Manager and Location Building:
John P. Duvendeck– Lewis Cass Building, 320 S. Walnut
Contract Number#_____

Amendment No. 1 to the Agreement Between
Michigan Department of Health and Human Services
And

PIHP_____
For
The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs

1. **Period of Agreement:**
   This agreement shall commence on October 1, 2018 and continue through September 30, 2019.

2. **Period of Amendment:**
   October 1, 2018 through September 30, 2019.

3. **Program Budget and Agreement Amount:**
   Payment to the PIHP will be based on the total funding available for specialty supports and services as identified in the annual Legislative Appropriation for community mental health services programs for the period of October 1, 2018 through September 30, 2019. The estimated value is contingent upon and subject to enactment of legislative appropriations and availability of funds.

4. **Amendment Purpose:**
   This amendment incorporates changes to boilerplate contract language and related contract attachments.

5. **The Specific Changes are Identified Below:**
   - Part II.A Sections 7.8.2.6 Programs with Community Inpatient Hospitals, 7.9.3 MDHHS Standard Consent Form, 8.4.2.1 Performance Bonus Incentive Pool
   - Part II.B New sections 32.1 Medication Assisted Treatment and 37.0 Michigan Gambling Disorder Prevention Project (MGDPP)
   - Contract attachment P7.7.1.1 PIHP Reporting Requirements adding reporting requirements for the Michigan Gambling Disorder Prevention Project
   - Contract attachment P8.0.1 PIHP Financing FY19 PIHP rate certification letter and 428 schedules

6. **Original Agreement Conditions**
   It is understood and agreed that all other conditions of the original agreement remain the same.

7. Special Certification:

The individuals signing this agreement certify by their signatures that they are authorized to sign this agreement on behalf of the organization specified.

Signature Section:

For the Michigan Department of Health and Human Services

Christine H. Sanches, Director Bureau of Grants & Purchasing	Date

For the CONTRACTOR:

Name (print)	Title (print)
Signature	Date

7.8.2.6. Programs with Community Inpatient Hospitals

Upon request from MDHHS, the PIHP must develop programs for improving access, quality, and performance with providers. Such programs must comply with 42 CFR 438.6(d). The community psychiatric inpatient hospital rate adjustment (HRA) directed payment process is designed to improve inpatient access and quality outcomes for Medicaid beneficiaries. The program is aligned with the state's overall Medicaid quality strategy. The HRA is independent of the local PIHP/CMHSP/Hospital rate setting process. The HRA directed payments are an add-on to the current locally negotiated rate.

1. **Hospital Eligibility**
   Hospital eligibility is determined by MDHHS. Community hospitals, including Institutes for Mental Disease, are eligible for HRA directed payments based on PIHP inpatient encounters. Out of state hospitals are not eligible. The hospital billing provider NPI on the original invoice must be enrolled in the state Medicaid management information system (CHAMPS).
2. **Determination of the Hospital Payment Amount**
   PIHP-reported community inpatient psychiatric encounters will be used by MDHHS as the basis for determining an annual add-on rate. Directed payment allocations are based on room and board encounters, identified by billing provider NPI. Encounters accepted in CHAMPS during the prior quarter will be included in the directed payment for that quarter. Medicaid and Healthy Michigan Plan encounters will be included in allocation pool.
3. **MDHHS Payment Process**
   PIHPs will receive a quarterly gross adjustment from MDHHS. The amount of a quarterly payment to a PIHP will be equal to the total amount shown on the HRA directed payment instructions for the prior quarter.
4. **Directed Payment Instructions**
   MDHHS will provide directed payment instructions indicating the payment amount per hospital, at the PIHP level. Instructions will be provided to PIHPs prior to the end of the 1st month in each quarter.
5. **PIHP Payment Obligations and Payment Process**
   Payment is made by the PIHP to each hospital identified in the HRA directed payment instructions at the amount specified. Payments are quarterly with no minimum payment threshold. Payments are due to hospitals every three months within 10 state business days of the PIHP receiving the quarterly HRA gross adjustment from MDHHS. MDHHS acknowledges that payments can be made without a current contractual arrangement between the PIHP/affiliate CMHSPs and the hospital receiving an HRA payment. PIHP delegation to affiliate CMHSPs is not recommended.
6. **PIHP Reporting Requirements**
   MUNC and financial status reports will continue to include HRA payment revenue and payment information requirements.

7.9.3 MDHHS Standard Consent Form

It is the intent of the parties to promote broader sharing of behavioral health records, including mental health records for the purposes of payment, treatment, and coordination of care in accordance with Public Act 559 of 2016, and substance use disorder records via electronic health information exchange environments pursuant to 42 CFR Part 2. To accomplish these ends, the parties shall use and accept the standard release form that was created by MDHHS under Public Act 129 of 2014. Accordingly, the PIHPs have the opportunity to (1) participate in the Department's annual review of the MDHHS-5515 and the related guidance; and (2) submit comments to the Department regarding challenges and successes with using MDHHS-5515.

For all electronic and non-electronic Health Information Exchange environments, the PIHP shall implement a written policy that requires the PIHP and its provider network to use, accept, and honor the standard release form that was created by MDHHS under Public Act 129 of 2014. The PIHP shall ensure its policies, procedures, forms, legal agreements, and applicable training materials are updated in accordance with Public Act 559 of 2016.

8.4.2 Contract Withholds

The Department shall withhold .2% of the approved capitation payment to each PIHP. The withheld funds shall be issued by the Department to the PIHP in the following amounts within 60 days of when the required report is received by the Department:

1. .04% for timely submission of the Projection Financial Status Report – Medicaid
2. .04% for timely submission of the Interim Financial Status Report – Medicaid
3. .04% for timely submission of the Final Medicaid Contract Reconciliation and Cash Settlement
4. .04% for timely submission of the Medicaid Utilization and Cost Report
5. .04% for timely submission of encounters (defined in Attachment P 7.7.1.1.)

8.4.2.1 Performance Bonus Incentive Pool

A. Withhold and Metrics

Pursuant to Sec. 105d(18) of PA 107 of 2013, the Department shall withhold 0.75% of payments to specialty prepaid health plans for the purpose of establishing a performance bonus incentive pool (hereafter referred to as "PBIP"). Distribution of funds from the PBIP is contingent on the PIHP's results on the joint metrics detailed in 8.4.2.1.1 below as it relates to compliance metric (a), and the narrative reports detailed in 8.4.2.1.2 and 8.4.2.1.3 below as it relates to compliance metrics (b), (c), and (d):

a. Partnering with other contracted health plans to reduce non-emergent emergency department utilization and increase data sharing;
b. Increased participation in patient-centered medical homes;
c. Identification of enrollees who may be eligible for services through the Veterans Administration; and
d. Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications.

B. Assessment and Distribution

PBIP funding awarded to the PIHPs shall be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system.

The 0.75% PBIP withhold shall be distributed as follows:

a. MHP/PIHP Joint Metrics (Section 8.4.2.1.1): 27%
b. PIHP Narrative Reports (Section 8.4.2.1.2): 67%
c. PIHP-only Pay for Performance Measure(s) (Section 8.4.2.1.3): 6%

8.4.2.1.1 Performance Bonus Joint Metrics for the Integration of Behavioral Health and Physical Health Services (27% of withhold)

In an effort to ensure collaboration and integration between Medicaid Health Plans (MHPs) and Pre-paid Inpatient Health Plans (PIHPs), MDHHS has developed the following joint expectations for both entities. There are 100 points possible for this initiative in F2019. The reporting process for these metrics is identified in the grid below. Care coordination activities are to be conducted in accordance with applicable state and federal privacy rules.

Category	Description	Criteria/Deliverables
1. Implementation of Joint Care Management Processes (35 points)	Collaboration between entities for the ongoing coordination and integration of services	Each MHP and PIHP will continue to document joint care plans in CC360 for members with appropriate severity/risk who have been identified as receiving services from both entities. The risk stratification criteria is determined in writing by the PIHP-MHP Collaboration Workgroup in consultation with MDHHS. MDHHS will quarterly select beneficiaries randomly and review their care plans within CC360. Measurement period will be October 1, 2018-September 30, 2019.
2. Follow-up After Hospitalization for Mental Illness within 30 Days (FUH) (50 points)	The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	Plans will meet set standards for follow-up within 30 Days for each rate (ages 6-20 and ages 21 and older). Plans will be measured against an adult minimum standard of 58% and a child minimum standard of 70%. See MDHHS BHDDA reporting requirement website for measure specifications, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html Measurement period will be July 1, 2018-June 30, 2019. The points will be awarded based on MHP/PIHP combination performance measure rates. The total potential points will be the same regardless of the number of MHP/PIHP combinations for a given entity.
3. Plan All-cause Readmission (PCR) (10 points)	For members 18 years of age or older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	This measure will be **informational only.** Data validation period will be July 1, 2018—June 30, 2019. Plans will be expected to review and validate data. By June 30, 2019, submit a narrative report (up to four pages) on findings of efforts to review and validate data, noting discrepancies found that impact the measure results, as well as actions taken to address data issues (as needed). See MDHHS BHDDA reporting requirement website for measure specifications, at

		https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
4. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) (5 points)	Members 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that had a follow-up visit within 30 days.	This measure will be **informational only.** Data validation period will be July 1, 2018 - June 30, 2019. Plans will be expected to review and validate data. By June 30, 2019, submit a narrative report (up to four pages) on findings of efforts to review and validate data, noting discrepancies found that impact the measure results, as well as actions taken to address data issues (as needed). Analysis should include disparities among racial and ethnic minorities. See MDHHS BHDDA reporting requirement website for measure specifications, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

8.4.2.1.2 Performance Bonus Narrative Reports (67% of withhold)

PIHPs will submit a qualitative narrative report to MDHHS in accordance with Contract Attachment P.7.7.1.1 PIHP Reporting Requirements by November 15th following the end of the Fiscal Year. The narrative shall contain a summary of efforts, activities, and achievements of the PIHP (and component CMHSPs if applicable) during FY2019 for the metrics outlined below. The weight given to each metric is indicated below, together with the specific information to be addressed in the narrative.

a. Metric: Increased participation in patient-centered medical homes (50%):
    1. Comprehensive Care
    2. Patient-Centered
    3. Coordinated Care
    4. Accessible Services
    5. Quality & Safety
b. Metric: Identification of enrollees who may be eligible for services through the Veteran's Administration (50%):
    1. Outreach efforts and activities with Veterans, Veterans Advocate Groups, and/or Veterans Providers of any type;
    2. Level of CMH and other PIHP Provider involvement on TriCare Panel; and
    3. Population Health and Integrated Care efforts with local VA Medical Centers and Clinics.

Additional areas other than those specified above that may be addressed by the PIHP in the narrative, but are not mandatory, include but are not limited to:

a. Veterans Community Action Team attendance;
b. Co-location of CMH staff in primary care settings, and vice versa;

c. Involvement with FQHCs, SIM, MI Health Link; and
d. Efforts to identify consumers without a primary care physician to facilitate establishing that relationship.

