneficiary. The total allowed amount reported for personal care plus community living support should add up to the per diem paid, net of SSI which pays for room and board, and less any other clinical or therapeutic services that were provided in the home.

Personal Care		Code/Modifier
High need	\$64/day and above	T 1020 TG
Moderate need	\$33-63/day	T1020 TF
Low need	\$ Up to \$32 /day	T1020
Community Living Supports		Code/Modifier
High need	\$64/day and above	H2016 TG
Moderate need	\$33-63/day	H2016 TF
Low need	Up to \$32/day	H2016

\*Add HK modifier for HSW CLS provided to an HSW beneficiary

The split between personal care and CLS will depend upon the activities or tasks performed that are consistent with the definitions in Chapter III of the Medicaid Policy Manual. Personal care should be used for activities of daily living that the worker performs for and/or assists the beneficiary with. CLS should be used for activities of daily living in which the worker reminds, observes, guides or trains the beneficiary, as well as assistance with other activities that personal care does not cover. Activities that are performed by a worker during the time the beneficiary is sleeping should be recorded as CLS.

Therapeutic or clinical services that are currently being delivered in the specialized residential setting and that are rolled into the provider's per diem, must be disaggregated and reported using the appropriate procedure code for the therapy or service. They should not be reported as personal care or CLS.

The allowed amount for each personal care and CLS service that is reported for each individual will be based on the level of care provided of each service. An individual might receive a high amount of personal care, but a moderate amount of CLS; another might receive high amounts of each; and a third low amounts of each. Some individuals may receive no amounts of one or the other. Determination of amounts of personal care and CLS to report (high, moderate, or low) must be based on either a reasonable professional estimate that can be substantiated, or a time study. Prior to October 1, 2004, a PIHP will want to conduct time studies of care being provided to samples of individuals with similar needs and classify them according to high, moderate or low personal care need, and high, moderate or low CLS need. Some PIHPs may choose to classify group homes if all individuals in the homes receive the same amount of personal care and CLS. By October 1, 2004, each PIHP should be basing allowed amounts on classification of individuals, using a time study.

Following is a sample grid that a PIHP might want to use to classify individuals:

	High CLS	Moderate CLS	Low CLS
High Personal Care		Person A	
Moderate Personal			Person C
Low Personal Care		Person B	

Examples: A. Adult with DD who requires total assistance with ADLs (he can do nothing for himself) = High personal care; and needs presence while sleeping and assistance with community integration once a week = moderate CLS

B. Adult with mental illness who requires assistance only with food prep, clothing and laundry = Low personal care; and needs presence while sleeping and assistance with community integration and money management once a week = moderate CLS

C. Child with SED who needs some assistance with ADLs = moderate personal care; and only presence while sleeping = low CLS

Below are guiding principles for “unbundling” specialized residential services into personal care and CLS.

1. Amount of personal care and CLS reported must be based on a professional estimate that can be substantiated; and eventually a time study that reflects amount of time spent for each service that can be linked to cost per service. Accuracy is key in these determinations.
2. PIHP needs to decide for its affiliation, if applicable, if there will be a common method for determining the amounts of personal care and CLS (e.g., estimation or time study, by home or by individual).
3. Personal care allowed amount plus the CLS allowed amount should equal the per diem paid to the provider, less any SSI that paid for room and board, and less any clinical or therapeutic service that was provided in the home. Room and board are not allowable Medicaid expenditures.

## Attachment B

4. Each person's IPOS must indicate amount of personal care and CLS to be provided (e.g., a day of personal care and a day of CLS, with activities outlined. The time allotted per activity does not need to be included) PIHPs will need to amend current IPOSs that do not have such documentation by 4/1/04.
5. The reporting system must be in place no later than 4/1/04.
6. Per diem contracts must be updated and changed by 4/1/04.
7. Develop mechanisms for reporting personal care and CLS so that group home staff do not have to spend an inordinate amount of time documenting their work. PIHPs can decide to use group home logs, shift notes, day sheets, or some other documentation method.
8. PIHP will need to train case managers, supports coordinators and group home staff on the amended IPOSs, and how to document time.
9. It is recommended that PIHPs clean up data for specialized residential reporting as far back to 10/1/03 as possible. PIHPs that do not clean up the specialized residential data will not be able report the complete cost of Medicaid services, especially for the HSW, which in turn will affect the '06 capitation rates

## ATTACHMENT C FAMILY FRIEND RESPITE CLARIFICATION

Family friend respite is a way for families to use people they know and trust to provide respite care for their family member who is a CMHSP consumer. Recently the department has received numerous questions about family friend respite. This popular model that has been used for several decades among CMHSPs, allows for the family to recruit the worker, register the worker with the CMHSP, schedule and receive the service, pay the worker, submit a voucher to the CMHSP, and then be reimbursed for that payment. The model can continue to be used if non-Medicaid funds reimburse the family. However, if Medicaid funds pay for respite, the model must be modified in order to comply with Medicaid policy regarding qualifications and payment of workers. Below are suggestions for modifying family friend in order to use Medicaid funds. As always, PIHPs are advised to consult with their own corporate counsel, and accountants, to assure that the model they use is compliant with local agency or county policies.