To the extent possible, measurement of performance in future years will be based on nationally recognized quality measures, for example, access to preventive/ambulatory health services and ambulatory care sensitive condition, ER and inpatient medical-surgical hospital utilization rates.

Points for Narrative Reports required under this section, and section 8.4.2.1.3, shall be awarded on a pass/fail basis, with full credit awarded for submitted narrative reports, without regard to the substantive information provided. MDHHS shall provide consultation draft review response to PIHPs by January 15th of the following Fiscal Year. PIHPs shall have until January 31st to reply to MDHHS with information.

8.4.2.1.3 PIHP-only Pay for Performance Measure(s) (6% of withhold)

PIHPs will be incentivized on at least one nationally recognized quality measure. For FY2019, the quality measure is as specified below:

Measure	Description	Deliverables
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Percentage of Adults Ages 18 to 64 with Schizophrenia or Bipolar Disorder who were Dispensed an Antipsychotic Medication and had a Diabetes Screening Test during the Measurement Year. Measure Steward: NCQA, HEDIS specifications	This measure will be **informational only**. Data validation period will be July 1, 2018 - June 30, 2019. Plans will be expected to review and validate data. By June 30, 2019, submit a narrative report (up to four pages) describing activities conducted to prepare for being measured against a set standard rate. See MDHHS BHDDA reporting requirement website for measure specifications, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.

NOTE: FY20 pay for performance measurement period will be based on prior calendar year, resulting in one quarter of measurement period falling in contract year.

32.1 Medication Assisted Treatment (MAT)

Medication-Assisted Treatment (MAT) is a standard of care that is broadly recognized as an essential pillar in any comprehensive approach to the national opioid addiction and overdose epidemic. The State of Michigan seeks to ensure that no consumer is denied access to or pressured to reject the full service array of evidence-based and potentially life-saving treatment options, including MAT, that are determined to be medically necessary for the individualized needs of that consumer.

Treatment options should be discussed in an objective way so each consumer can make an informed decision based on research and outcome data. The State of Michigan expects that PIHP-contracted SUD treatment providers will do the following:

1) Adopt a MAT-inclusive treatment philosophy that recognizes multiple pathways to recovery;
2) Reject pressuring MAT clients to adopt a tapering schedule and/or a mandated period of abstinence;
3) Develop and/or strengthen policies that prohibit disparaging, delegitimizing, and/or stigmatizing of MAT either with individual clients or in the public domain;
4) When a consumer on MAT (or considering MAT) is seeking treatment services at the point of access, access staff will respect MAT as a choice without judgment, stigma, or pressure to change recovery pathways.

If a provider does not have capacity to work with a person receiving MAT, the provider will work with the consumer and with local PIHP or appropriate Access Departments to facilitate a warm handoff/transfer to another provider, who can provide ancillary services (counseling, case management, recovery supports, recovery housing) while the client pursues his or her chosen recovery pathway.

37.0 Michigan Gambling Disorder Prevention Project (MGDPP)

The Michigan Gambling Disorder Prevention Project (MGDPP) will increase state-wide awareness of Gambling Disorder (GD) across all populations. Participation is optional and at the discretion of each PIHP. A PIHP's decision to participate will be evidenced by the submission of a Request for Application (RFA) from the PIHP and approved by the MDHHS. Each participating PIHP will designate GD Prevention Coordinating staff for the development of prevention programs that will provide GD education, improve GD outcomes and strengthen family and support services.

Program objectives include the following:

- **Increase awareness of the risks associated with GD** – Reduce the stigma associated with GD. Identify the warning signs, address comorbidity, use evidence-based practices to develop prevention and outreach efforts to underserved populations; promote utilization of the GD help-line and identify treatment and recovery options;
- **Provision of GD training to administrative teams and participating provider staff** – Arrange to provide thirty (30) hours of basic GD training facilitated by North American Training Institute (NATI), with technical support provided by Health Management Systems of America (HMSA).
- **Provision of GD assessment training to participating Access Management staff** – Provide National Opinion Research Center DSM-IV Screen (NODS); training facilitated by HMSA.
- **Address past 30 days gambling activity in adults and youth** - Use of new and existing prevention infrastructure to build and/or maintain partnerships with individuals, agencies and community groups to garner support of GD prevention.

Expected Performance Outcomes

During the Agreement, the Contractor shall demonstrate measurable progress toward the achievement of the outcomes listed below:

- Ensure prevention staff completes GD training;
- Ensure Access Management Staff completes NODS assessment training;
- Provide referral to GD help-line when applicable;
- Increase GD education and prevention to adults; and,
- Increase GD education and prevention to the youth

Training Requirements

Basic Gambling Disorder Online Training – https://nati.org/oll/default.aspx
All designated provider staff are required to complete thirty (30) hours of basic GD online training. Training will include coursework and written assignments required by NATI. The NATI training curriculum has been approved by the National Council on Problem Gambling (NCPG) Education Committee. Designated staff will have ninety (90) days from the beginning of the fiscal year or date of hire, whichever occurs later, to complete the required training.

60 Minute NODS Assessment Training – All participating Access Management staff will receive NODS assessment training to ensure appropriate GD help-line referral. Staff will learn the importance of GD assessment within the SUD community and use of the assessment tool. Training will be provided by HMSA at the following BHDDA website page "Gambling Treatment Provider Training": https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_43661_48565-165085--,00.html

Reporting Requirements

Report forms and instructions are available on the MDHHS website address at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html For report due dates and submission instructions, refer to attachment P7.7.1.1 PIHP Reporting Instructions.

The following indicates the GD reports to be submitted to the Department under this agreement:

GD Quarterly Narrative Report

GD Monthly Training Schedule

Program Restrictions

All written materials such as brochures, training materials, screening materials, referral lists, etc., developed by the applicant, employees or subcontractors, in fulfilling the obligations of this agreement, are considered Department property. All such materials developed must be reviewed and approved by the Department prior to distribution. Approved material may be freely distributed without charge as long as the Department involvement with the program is acknowledged. In addition, the Contractor, its employees or subcontractors may not charge others for such materials, other than reasonable reproduction and handling fees, without expressed written approval of the Department.

The Department retains exclusive authority for advertising and promoting the toll free "800" Statewide Problem Gambling Help-line. Contractors, its employees or subcontractors may not promote the Statewide Gambling Help-line without the expressed permission of the Department. The toll free "800" helpline number advertised by the Department shall be publicized in promotional materials.

PIHP NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE INCLUDING SUD REPORTS

The PIHP shall provide the following reports to MDHHS as listed below.

Due Date	Report Title	Report Period
10/31/2018	Recovery Policy & Practice Annual Survey Information Forms – Tables 3a & 3b	TBD See attachment P4.13.1
1/15/2019	Michigan Gambling Disorder Prevention Project (MGDPP) 1Q Narrative Report*	October 1 to December 31. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
1/31/2019	Children Referral Report	October 1 to December 31
1/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 to December 31
2/19/2019	SUD Master Retail List	October 1 to September 30
03/31/2019	Performance Indicators	October 1 to December 31, 2018 Submit to: QMPMeasures@michigan.gov
4/15/2019	Michigan Gambling Disorder Prevention Project (MGDPP) 2Q Narrative Report*	January 1 to March 31 Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
4/30/2019	Children Referral Report	January 1 to March 31
4/30/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	January 1 to March 31
06/30/2019	Performance Indicators	January 1 to March 31, 2019 Submit to: QMPMeasures@michigan.gov
7/11/2019	Compliance Check Report (CCR) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov	Email OROSC backup to: ohs@michigan.gov and cc NordmannA@michigan.gov.
07/11/2019	SUD – Tobacco/Formal Synar Inspections – To be reported in Youth Access to Tobacco (YAT) Compliance Checks Report	June 1 to 30 Coverage study activities should be conducted between Aug. 29 to Sept. 17, 2018
7/15/2019	Michigan Gambling Disorder Prevention Project (MGDPP) 3Q Narrative Report*	April 1 to June 30. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
7/31/2019	Children Referral Report	April 1 to June 30
7/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	April 1 to June 30
08/31/2019	Consumer Satisfaction Survey raw data	Survey conducted in May
09/30/2019	Performance Indicators	April 1 to June 30, 2019 Submit to: QMPMeasures@michigan.gov
10/15/2019	Michigan Gambling Disorder Prevention Project (MGDPP) 4Q Narrative Report*	July 1 to September 30. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
10/31/2019	Children Referral Report	July 1 to September 30
10/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	July 1 to September 30
10/31/2019	SUD – Youth Access to Tobacco Activity Annual Report	October 1 to September 30

Applicable in FY19	SUD – Synar Coverage Study Canvassing Forms	Next Synar Coverage Study occurs in 2019
11/30/2019	SUD – Communicable Disease (CD) Provider Information Report (Must be submitted only if PIHP funds CD services)	October 1 to September 30 (e-mail to mdhhs-BDDHA@michigan.gov)
11/30/2019	Women Specialty Services (WSS) Report	October 1 to September 30
12/31/2019	Performance Indicators	July 1 to September 30, 2019 Submit to: QMPMeasures@michigan.gov
2/28/2019	Recovery Policy & Practice Annual Reporting Matrice – Table 2	See attachment P4.13.1
Quarterly	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 – September 30 – Due end of month following the last month of the quarter.
Quarterly	Children Referral Report	October 1 – September 30 – Due end of month following the last month of the quarter.
Monthly (Last day of month following month in which exception occurred) Must submit even if no data to report	SUD - Priority Populations Waiting List Deficiencies Report	October 1 – September 30
Monthly (Last day each month)	SUD – Behavioral Health Treatment Episode Data Set (BH-TEDS)	October 1 to September 30 via DEG. Login at: https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly (Last day of month following the month in which the data was uploaded)	SUD - Michigan Prevention Data System (MPDS)	October 1 to September 30 Submit to: mdhhs.sudpds.com)
Monthly (minimum 12 submissions per year)	SUD - Encounter Reporting via HIPPA 837 Standard Transactions	October 1 to September 30 Submit via Login at: https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly*	Consumer level* a. Quality Improvement Encounter	October 1 to September 30 See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly	Critical Incidents	Submit to PIHP Incident Warehouse at: https://mipihpwarehouse.org/MVC/Documentation
Annually (Same due date as Annual Plan)	SUD - Communicable Disease (CD) Provider Information Plan (Must be submitted only if PIHP funds CD services)	October 1 to September 30
Monthly*	Michigan Gambling Disorder Prevention Project (MGDPP) Monthly Training Schedule*	Due on the 15th of every month which includes Gambling Disorder (GD) training dates and activities. Send to MDHHS-BHDDA-Contracts-

		MGMT@michigan.gov and a copy to LucasA3@michigan.gov.

*Reports required for those PIHPs participating in optional programs

Amendment #1

CONTRACT FINANCING

1. **Insert Milliman Rate Certification letter for the time period covered by the contract.**
   October 1, 2018 to September 30, 2019

2. **Insert Milliman Paid Rate letter for the time period covered by the contract.**
   October 1, 2018 to September 30, 2019

3. **Insert 428 Schedule**
   A separate 428 schedule for each PIHP

4. **Insert SUD Community Grant Authorization**

SUD COMMUNITY GRANT AGREEMENT AMOUNT
Not available at this time. Will be sent at a later date.

The total amount of this agreement is $_____. The Department under the terms of this agreement will provide funding not to exceed $_____. The federal funding provided by the Department is $_____, as follows:

Federal Program Title	Catalog of Federal Domestic Assistance (CFDA)	CFDA #	Federal Agency Name	Federal Grant Award Number	Award Phase	Amount
SAPT Block Grant	Block Grant for Prevention & TX of Substance Abuse	93.959	Department of Health & Human Services/SAMHSA	13 B1 MI SAPT	2019	
					Total FY 2019 Federal Funding	

_____sub-recipient relationship; or
_____vendor relationship.

The grant agreement is designated as:
_____Research and development project; or
_____Not a research and development project

MILLIMAN CLIENT REPORT

SFY 2019 Behavioral Health Capitation Rate Certification

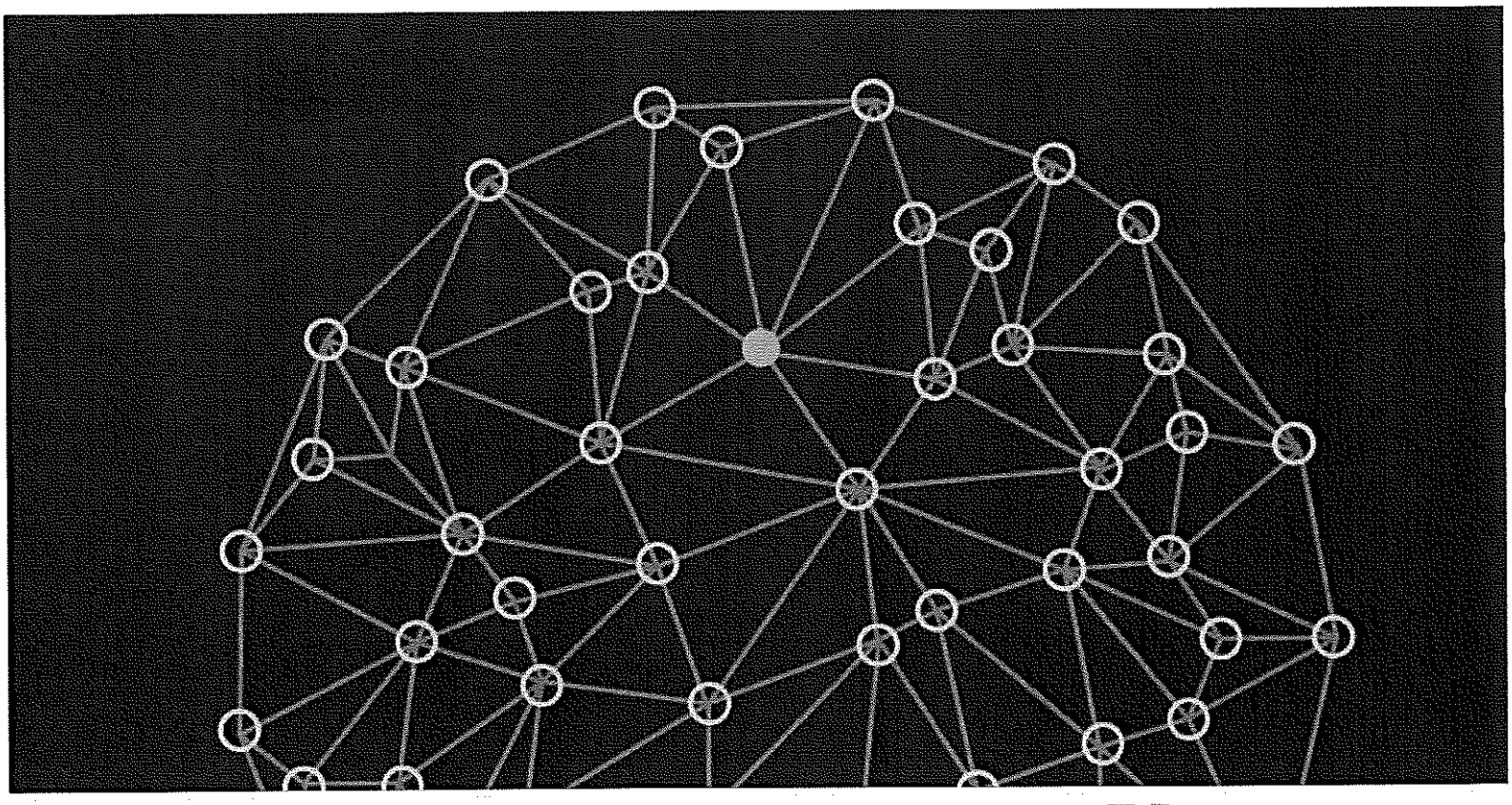
October 1, 2018 through September 30, 2019

State of Michigan Department of Health and Human Services

September 14, 2018

Prepared for:
Lynda Zeller
Director of Behavioral Health and Developmental Disabilities Administration
Michigan Department of Health and Human Services

Christopher T. Pettit, FSA, MAAA, Principal and Consulting Actuary
Jeremy A. Cunningham, FSA, MAAA, Consulting Actuary



Milliman

Table of Contents

Introduction & Executive Summary

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of Michigan, Department of Health and Human Services (MDHHS) to provide actuarial and consulting services related to the development of capitation rates for its behavioral health managed care programs. The rates being certified in this report are for the Specialty Services and Supports 1915(b)/(c) Waiver (SSSW), which includes the Autism benefit, and the Healthy Michigan Plan (HMP) 1115 Waiver. The rates being certified as actuarially sound are to be effective October 1, 2018. These rates will be in effect for 12 months through September 30, 2019. However, we anticipate making updates to the geographic factors to reflect SFY 2017 experience.

This letter provides documentation for the development of the actuarially sound capitation rates. It also includes the required actuarial certification in Appendix 1.

To facilitate review, this document has been organized in the same manner as the 2018-2019 Medicaid Managed Care Development Guide, released by the Center for Medicare and Medicaid Services in April 2018 (CMS guide). Section II of the CMS guide is applicable to this certification as the covered services include long-term services and supports. Section III of the CMS Guide is only applicable to the HMP population in this certification.

In developing the capitation rates and supporting documentation herein, we have applied the three principles of the regulation outlined in the CMS Guide:

- The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care.
- The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity.
- The documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR 438 and generally accepted actuarial principles and practices.

The State of Michigan, Department of Health and Human Services operates a statewide managed care program for the DAB, TANF, and HSW populations under the SSSW and the Healthy Michigan population under the HMP. Services provided under these managed care programs include treatment for people with serious mental illness, substance use disorders, intellectual and developmental disabilities, and serious emotional disturbances. This report contains the supporting materials and documentation for the development of the actuarially sound capitation rates for the ten regional PIHP contracts during the twelve-month period, October 1, 2018 through September 30, 2019.

SUMMARY OF CAPITATION RATES

Appendix 2 provides the certified capitation rates effective during state fiscal year (SFY) 2019, from October 1, 2018 through September 30, 2019, for the Disabled, Aged, and Blind (DAB), TANF, and HMP populations. Capitation rates paid to the ten regional prepaid inpatient health plans (PIHPs) are calculated by multiplying the base rate by the age gender factor and corresponding PIHP geographic factor of the beneficiary. Appendix 3 provides the final certified SFY 2019 capitation rates for the Habilitative Supports 1915(c) Waiver (HSW) program. Table 1a and Table 1b provide a comparison of the SFY 2019 rates relative to the average rates effective throughout SFY 2018 for the covered populations. The rates noted in table 1a reflect base claims costs plus amounts for administrative load. Table 1b reflects a comparison of estimated fully loaded capitation rates including amounts related to Insurance Provider Assessment (IPA) and Hospital Reimbursement Adjustment (HRA).

Table 1a
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Capitation Rate PMPM Comparison (excluding HRA/IPA)

Rate Category	SFY 2018 Rates	SFY 2019 Rates	Increase/Decrease
TANF			
Mental Health	$ 17.34	$ 17.66	1.8%
Substance Abuse	2.09	2.17	3.8%
Autism	3.76	4.40	17.0%
DAB			
Mental Health	265.41	273.31	3.0%
Substance Abuse	5.18	5.37	3.7%
Autism	20.25	22.14	9.3%
HMP			
Mental Health	30.45	32.25	5.9%
Substance Abuse	10.29	11.09	7.8%
Autism	0.32	0.38	18.8%
Waiver (c)			
HSW	4,769.45	4,938.91	3.6%

Table 1b
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Capitation Rate PMPM Comparison (including HRA/IPA)

Rate Category	SFY 2018 Rates	SFY 2019 Rates	Increase/Decrease
TANF			
Mental Health	$ 17.50	$ 19.44	11.1%
Substance Abuse	2.11	2.17	2.8%
Autism	3.80	4.40	15.8%
DAB			
Mental Health	275.59	278.31	1.0%
Substance Abuse	5.23	5.37	2.7%
Autism	20.45	22.14	8.3%
HMP			
Mental Health	30.73	36.94	20.2%
Substance Abuse	10.39	11.09	6.7%
Autism	0.32	0.38	18.8%
Waiver (c)			
HSW	4,815.71	4,938.91	2.6%

The capitation rate values were developed using the PIHP submitted encounter data and the Medicaid utilization net cost (MUNC) reports. The mental health DAB and TANF population capitation rates have been split between state plan services, 1915 (b)(3) services, and autism services in Appendix 2. The DAB and TANF substance abuse capitation rates reflect eligible state plan services. The Healthy Michigan capitation rates reflect the eligible 1115 waiver mental health and substance abuse services. Please note that the tables and appendices in this report for the Healthy Michigan population reflect the 1115 eligible services instead of the labeled state plan services. The Waiver (c) capitation rates are paid in addition to the base mental health capitation rates for individuals enrolled in the HSW program.

FISCAL IMPACT ESTIMATE

The estimated fiscal impact of the SFY 2019 capitation rates documented in this report represent a $120.5 million increase to aggregate expenditures, based on the rates noted in Table 2b. These amounts are on a state and federal expenditure basis using the projected monthly enrollment for SFY 2019.

Tables 2a and 2b provide the development of estimated total expenditures, as well as federal only and state only expenditures, for the average SFY 2018 contracted capitation rates and the proposed SFY 2019 capitation rates illustrated in Tables 1a and 1b. The federal expenditures illustrated in Tables 2a and 2b are based on the federal fiscal year 2019 FMAP of 64.45% for non-HMP populations, 94% for October to December 2018, and 93% for January to September 2019 for HMP.