Family recruitment of worker. Families should be permitted to recruit their own family friends or extended family members to provide respite care.

Qualifications of a respite care worker. A respite care worker should meet the basic provider qualifications stated in Chapter III of the Medicaid Policy Manual:

- 18 years of age
- Able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports
- Able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed
- In good standing with the law according to the MDCH/PIHP contract

And, additional qualifications that the family may establish.

Background checks If the potential respite care worker is truly a family friend or extended family member, then the family knows the background. If the potential respite care worker's background is unknown, the PIHP may want to assist the family in checking it. Potential workers who are found to have a criminal background should be discussed with the family. A family who insists on hiring the individual in spite of the PIHP's expressed discomfort should be asked to sign a statement attesting to their knowledge about the questionable suitability of the potential worker.

Hiring the worker: Family friends can be employees of 1) the family; 2) the PIHP; or 3) a contract agency. PIHPs who are considering respite workers as independent contractors are advised to review IRS regulations (attached) about how to distinguish between an employee and an independent contractor. It would appear that family friend respite workers are considered "employees."

Training the worker: There is no specific requirement about training respite care workers. Whether the respite care worker should be trained, and if so, the content and who

provides it will depend on what the beneficiary needs, should be determined during person-centered planning. The adult sister of a beneficiary, for example, may need no training at all as she is familiar with all aspects of care. A family friend might be oriented by the family to the needs of the beneficiary. A new "family friend", might require more intensive training from agency staff if the beneficiary has complex medical or behavioral needs.

Scheduling the respite care: Based on the allowances of respite care agreed to in person-centered planning and detailed in the individual plan of service, the family should be permitted to schedule the respite care with the worker directly when it is needed. The family and the agency need to keep track of the amount of respite that is being used so that the amount identified in the plan of service is not exceeded.

Documenting the respite care provided: The worker and/or the family must document the hours of care provided each day of the "pay period" on a log or voucher that is submitted to the PIHP or contract agency. This accounting of the time will be translated into encounter data reported by the PIHP to MDCH.

Payment for respite care According to Medicaid regulation, Medicaid funds may not be paid directly to a beneficiary or his/her responsible parent or guardian. Therefore, the PIHP must pay the worker as one of its own employees; pay the worker as an independent contractor (see note above); reimburse a contract agency that has hired the worker as one of its employees; or use a fiscal intermediary to pay a worker who is an employee of the family.

## IRS TAX PUBLICATIONS

If you are not sure whether you are an employee or an independent contractor, get Form SS-8, *Determination of Employee Work Status for Purposes of Federal Employment Taxes and Income Tax Withholding*. Publication 15-A, *Employer's Supplemental Tax Guide*, provides additional information on independent contractor status.

## IRS ELECTRONIC SERVICES

You may download and print IRS publications, forms, and other tax information materials on the Internet at [www.irs.gov](http://www.irs.gov) and you may call the IRS at 1-800-829-3676 (1-800-TAX-FORM) to order free tax publications and forms.

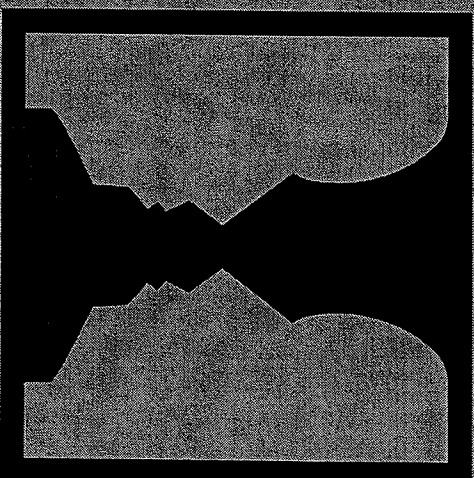
From a fax machine, dial (703) 368-9694 and you will immediately get a list of IRS tax forms faxed back to you. Follow the voice prompts to get specific forms faxed to you.

Publication 1796, *Federal Tax Products on CD-ROM*, of current and prior year tax publications and forms, can be purchased from the National Technical Information Service (NTIS). You may order Publication 1796 toll-free through the IRS at 1-877-233-6767 or via the Internet at [www.irs.gov/cdorders](http://www.irs.gov/cdorders).

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*Often your tax questions can be answered by reading tax publications and related forms. But when you need more information, you may call the IRS at 1-800-829-1040.*

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