Table 2a
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Comparison of Projection of Capitation Rate Expenditures
Values in $ Millions (excluding HRA/IPA)

Rate Category	SFY 2018 Rates	SFY 2019 Rates	Increase/Decrease
TANF			
Mental Health	$ 245.0	$ 249.4	$ 4.5
Substance Abuse	29.5	30.6	1.1
Autism	53.3	62.1	8.8
DAB			
Mental Health	1,565.4	1,604.1	38.7
Substance Abuse	30.6	31.5	1.0
Autism	119.5	129.9	10.4
HMP			
Mental Health	237.8	250.6	12.7
Substance Abuse	80.4	86.2	5.8
Autism	0.3	0.3	0.0
Waiver (c)			
HSW	436.3	451.8	15.5
Total State & Federal	**$ 2,798.0**	**$ 2,896.6**	**$ 98.5**
Total State Only	**$ 903.0**	**$ 932.7**	**$ 29.7**
Total Federal Only	**$ 1,895.0**	**$ 1,963.9**	**$ 68.8**

Notes:
[1] Values have been rounded.
[2] Values exclude HRA and IPA.
[3] FMAP of 64.45% used for non-HMP populations. FMAP of 93.25% used for HMP. The FMAP reflects the SFY 2019 FMAP values. We have not reflected the enhanced FMAP for the MiChild population.
[4] Values have been adjusted to exclude all expenditures in a given month for individuals who stayed more than 15 days in an IMD setting in that month.

Table 2b
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Comparison of Projection of Capitation Rate Expenditures
Values in $ Millions (including HRA/IPA)

Rate Category	SFY 2018 Rates	SFY 2019 Rates	Increase/Decrease
TANF			
Mental Health	$ 247.2	$ 274.6	$ 27.3
Substance Abuse	29.8	30.6	0.8
Autism	53.9	62.1	8.2
DAB			
Mental Health	1,625.4	1,633.4	8.0
Substance Abuse	30.9	31.5	0.7
Autism	120.7	129.9	9.2
HMP			
Mental Health	240.0	287.0	47.0
Substance Abuse	81.1	86.2	5.0
Autism	0.3	0.3	0.0
Waiver (c)			
HSW	440.5	451.8	11.3
Total State & Federal	**$ 2,869.8**	**$ 2,987.5**	**$ 117.6**
Total State Only	**$ 927.7**	**$ 954.5**	**$ 26.8**
Total Federal Only	**$ 1,942.2**	**$ 2,033.0**	**$ 90.8**

Notes:
[1] Values have been rounded.
[2] Values include HRA and IPA.
[3] FMAP of 64.45% used for non-HMP populations. FMAP of 93.25% used for HMP. The FMAP reflects the SFY 2019 FMAP values. We have not reflected the enhanced FMAP for the MI Child population.
[4] Values have been adjusted to exclude all expenditures in a given month for individuals who stayed more than 15 days in an IMD setting in that month.

Appendix 1 contains the actuarial certification regarding the capitation rates illustrated in Appendices 2 and 3. The actuarial certification indicates that the rates developed on a statewide basis are considered to be actuarially sound as defined in Federal Regulation 438.4(a).

Section I. Medicaid managed care rates

1. General information

This section provides information listed under the General Information section of CMS guide, Section I.

The capitation rates provided under this certification are "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the SFY 2018 managed care program rating period.
- The most recent CMS guide.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term "actuarially sound" will be defined as in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."[1]

A. RATE DEVELOPMENT STANDARDS

i. Annual basis

The actuarial certification contained in this report is effective for the capitation rates for the twelve-month period from October 1, 2018 through September 30, 2019.

ii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Christopher Pettit, FSA, is in Appendix 1. Mr. Pettit meets the qualification standards established by the American Academy of Actuaries, follows the practice standards established by the Actuarial Standards Board, and certifies that the final rates meet the applicable standards in 42 CFR 438 that are effective for the SFY 2019 managed care program rating period.

[1] http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

(b) Certified capitation rates for each rate cell

The certified capitation rates are illustrated in Appendices 2 and 3. IPA amounts are illustrated separately from the base rate.

(c) Program information

(i) Managed Care program

The State of Michigan, Department of Health and Human Services operates a statewide managed care program for the DAB, TANF, and HSW populations under the SSSW and the Healthy Michigan population under the HMP.

(A) There are ten prepaid inpatient health plans (PIHPs) included in the rate development. Appendix 11 describes the regional allocation of county to each PIHP.

(B) Within the SSSW, MDHHS implemented an Autism program on April 1, 2013 for children ages 18 months through 5 years who had an autism spectrum disorder (ASD) diagnosis. Effective January 1, 2016, the Autism program expanded to serve children up to age 21 with an ASD diagnosis, consistent with the CMS guidance in the July 7, 2014 bulletin entitled *Clarification of Medicaid Coverage of Services to Children with Autism.* Historically, the PIHPs received capitation payments to cover this benefit on a per recipient basis. Effective October 1, 2017, the PIHPs began receiving payments on a per member per month basis for all children under age 21.

This capitation rate certification also reflects the behavioral health services provided to the Healthy Michigan population under the State's Alternative Benefit Plan, the HMP. The State of Michigan began this mandatory managed care program on April 1, 2014.

Appendix 7 provides a listing of the services provided by the PIHPs under this managed care program. Mental health and substance abuse services are provided to beneficiaries with serious mental illness, substance use disorders, intellectual and developmental disabilities, and serious emotional disturbances. HSW services are only provided to beneficiaries eligible for the corresponding HSW benefit. Autism services, including Applied Behavioral Analysis (ABA), are provided to children under age 21 with an ASD diagnosis.

HSW services were extracted from the base encounter data by identifying HSW service codes, HSW Medicaid eligibility periods, and the presence of the 'HK' modifier code on the encounter line. In Appendix 7, services that have an "X" under both the "HSW" column and another column are allocated as HSW costs for HSW beneficiaries and non- HSW costs for non- HSW beneficiaries. Services that apply only to HSW beneficiaries are illustrated as only having an "X" under the "HSW" column of Appendix 7.

We are not aware of any value-added services being provided by the PIHPs outside of those covered under the contract. To the extent that these services are being provided, they are not included in the base experience used in the development of the certified capitation rates.

(C) The State of Michigan has operated this mandatory managed care program since 1998.

(ii) Rating period

This actuarial certification contained in this report is effective for the twelve-month rating period, October 1, 2018 through September 30, 2019.

(iii) Covered populations

MDHHS's behavioral health benefit is available to beneficiaries covered by either the SSSW or the HMP. The SSSW Medicaid managed care program includes Medicaid beneficiaries in two distinct populations:

- TANF, which includes the MIChild population; and,
- Disabled, Aged, and Blind.

The HSW population is a subset of the DAB and TANF populations that receive additional Waiver (c) benefits. For these beneficiaries, PIHPs will receive both a DAB or TANF capitation payment and the corresponding HSW payment.

(iv) Eligibility criteria

The Medicaid eligibility file that Milliman receives from MDHHS includes program code, scope, and coverage information for each beneficiary among other eligibility information. In order to be included in these populations, a beneficiary must have **both**:

1. A DAB, TANF, or MIChild program code
    a. DAB Program Codes: A, B, E, M, O, P, Q
    b. TANF Program Codes: C, L, N
    c. MIChild Program Code: T
2. A qualifying scope/coverage code combination

    1D, 1F, 1K, 1P, 1T, 2F, 2T, 7E, 7W

For the Healthy Michigan population, a beneficiary must have **both**:

1. A Healthy Michigan program code (G or H)
2. A qualifying scope/coverage code combination (3G)

Individuals are eligible for the Healthy Michigan Plan if they:

- Are age 19-64 years
- Have income at or below 138% of the federal poverty level
- Do not qualify for or are not enrolled in Medicare
- Do not qualify for or are not enrolled in other Medicaid programs
- Are not pregnant at the time of application
- Are residents of the State of Michigan

To qualify as a Waiver (c) individual, a beneficiary must meet all of the following criteria:

- Have an intellectual disability (no age restrictions)
- Reside in a community setting
- Be Medicaid eligible and enrolled
- Would otherwise need the level of services similar to an ICF/IID

Appendix 8 documents the description of the scope, coverage, and program codes listed above.

(v) Special contract provisions

This rate certification report contains documentation of the following special contract provisions related to payment included within rate development.

- Withhold arrangements
- Certain delivery system and provider payment initiatives

Please see Section I, item 4 for additional detail and documentation.

(vi) Retroactive adjustment to capitation rates

This rate certification report does not include a retroactive adjustment to the capitation rates for prior rating periods.

iii. Differences among capitation rates

Any proposed differences among capitation rates according to covered populations are based on valid rate development standards and are not based on the rate of federal financial participation associated with the covered populations.

iv. Cross-subsidization of rate cell payment

The capitation rates were developed at the rate cell level and neither cross-subsidize nor are cross-subsidized by payments from any other rate cell.

v. Effective dates

To the best of our knowledge, the effective dates of changes to the Michigan SSSW managed care program and the HMP are consistent with the assumptions used in the development of the certified SFY 2019 capitation rates.

vi. Generally accepted actuarial practices and principles

(a) Reasonable, appropriate, and attainable

In our judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs, and have been included in the certification.

(b) Outside the rate setting process

There are no adjustments to the rates performed outside the rate setting process.

(c) Final contracted rates

The SFY 2019 capitation rates certified in this report represent the final contracted rates.

vii. Rate certification for effective time periods

This actuarial certification is effective for the one year rating period October 1, 2018 through September 30, 2019.

viii. Procedures for rate certification and amendment

In general, a new rate certification will be submitted when the rates change. The following exceptions are allowed per §438.7 of CMS 2390-F:

1. A contract amendment that does not affect the rates.
2. An increase or decrease of up to 1.5% in the capitation rate per rate cell.
3. Risk adjustment, under a methodology described in the initial certification, changes the rates paid to the PIHPs

In case 1 listed above, a contract amendment must still be submitted to CMS.

B. APPROPRIATE DOCUMENTATION

i. Documentation of required elements

This report contains appropriate documentation of all elements described in the rate certification, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

ii. Index

The index to this rate certification is the table of contents, found immediately after the title page. The index includes section numbers and related page numbers. Sections not relevant to this certification continue to be provided, with an explanation of why they are not applicable.

iii. Different FMAP

All populations, with the exception of the HMP population, receive the regular state FMAP of 64.45% for FFY 2019. The FMAP for the HMP population is 93.25% (94% for October 2018 to December 2018 and 93% for January 2019 to September 2019). The TANF population includes MIChild eligibility, which receives an enhanced FMAP of 98.12%. We did not develop a separate fiscal estimate in this certification report that reflects the impact of the MIChild FMAP.

iv. Comparison to final certified rates in the previous rate certification.

The previous rate certification applied to the SFY 2018 capitation rates. A comparison to the SFY 2018 certified rates by rate cell is provided in Table 1.

2. Data

This section provides information on the data used to develop the capitation rates.

A. RATE DEVELOPMENT STANDARDS

In accordance with 42 CFR §438.5(c), we have followed the rate development standards related to base data. The remainder of Section I, item 2 provides documentation of the data types, sources, validation process, material adjustments and other information relevant to the documentation standards required by CMS.

B. APPROPRIATE DOCUMENTATION

i. Requested data

As the actuary contracted by MDHHS to provide consulting services and associated financial analyses for many aspects of the Michigan Medicaid program (and not just limited to capitation rate development), Milliman intakes and summarizes eligibility and encounter claims data on a monthly basis from Optum, MDHHS's data administrator. As such, there is no separate data request from Milliman to the state specifically related to the base data for the capitation rate development. We also received the MUNC reports from MDHHS. The remainder of this section details the base data and validation processes utilized in the SFY 2019 capitation rate development.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

The primary data sources used or referenced in the development of the mental health, autism, substance abuse, and Waiver (c) capitation rates provided in Appendices 2 and 3 are the following:

- Encounter data submitted by the PIHPs (October 1, 2014 through June 2018);
- Historical Medicaid eligibility data;
- Historical capitation payments made by MDHHS to the PIHPs;
- MUNC reports, financial status reports (FSR), and administrative cost reports (ACRs) submitted by each PIHP; and,
- Behavioral health treatment episode dataset (BH-TEDS) data;

The DAB, TANF, HMP, and Waiver (c) population's mental health and substance abuse capitation rates utilize SFY 2017 encounter data and MUNC reports. The combined information from all data sources provides a comprehensive summary of the historical enrollment, capitation data, utilization, and cost of the covered services for the populations eligible for the SSSW and HMP.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during SFY 2017. The encounter data for the SFY 2017 base period reflected encounters adjudicated and submitted through the monthly encounter data warehousing process through June 2018. The MUNC reports were submitted by each PIHP to MDHHS in March following the September state fiscal year end and reflect five months of run-out.

The encounter data provided by MDHHS was also used for purposes of trend development, where we reviewed encounter experience from SFY 2015 through SFY 2017. SFY 2016 experience is currently being utilized for geographic factor development consistent with the factors utilized for SFY 2018.

(iii) Data sources

The historical claims and enrollment experience for the encounter data obtained through the encounter data warehousing process was provided to Milliman by Optum, the data administrator for MDHHS. The sources of other data are noted in (i) and (ii) above.

(iv) Sub-capitation

We are not aware of any subcapitated arrangements that the PIHPs have with other contracted entities. We receive encounters for all the services provided under the contract and review the overall data for reasonability.

(b) Availability and quality of the data

(i) Steps taken to validate the data

The base experience used in the capitation rates relies on encounter data submitted to MDHHS by participating PIHPs. Managed care eligibility is maintained in the data warehouse by MDHHS. The actuary, the PIHPs, and MDHHS all play a role in validating the quality of encounter data used in the development of the capitation rates. The PIHPs play the initial role, collecting and summarizing data sent to the state. MDHHS works with the data warehouse managers on data quality and PIHP performance measurement. Additionally, we perform independent analysis of encounter data to evaluate the quality of the data being used in the rate development process.

PIHPs may contract with related parties to provide services. This commonly occurs as community mental health service providers (CMHSPs) provide services for the PIHPs. Beginning in SFY 2014, MDHHS expanded the required encounter data fields to include both the provider and actual cost information. Milliman, MDHHS, and the PIHPs are currently working together to improve the completeness of these fields so that we can further evaluate the base data for reasonability and appropriateness for services provided by related parties.

Below is a summary of measures specific to each quality area that are applied by MDHHS or the actuary.

Completeness

MDHHS reviews the submitted encounter data to evaluate the completeness of the data. A sample of measures focused on the completeness of the data include:

- Encounter data volume measures by population;
- NPI provider number usage without Medicaid / reporting provider numbers;
- Percentage of encounters that are submitted by a PIHP and accepted by the data warehouse.

As the actuary, we also summarize the encounter data to assess month to month completeness of the encounter data. These measures include:

- Encounter per member per month (PMPM) by PIHP and high level service categories;
- Distribution of members by encounter-reported expenditures; and,
- Review of month to month activity across PIHPs.

These measures are applied to identify any months where encounter data volume is unusually large or small, indicating a potential issue with the submitted encounter data.

We also compare the MUNC report costs to the base encounter data for eligible populations. The base encounter data is developed by merging the encounter data with the Medicaid eligibility file and limiting the experience to only individuals eligible for the managed care programs. To the extent that there are material differences between the MUNC report and the base encounter data, MDHHS works with the PIHPs to reconcile the differences.

We have included incurred but not paid (IBNP) claim liability estimates reported in the SFY 2017 MUNC reports for inpatient hospital services. We have not applied any additional claims completion to the SFY 2017 experience used in the development of the capitation rates.

Accuracy

Checks for accuracy of the data begin with the PIHPs' internal auditing and review processes. MDHHS reviews the accuracy of the encounter data by reviewing the percentage of accepted encounters between the MDHHS encounter data files and the files submitted by the PIHPs. As the state actuary, we also review the encounter data to ensure each claim is related to a covered individual and a covered service. Claims utilized in the rate development process are those that have matching beneficiary IDs that are eligible for the noted service date.

We summarize the encounter data by service category. Base period data summaries are created to ensure that the data for each service is consistent across the PIHPs and with prior historical periods. Stratification by rate cell facilitates this review, as it minimizes the impact of changes in population mix. This process identifies health plan and service category combinations that may have unreasonable reported data.

Consistency of data across data sources

As historical encounter data is the primary source of information used in the development of capitation rates effective October 1, 2018, it is important to assess the consistency of the encounter data with other sources of information. The main source of comparison was the PIHP submitted MUNC reports that were provided in March 2018. The MUNC reports provide expenditure information for SFY 2017 for each service covered under the contract. We utilized the MUNC reports to validate the encounter data being utilized for rate development was appropriate and consistent between the two sources of information.

(ii) Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that Milliman has relied upon certain data and information provided by MDHHS and their vendors, primarily the PIHPs. The values presented in this letter are dependent upon this reliance.

We found the encounter data to be of appropriate quality for purposes of developing actuarially sound capitation rates. The following actions were performed to ensure compliance with ASOP 23:

- Selected data that were both appropriate and sufficiently current for the intended purpose: we used data that reflected the covered population and services under the contract;
- Reviewed the data for reasonability, consistency, and comprehensiveness: documented in the certification report;
- Disclosed any known limitations of the data: documented in the certification report; and,
- Placed reliance on the data supplied by MDHHS and its vendors: documented in the certification report.

While there are areas for data improvement, as detailed in the *Data concerns* section below, we found the encounter data to be of appropriate quality for the purposes of developing the base experience data for the capitation rates, as well as specific adjustments for reimbursement and program changes that impact PIHP expenditures beyond the base experience period.

(iii) Data concerns

The cost information provided in the encounter data was not a reliable source of cost for the services provided. As noted above, we are working with MDHHS and the PIHPs to improve the cost information submitted on the encounter data.

We have adjusted both the mental health and substance abuse encounter data to match the PIHP submitted financial reports (described in section I.2.B.iii.f). While adjustments made to the encounter data to match the MUNC reports for SFY 2017 are higher for the HMP mental health benefit than historical time periods, we do not have any concerns with the quality of the information for purposes of base rate development.

Lastly, as noted previously in the report, we have identified incomplete diagnostic information for some of the encounter data in SFY 2017, which is only relied upon by the geographic factor and does not impact the base rate development. We have discussed this issue with MDHHS and the PIHPs, and are working to receive more accurate diagnostic information. As a result, we are using the PIHP geographic factors developed using SFY 2016 encounter data, which were utilized in the SFY 2018 capitation rates, for the first quarter of SFY 2019. We anticipate updating this certification to utilize SFY 2017 encounter data for purposes of developing the PIHP geographic factors for the last nine months of SFY 2019, January 1, 2019 through September 30, 2019. Please note that the Autism geographic factors reflect SFY 2017 encounter data because they solely reflect treatment prevalence differences between PIHPs and do not rely on diagnostic information.

Appropriate data

(i) Use of encounter and fee-for-service data

All populations enrolled in managed care during the rate period were included in the risk-based managed care delivery system in the SFY 2017 base experience period. Fee-for-service (FFS) data was not included in the base experience used to develop the capitation rates.

(ii) Use of managed care encounter data

Managed care encounter data adjusted to reflect the expenditures in the PIHP submitted MUNC reports were utilized in the development of the capitation rates.

(c) Reliance on a data book

We did not rely on a data book.

iii. Data adjustments

The following sections describe any adjustments made to the base experience for data credibility, completion, reimbursement changes, and other program adjustments.

(a) Credibility adjustment

Based on our review of the SFY 2017 mental health and substance abuse encounter data and PIHP submitted MUNC reports, we believe combined data sources are an appropriate source of utilization and expenditures for the covered populations. We did not make any adjustments related to the credibility of the populations.

(b) Completion adjustment

The encounter data utilized to develop the capitation rates includes all data submitted to MDHHS as of June 2018, which includes nine months of runout from the end of the base data period. The MUNC reports were submitted to MDHHS in March and reflect five months of runout from the end of the state fiscal year. We have included IBNP claim liability estimates reported in the SFY 2017 MUNC reports for inpatient hospital services. Based on our review of monthly encounter submissions, we believe the run-out period negates the need for additional completion factors outside of the inpatient hospital category of service.

(c) Errors found in the data

Utilization Adjustment

We modified the reported utilization to adjust for excessive utilization of services. The adjusted encounters were identified by a single recipient having multiple encounter lines for the same procedure and service date, with different internal control numbers, and the cumulative units of the encounter lines exceeding a maximum amount as determined by MDHHS. Table 3 illustrates an example of two encounters with de-identified beneficiaries. The procedure code H2016 has a maximum units allowed of 1 unit per day.

If the encounter data submitted shows a recipient having the same procedure and service dates that exceed the units allowed, we consider the units in excess of the maximum as duplicate encounters, and adjust the units on these encounter lines down to the maximum number of units allowed. This adjustment would also impact a single encounter if the utilization reported was above the maximum utilization possible for the service date window of the encounter.

Table 3
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Duplicate/Excessive Utilization Logic Example

Related Plan ID	Consumer Unique ID	Line Service Begin Date	Line Service End Date	Procedure Code	Internal Control Number	Quantity
1705289	Beneficiary A	9/1/2017	9/1/2017	H2016	C012	1
1705289	Beneficiary A	9/1/2017	9/1/2017	H2016	C018	1
1705289	Beneficiary A	9/2/2017	9/2/2017	H2016	C010	1
1705289	Beneficiary A	9/2/2017	9/2/2017	H2016	C020	1

Note: In this example, we would adjust the quantity of encounter lines 1 through 4 as a result of the duplicate logic.

(d) Program change adjustments

Direct Care Wages (DCW) adjustment

Effective October 1, 2017, MDHHS increased reimbursement for direct care wage (DCW) services by $0.50 per hour based on the Section 1009 boilerplate language. Using the historical experience, we determined that a cost per hour increase of $0.50 for DCW services would produce approximately a $58.3 million increase to base experience for SFY 2017. Appendix 4 documents the adjustment made to underlying base experience for the increased reimbursement amounts for DCW services. The following services were considered DCW services for purposes of this analysis:

- H0043 - Community Living Supports in Independent living/own home
- H0045 - Respite Care
- H2014 - Skill-Building
- H2015 - Community Living Supports (15 Minutes)
- H2016 - Community Living Supports (Daily)
- H2023 - Supported Employment Services
- S5151 - Respite
- T1005 - Respite Care
- T1020 - Personal Care in Licensed Specialized Residential Setting
- T2015 - Out of Home Prevocational Service
- T2036 - Community Living Supports/Respite Care-Therapeutic Camping
- T2037 - Community Living Supports/Respite Care-Therapeutic Camping

Medical Consumer Price Index (Medical-CPI) adjustment

We limited the unit cost increases from SFY 2016 to SFY 2017 based on Medical-CPI of 3.8% for the applicable time period. We determined whether a cap was necessary for each PIHP and population combination for mental health, substance abuse, and autism independently. For example, if a PIHP experience a 5% increase to the DAB unit cost, but a 3% increase to TANF, we limited the DAB change to 3.8% without impacting the TANF experience. This adjustment was not performed at an individual procedure code level. We estimated that applying the Medical-CPI adjustment resulted in approximately $60.8 million decrease to the base experience. Appendix 4 documents the adjustment made to underlying base experience for the Medical-CPI.

Substance Abuse Assessment adjustment

Effective October 1, 2018, MDHHS will be introducing a standardized SUD assessment into the PIHP contracts. PIHPs will be required to implement the GAIN assessment and replace all of their current SUD assessment instruments. MDHHS estimates that this requirement will increase SUD assessment costs for the PIHPs by about fifty percent. We estimated the impact of this adjustment to be approximately a $2 million increase to the base experience. Appendix 4 documents the adjustment made to the underlying base experience for the substance abuse assessment service. We have applied this adjustment to the following procedure codes under the substance abuse benefit:

- H0001 - Substance Abuse: Individual Assessment
- 90791 (with HF modifier) - Substance Use: Assessment
- 90792 (with HF modifier) - Substance Use: Assessment

Autism Fee Schedule adjustment

Effective October 1, 2018, MDHHS will be introducing the Autism fee schedule illustrated in Appendix 12. We repriced the Autism encounter data to match the unit cost illustrated in the fee schedule after adjusting the encounter data to match the utilization and expenditures in the Autism MUNC report. Appendix 4 documents the adjustment made to the underlying base experience. Table 4 illustrates the projected Autism fee schedule impact to the base experience.

Table 4
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Autism Fee Schedule Adjustment

Population	SFY 2017 MUNC Expenditures	Reduction due to Fee Schedule	SFY 2017 Base Expenditures
Statewide	$ 116,400,000	$ 19,600,000	$ 96,800,000

(e) Exclusion of payments or services from the data

Removal of Child and SED Waiver Population Encounter Data

We excluded Medicaid-eligible recipients in the Children's Waiver and Children with Serious Emotional Disturbance Waiver (SEDW) populations from the base encounter data because MDHHS has historically paid the PIHPs for these populations on a fee-for-service basis. MDHHS provided us with a list of Medicaid beneficiaries in these two waiver programs during SFY 2017.

Children's Waiver and SEDW recipient's encounter data was excluded from the final base data, with the exception of services that were provided during a time period when the recipient was not actively enrolled on either the Children's or SED waiver.

Spend-down adjustment

In determining the appropriate encounter claims to include in the capitation rate setting process, we included services for the spend-down eligible population. However, we were unable to determine the services rendered prior to full eligibility for benefits. Therefore, we relied on the reported total spend-down amount included in the MUNC report line items by each PIHP. The reported spend-down values were applied as reductions to the DAB and TANF population mental health and substance abuse capitation rates. The reduction was applied at an aggregate level for each PIHP based on the overall health expenditures. The total reduction across all PIHPs was approximately $2.3 million in SFY 2017.

We did not perform a detailed review of the total spend-down amount; however, the aggregate amount was consistent with prior years. The Medicaid eligibility file we receive from MDHHS does not provide the level of detail necessary to identify the spend-down population and their associated encounter claims experience.

Fraud, waste, and abuse

We did not make any adjustments for fraud, waste, and abuse. Fraud recoveries by the PIHP should result in correcting warehouse encounters and impact financial status reporting by not allowing those expenses to be categorized as allowable Medicaid expenses.

First and third party liabilities

We utilized the first and third party liabilities reported in the MUNC reports, which reflect the total amount due. The rates are developed with the full amount of first and third party liabilities removed from the capitation rate's base experience. Removing first and third party liabilities for SFY 2017 accounted for approximately $5.9 million decrease to the base encounter experience costs on a statewide basis.

(f) Encounter data financial statement adjustment

The encounter data was adjusted to reflect the financial reports prepared by the PIHPs for the comparable time periods. The financial reports utilized in the rate setting process were the SSSW MUNC report, the HMP MUNC report, and the Autism MUNC report.

The MUNC reports provide information regarding utilization and cost per unit of service for the Medicaid eligible population split between state plan (1115 for HMP), Early Periodic Screening, Diagnosis, and Treatment (EPSDT), 1915(b)(3), and HSW services. The following steps were used to adjust the encounter data to match the MUNC reports:

Step 1: Apply MUNC report cost per unit to encounter data

The cost per unit of service was developed from the SFY 2017 MUNC reports submitted by each PIHP. The MUNC reports illustrated the incurred cost per unit of service by procedure code or revenue code for each covered service, split between state plan (1115 for HMP), EPSDT, (b) (3), and HSW services. Cost per service amounts specific to each PIHP and fiscal year were applied to the encounter data.

For instances where a procedure or revenue code contained in the encounter data did not have a corresponding cost per service amount on the MUNC report for a given PIHP and cost bucket, the composite cost per service was calculated as follows:

i. The sum of state plan (1115 for HMP), (b)(3), EPSDT, and HSW dollars divided by the total number of units (if any are available) within a given PIHP for said service, or;
ii. The sum of state plan (1115 for HMP), (b)(3), EPSDT, and HSW dollars divided by the total number of units (if any are available) across all PIHPs for said service, or;
iii. If there are no units available for the previous methods, a benchmark Medicaid fee schedule was used.

Step 2: Calculate encounter expenditures by multiplying the MUNC cost per unit by the encounter utilization

Base encounter expenditures were developed by applying the MUNC cost per unit from the previous step to the encounter utilization.

Step 3: Summarize encounter and MUNC report expenditures

Base encounter and MUNC report expenditures for SFY 2017 were summarized at consistent levels of detail. We are adjusting at the service level of detail (procedure code) for the highest cost mental health services; otherwise, we are adjusting at the service category level of detail. The mental health categories are adjusted separately for the state plan (1115 for HMP), (b)(3), EPSDT, and HSW cost buckets when applicable.

Step 4: Calculate the adjustment factor and apply it to utilization and expenditures

The adjustment factor is calculated as the MUNC report expenditures divided by the encounter dollars for each respective PIHP at the adjustment category level of detail. We apply each respective adjustment factor to the corresponding utilization and expenditure fields on the encounter data.

Table 5 illustrates the overall impact of the adjustment to the base encounter data for both mental health and substance abuse in SFY 2017. Please note that the adjustment factors illustrated are at an aggregate level; each respective PIHP's adjustment factor may be above or below the aggregate adjustment factor.

Table 5 State of Michigan Department of Health and Human Services October 1, 2018 to September 30, 2019 Capitation Rates SFY 2017 MUNC Report Reconciliation Factors	
Rate	**Adjustment Factor**
Specialty Services	
Mental Health	1.02
Substance Abuse	1.14
Healthy Michigan	
Mental Health	1.15
Substance Abuse	1.10
Autism	0.99

(g) Repricing of Autism benefit treatment prevalence adjustment

The cost of the Autism benefit is sensitive to the number of beneficiaries receiving ABA services because of the high per recipient per month cost. As a result, we worked closely with MDHHS in the development of the estimated number of Autism recipients expected to receive ABA services during the SFY 2019 rating period.

The Autism program has experienced significant growth in the number of recipients receiving ABA services since program inception. However, this growth has been constrained by the provider network capacity. To develop estimated ABA recipients for SFY 2019, we reviewed historical recipient data, as well as information from MDHHS on the number of ASD children waiting to receive ABA services. Note that the historical recipient data only reflects those who receive ABA services and excludes individuals who only receive assessment services in a month. Based on this data, we estimated an additional 90 recipients will receive ABA services each month from the February 2018 to September 2019. Table 6 illustrates the development of the adjustment factor applied to the SFY 2017 experience to reflect the increased number of beneficiaries estimated to receive ABA services during the rating period. Note that Table 6 illustrates the recipient changes from the historical period to the estimated rating periods, while the adjustment factor reflects the change in the treatment prevalence, which incorporates the estimated enrollment change from the historical period to the rating period.

Table 6 State of Michigan Department of Health and Human Services October 1, 2018 to September 30, 2019 Capitation Rates Autism Benefit Treatment Prevalence Adjustment				
Population	**Average Monthly SFY 2017 ABA Recipients**	**February 2018 ABA Recipients**	**Estimated SFY 2019 Average Monthly ABA Recipients**	**Adjustment Factor**
DAB	1,721	2,256	3,093	1.8116
TANF	755	1,110	1,488	1.9810

Appendix 4 incorporates these adjustment factors in the development of the SFY 2019 Autism benefit expense for each population. We are utilizing the TANF adjustment factor in the development of the HMP Autism benefit expense because of the limited experience for the HMP 19-21 age group.

3. Projected benefit cost and trends

This section provides information on the development of projected benefit costs in the capitation rates.

A. RATE DEVELOPMENT STANDARDS

i. Final Capitation Rate Compliance

The final capitation rates are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.3(c)(1)(ii) and 438.3(e). Non-covered services provided by the PIHPs, with the exception of approved in-lieu of services, have been excluded from the capitation rate development. PIHPs utilize institutions for mental disease (IMD), as an approved in-lieu of service.

ii. Basis for Variation in Assumptions

Any assumption variation between covered populations is the result of program differences and is in no way based on the rate of Federal financial participation associated with the population.

iii. Benefit Cost Trend Assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends is historical claims and enrollment from the covered populations. Additionally, consideration of other factors and data sources appropriate for benefit cost trend development is further documented in Section I, item 3.B.iii.

iv. In Lieu Of Services

The projected benefit costs include costs for in-lieu-of services for IMD only. Effective October 1, 2016, all services provided to a beneficiary in a month where the beneficiary exceeds 15 days in an IMD setting should be excluded from the capitation rates based on the publication of the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (CMS-2390-F, 81 FR 27498) on May 6, 2016 ("final rule"). Appendix 4 documents the adjustment made to the underlying base experience to remove all expenditures associated with IMD stays of greater than 15 days. To develop this adjustment factor, we flagged recipient months where the beneficiary stayed more than 15 days in an IMD, and then removed all services (including non-IMD services) provided to the beneficiary in that month as well as the corresponding membership from the base experience because capitation payments cannot be made for these months.

v. Benefit expenses associated with members residing in an IMD

For enrollees aged 21 to 64, the projected benefit costs do not include the costs associated with an IMD stay of more than 15 days, as well as other managed care plan costs delivered in a month when an enrollee has an IMD stay of more than 15 days. We have also excluded member months from the base rate development where an enrollee had an IMD stay of more than 15 days.

vi. IMDs as an in lieu of service provider

Table 7 illustrates (a) the number of IMD enrollees, (b) the average length of stay, and (c) the impact that providing treatment through IMDs has had on the rates. The impact on the rates is limited to individuals who stayed in an IMD less than 15 days in a month.

Table 7 State of Michigan Department of Health and Human Services October 1, 2018 to September 30, 2019 Capitation Rates IMD as in lieu of service				
Population	Admissions	Average Length of Stay	Statewide Cost per Day	Total Dollar Impact
DAB	4,702	7.9	$ 676.73	$ 25,180,000
TANF	2,862	7.0	$ 676.73	$ 13,599,000
HMP	3,601	7.3	$ 676.73	$ 17,885,000

B. APPROPRIATE DOCUMENTATION

i. Projected Benefit Costs

This section provides the documentation of the methodology utilized to develop the benefit cost component of the capitation rates at the rate cell level.

ii. Development of Projected Benefit Costs

(a) Description of the data, assumptions, and methodologies

This section of the report outlines the data, assumptions, and methodology used to project the benefit costs to the rating period. The baseline benefit costs were developed using the following steps:

Step 1: Apply historical and other adjustments to base encounter data

As documented in the previous section, the base experience was adjusted for a number of items, including but not limited to, utilization adjustment, spend-down population expenditures, and Child and SED Waiver population enrollment and encounter expenditures.

Step 2: Adjust base data to financial reports

Section I, item 2.B.iii.(f) documents the adjustment of the base encounter experience to match the expenditures reported in the PIHP submitted MUNC reports.

Step 3: Create per member per month (PMPM) cost summaries

The capitation rates were developed from historical encounters and enrollment data from the managed care enrolled populations. This data consisted of SFY 2017 incurred encounter data that has been submitted by the PIHPs as well as SFY 2017 MUNC reports developed by each PIHP.

Step 4: Adjust for program and policy changes and trend to the rating period

Section I, item 2.B.iii.(d) documents the program and policy changes included in the projected benefit expense. We also adjusted the SFY 2017 base experience to reflect changes in the covered population between the base period and effective rate period. The resulting PMPMs established the adjusted benefit expense by population and rate cell for the rating period.

The adjusted PMPM values from the base experience period were trended forward from the midpoint of the base experience period to the midpoint of the rate period (April 1, 2019).

The following items provide more information regarding significant and material items in developing the projected benefit costs.

Managed care efficiency

In our prior rate certification, we had applied a managed care adjustment for Macomb County PIHP's utilization to reduce community living support (CLS) services to levels observed by other PIHPs. After our review of the SFY 2017 encounter data, the CLS experience is not materially different from other PIHPs. We have not made any adjustment for managed care efficiencies related to this prior observation or for other experience.

(b) Material changes to the data, assumptions, and methodologies

All rate development data and material assumptions are documented in this rate certification report and the overall methodology utilized to develop the capitation rates is consistent with the prior rate-setting analysis.

iii. Projected Benefit Cost Trends

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period (SFY 2017) to the SFY 2019 rating period of this certification. We evaluated prospective trend rates using historical experience for the SSSW managed care program and the HMP, as well as external data sources.

(a) Required elements

(i) Data

As services are on a multitude of unit bases (per diem, 15-minute, 30-minute, 1 hour, etc.), it is difficult to assess utilization and unit changes on a composite level. For example, if a PIHP moved services from a per diem service in SFY 2016 to an hourly basis in SFY 2017, composite utilization would artificially increase, while cost per unit would decrease. As a result, we have utilized a relative value unit (RVU) scale to help normalize for the different unit cost bases.

Using data from all PIHPs in SFY 2011 through SFY 2017, we established a RVU scale for all services covered under the contract. The RVU scale was established by comparing the cost per unit of a specific service to the composite cost per unit for all services. After identifying the relative value units for each unit of service, the aggregate number of RVUs for a service can be calculated as the number of units multiplied by the relative value units for the unit of service. For MUNC report cost data in SFY 2011 through SFY 2017, we calculated the average reimbursement per RVU for all services. By examining reimbursement on a RVU basis rather than per unit basis, we normalize for changes in the mix of services from year to year that will influence the average cost per unit.

Annual utilization and unit cost trend rates were developed for mental health, Waiver (c), and substance abuse services using normalized cost and RVU PMPMs from SFY 2015 to SFY 2017. Normalized cost and RVU PMPMs were determined separately for following service categories for the TANF, DAB, and HMP populations:

- Mental Health State Plan/1115 Inpatient;
- Mental Health State Plan/1115 Outpatient;
- Mental Health State Plan/1115 Professional Community Living Supports;
- Mental Health State Plan/1115 Professional Non-Community Living Supports;
- Mental Health 1915(b)(3) Professional Community Living Supports;
- Mental Health 1915(b)(3) Professional Non-Community Living Supports;
- Mental Health Autism
- Waiver (c) Community Living Supports;
- Waiver (c) Non-Community Living Supports; and,
- Substance Abuse State Plan;

External data sources that were referenced for evaluating trend rates developed from MDHHS data include:

- *National Health Expenditure (NHE) projections* developed by the CMS office of the actuary, specifically those related to Medicaid. Please note that as these are expenditure projections, projected growth reflects not only unit cost and utilization, but also aggregate enrollment growth and enrollment mix changes such as aging. For trends used in this certification, we are interested only in unit cost and utilization trends, so in general, our combinations of unit cost and utilization trends should be lower than NHE trends. NHE tables and documentation may be found in the location listed below:
  - https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html
- *U.S. Bureau of Labor Statistics (BLS)* wage trends over the past three years for those occupations providing behavioral health services (e.g. direct care wage and home health workers).
- *Other sources:* We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries.

(ii) Methodology

For internal MDHHS data, historical utilization and per member per month cost data was stratified by month, rate cell, and category of service. The data was adjusted for completion and normalized for historical program and reimbursement changes. We developed trend rates to adjust the base experience data (midpoint of April 1, 2017) forward 24 months to the midpoint of the contract period, April 1, 2019.

Appendix 6 illustrates the historical unit cost and utilization experience for the past three fiscal years by population and service category. Note that this summary reflects encounter data repriced to the MUNC report without any other adjustments. In some cases, the experience reflects large trend increases or decreases. In general, we set best estimate trend rates at a composite level (state plan or (b)(3)) to smooth out trend variations within the service categories.

Historical trends should not be used in a simple formulaic manner to determine future trends; actuarial judgment is also required. We also referred to alternative sources, both publicly available and internal Milliman information. We also considered changing practice patterns, shifting population mix, and the impact of reimbursement changes on utilization in this specific population.

(iii) Comparisons

As noted above, we did not explicitly rely on the historical PIHP encounter data and MUNC report trend projections due to anomalies observed in the historical trend data. In addition to referencing external data sources and emerging experience in the encounter data, we also reviewed the utilization trends assumed in the SFY 2018 capitation rate development to determine if any adjustment to the trend assumption was appropriate for the SFY 2019 rating period.

Explicit adjustments were made outside of trend to reflect all recent or planned changes in reimbursement from the base period to the rating period.

(b) Benefit cost trend components

Table 8 illustrates the unit cost and utilization trends used to develop the projected mental health, substance abuse, and Waiver (c) benefit cost for the DAB, TANF, and Waiver (c) populations.

Table 8
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Estimated Annual Trend Rates

	DAB		TANF		HMP	
Capitation Category	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**	**Unit Cost**	**Utilization**
Mental Health						
State Plan Inpatient	2.0%	0.5%	1.5%	2.0%	1.5%	2.0%
State Plan Outpatient	2.0%	0.5%	1.5%	2.0%	1.5%	2.0%
State Plan Professional CLS	2.0%	0.5%	1.5%	2.0%	1.5%	2.0%
State Plan Professional Non-CLS	2.0%	0.5%	1.5%	2.0%	1.5%	2.0%
(b)(3) Professional CLS	2.0%	0.5%	1.5%	2.0%		
(b)(3) Professional Non-CLS	2.0%	0.5%	1.5%	2.0%		
Autism	0.0%	2.0%	0.0%	2.0%	0.0%	2.0%
Substance Abuse						
State Plan	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Waiver (c) Enrollees						
Professional CLS	2.0%	0.5%				
Professional Non-CLS	2.0%	0.5%				

Note: HMP trends illustrated in the table above under state plan represent the trends applied to the eligible 1115 Waiver services.

(c) Variation

This section describes the development of the age, gender, and residential living arrangement factors utilized in the development of the SFY 2018 capitation rates.

1. Age/Gender Factors – State Plan and (b)(3) Services

The encounter data and MUNC reports were used to develop the mental health age/gender factors for each PIHP's state plan and (b)(3) capitation rates. Separate factors were developed for the TANF and DAB populations and between state plan and (b)(3) services. Due to the addition of EPSDT services for under 21 year olds, which shifts (b)(3) dollars to state plan, maintaining a single set of age/gender factors would produce capitation payments that would not be actuarially sound. The creation of separate age/gender factors for state plan and (b)(3) services is cost neutral. The age / gender factors for both state plan and (b)(3) services were calculated on a statewide basis using the SFY 2017 encounter data. Table 9 illustrates a demonstration of the state plan age/gender factor calculation for the DAB population. The age/gender factors were developed from encounter PMPMs for each age/gender cohort, separated by population (DAB or TANF) and service type (state plan or (b)(3)).

Table 9
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Age/Gender Factor Development - DAB Population - State Plan Mental Health

Cohort		PMPM	Age/Gender Factors	Est. Enrollment	Normalized Factor
Gender	Age Group	SFY 2017	SFY 2017	SFY 2019	
M	0 - 5	$75.23	0.651	115,980	0.6551
M	6 - 18	126.87	1.099	475,875	1.1048
M	19 – 21	202.54	1.754	112,874	1.7637
M	22 - 25	140.09	1.213	128,498	1.2199
M	26 - 39	183.59	1.590	364,082	1.5987
M	40 - 49	176.49	1.528	279,303	1.5368
M	50 - 64	147.11	1.274	762,288	1.2810
M	65+	62.41	0.540	510,815	0.5435
F	0 - 5	46.29	0.401	91,970	0.4031
F	6 - 18	109.09	0.945	315,911	0.9500
F	19 – 21	152.45	1.320	82,191	1.3275
F	22 - 25	141.91	1.229	92,994	1.2357
F	26 - 39	162.15	1.404	322,653	1.4120
F	40 - 49	141.82	1.228	329,384	1.2349
F	50 - 64	113.21	0.980	905,937	0.9858
F	65+	38.68	0.335	978,326	0.3368
Composite		**$ 115.48**	**0.994**	**5,899,680**	**1.0000**

2. HSW Base and Residential Status Adjustment Factors

MDHHS maintains profile information in the Behavioral Health Treatment Episode Data Set (BH-TEDS), which documents certain insurance, employment, residential, and other characteristics about the HSW population. The residential living arrangement identified using the BH-TEDS data was deemed correlated with the cost contained in the encounter data utilization.

The SFY 2017 encounter data and MUNC reports were used to update the residential status adjustment factors utilized in the SFY 2019 HSW capitation rates. The residential status adjustment factors were calculated on a statewide basis. Table 10 illustrates the development of the residential status adjustment factors.

Table 10
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Waiver (c) Residential Status Adjustment Factor Development

Residential Status	Member Months	Total PMPM	Initial Factor	Est. SFY 2019 Capitation Payments	Normalized Factor
Other	430	3,881.60	0.3315	100	0.3350
Private Residence with Spouse or Non-family/Supported Independence Program	26,515	5,931.25	1.3996	2,036	1.4143
Private Residence with Family or Foster Home	16,004	3,153.49	0.7179	1,683	0.7255
Specialized Residential Home	48,347	4,171.90	0.9106	3,952	0.9202
Composite	**91,296**	**4,502.98**	**0.9896**	**7,770**	**1.0000**

The Other residential status adjustment factor is multiplied by the statewide PMPM cost to create the base rate. The three residential status' adjustment payments are calculated as the statewide PMPM cost multiplied by the corresponding residential status adjustment factor less the base rate. Appendix 3 provides the 1915(c) HSW base capitation rate as well as the residential status adjustment payments for the SFY 2019 period.

The capitation rate for each HSW eligible is calculated by the following equation:

HSW Capitation Rate = (Base Rate + Residential Status Adjustment) × (Geographic Factor)

The HSW capitation rates do not vary by age group because the residential living arrangement is the primary driver of cost, and it is highly correlated with a person's age. Approximately 96% of children reside in a private residence with family or foster home.

(d) Material adjustments

Historical trends should not be used in a simple formulaic manner to determine future trends; a great deal of actuarial judgment is also needed. We did not explicitly rely on the historical encounter data trend projections due to anomalies observed in the historical trend data. We referred to the sources listed in the prior section, considered changing practice patterns, the impact of reimbursement changes on utilization in the populations, and shifting population mix.

We made adjustments to the trend rates derived from historical experience in cases where the resulting trends did not appear reasonably sustainable, or were not within consensus parameters derived from other sources.

(e) Any other adjustments

(i) Impact of managed care

We did not adjust the trend rates to reflect a managed care impact on utilization or unit cost.

(ii) Trend changes other than utilization and cost

We did not adjust the benefit cost trend for changes other than utilization or unit cost.

iv. Mental Health Parity and Addiction Equity Act Service Adjustment

It was not necessary for projected benefit costs to include additional services for compliance with the Mental Health Parity and Addiction Equity Act as required by 42 CFR 438.3(c)(ii).

v. In Lieu of Services

(a) Categories of service that contain in lieu of services

Section 438.6(e) of the final rule clarifies that states can receive FFP and make a capitation payment on behalf of an enrollee that spends 15 days or less as a patient in an IMD in any given month if the conditions described in the final rule are met. As a result, during SFY 2019 rating period, the PIHPs may provide inpatient services in an IMD setting in lieu of providing that service in an inpatient acute community psychiatric hospital.

(b) Percentage of cost that in lieu of services represent

The SFY 2017 experience reflects that approximately 40% of combined cost for the DAB, TANF, and HMP populations in the inpatient category of service are provided to beneficiaries who spend 15 days or less in a given month in an IMD setting.

(c) Development of the projected benefit costs

Section I, item 2.B.iii.d describes how services provided in an IMD were included in the development of the projected benefit cost.

(d) 42 CFR §438.6(e) Compliance

The capitation rates developed in this certification comply with the requirements of 42 CFR §438.6(e). The data and assumptions utilized are described both in Section 1, item 2.B.iii.d and Section 1, item 3.A.v.

vi. Retrospective Eligibility Periods

(a) MCO responsibility

PIHPs are contractually obligated to provide services to all Medicaid eligible members, including during retrospective eligibility periods.

(b) Claims treatment

The encounter data and MUNC reports submitted by the PIHPs included experience from a member's retrospective eligibility period.

(c) Enrollment treatment

The Medicaid eligibility data includes eligibility months for individuals during their retrospective eligibility period, allowing us to include beneficiary cost from the retrospective eligibility periods. However, capitation payments are not made to members who become retroactively eligible for a given month after the end of the month in question. Table 11 illustrates an example of the methodology used to calculate the capitation payment to eligibility month ratios. The figures in Table 11 are for illustrative purposes only.

Table 11
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Capitation Payment to Eligibility Month Ratio Calculation Example – October 2017

Population	Members Eligible as of 9/30/2017	Members Becoming Eligible during October 2017	Members Become Eligible after 10/31/2017	Capitation Payment to Eligibility Month Ratio
DAB	930	20	50	(930+20) / 1,000 = 95.0%
TANF	896	50	54	(896+50) / 1,000 = 94.6%

Note: Figures illustrated in this table are for illustrative purposes only and were not directly utilized in the development of the capitation rates.

Members eligible as of 9/30/2017 are those who entered the eligibility system before 9/30/2017 and are Medicaid eligible during October 2017. Members becoming eligible during October 2017 are those who entered the eligibility system at some point during October 2017. Members eligible after 10/31/2017 are those members who become retro-actively eligible for October after October 31, 2017. We estimated the number of eligibility months for which PIHPs will not receive a capitation payment by comparing the historical capitation payments made to the eligibility months by population and month. Our estimate reflected the average of the most recent six months of complete experience.

(d) Adjustments

The encounter data and MUNC reports submitted by the PIHPs included experience from a member's retrospective eligibility period. However, the PIHPs do not receive a capitation payment for these Medicaid eligibility periods. Capitation rates are developed to include costs associated with these periods of eligibility by increasing the capitation PMPM to reflect the estimated percentage of eligibility months for which the PIHPs will not receive a capitation payment.

Table 12 illustrates the estimated capitation payment to eligibility month ratio for the DAB, TANF, HMP, and HSW populations for the SFY 2018 and the SFY 2019 period.

Table 12
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Capitation Payment to Eligibility Month Ratio

Population	SFY 2018	SFY 2019
DAB	0.964	0.959
TANF	0.960	0.959
HMP	0.955	0.950
Waiver (c)	0.981	0.981

In the development of the capitation rates, we divided the benefit expense eligibility PMPM by the estimated capitation payment to eligibility month ratio to calculate the benefit expense capitation PMPM.

vii. Impact of Material Changes

This section relates to material changes to covered benefits or services since the prior rate certification. The prior rate certification was for the SFY 2018 rating period.

(a) Change to covered benefits

There were no material changes to covered benefits or services from the prior certification.

(b) Recoveries of overpayments

To the best of our knowledge, all information related to any payment recoveries not reflected in the base period encounter data was provided to us by the PIHPs in their MUNC Report. We are accounting for these recoveries when we are repricing to the PIHP MUNC report expenditure amounts.

(c) Change to payment requirements

Material changes to required provider payments have been described in program adjustments described in Section I, item 2.B.iii.(d) Program change adjustments.

(d) Change to waiver requirements

There were no material changes to waiver requirements or conditions.

(e) Change due to litigation

There were no material changes due to litigation.

(f) Covered population changes

The mental health and substance abuse expenditures from SFY 2017 were individually normalized to the estimated SFY 2019 population for each the following population changes:

- Morbidity mix (including age/gender mix); and,
- PIHP mix (based on Mental Health Professional Shortage Area).

Morbidity and PIHP mix adjustments are needed to appropriately reflect the distribution of estimated individuals covered by the PIHPs during the rate period relative to the distribution of individuals covered by the PIHPs during the base experience period.

The morbidity mix factors are calculated by weighting enrollment in the historical experience and the rate certification period by historical PMPMs stratified by population cohort. The population cohorts were created by identifying members with common demographic information. We split the population into a cohort for each unique age group, gender, and program code combination from the SFY 2017 to SFY 2019, consistent with the variables utilized to project enrollment for the time period of October 1, 2018 to September 30, 2019. Table 13 provides a simplified quantitative example for how the morbidity mix factors are calculated, assuming only the 0-5 age group is eligible.

Table 13
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Example Morbidity Mix Calculation

Cohort	SFY 2017 PMPM	SFY 2017 Membership	Est. SFY 2019 Membership
Program Code A, 0-5	$ 20	10	10
Program Code B, 0-5	40	10	10
Program Code E, 0-5	60	10	10
Program Code M, 0-5	100	10	10
Program Code O, 0-5	150	10	10
Program Code P, 0-5	200	10	20
Program Code Q, 0-5	20	10	10
Composite PMPM		**$ 82.86**	**$ 97.50**
Morbidity Mix Adjustment		**= 97.50 / 82.86**	**= 1.18**

Note: Figures illustrated in this table are for illustrative purposes only and were not directly utilized in the development of the capitation rates.

Table 14 illustrates the morbidity mix adjustments applied to the SFY 2017 base experience by population for the mental health and substance abuse experience data. A morbidity mix factor below a 1.0 indicates that the population distribution in the projection period is less expensive relative to the historical experience, while a morbidity mix factor above a 1.0 indicates that the population distribution in the projection period is more expensive relative to the historical experience.

Table 14
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Base Experience Morbidity Mix Cost Adjustments

	Mental Health			Substance Abuse		
SFY	TANF	DAB	HMP	TANF	DAB	HMP
2017	1.0001	0.9920	0.9973	0.9955	1.0001	0.9958

A final adjustment was made to the base experience to account for differences in the enrollment mix by PIHP between the base experience periods and the rating period.

The PIHP mix factors are calculated by weighting enrollment in the historical experience and the rate certification period by the mental health professional shortage area (HPSA) factors. Health professional shortage area designations are used to identify geographic regions within the U.S. that are experiencing a shortage of health professionals. The development of the HPSA factors can be found in Appendix 13. Table 15 provides a quantitative example for how the PIHP mix factors are calculated for the SFY 2017 experience.

Table 15 State of Michigan Department of Health and Human Services October 1, 2018 to September 30, 2019 Capitation Rates PIHP Mix Calculation –DAB Population			
Cohort	**HPSA Factor**	**SFY 2017 Membership**	**Est. SFY 2019 Membership**
Northcare	1.0487	174,606	171,514
Northern Michigan	1.0523	316,030	311,390
Lakeshore	0.9909	627,421	624,989
Southwest	1.0088	508,386	510,021
Mid-State	1.0237	985,556	977,210
Southeast	0.9859	279,053	279,993
Detroit-Wayne	0.9983	1,636,164	1,609,435
Oakland	0.9694	484,063	477,566
Macomb	0.9694	446,287	443,604
Region 10	0.9748	470,568	463,358
Composite HPSA Factor		**1.0000**	**1.0000**
PIHP Mix Adjustment (Multiplicative)			**=1.0000/1.0000 =1.0000**

A PIHP mix factor below a 1.0 indicates that the population distribution in the projection period is less expensive relative to the historical experience, while a PIHP mix factor above a 1.0 indicates that the population distribution in the projection period is more expensive relative to the historical experience. For purposes of this adjustment, a factor greater than a 1.0 indicates there is a higher percentage of enrollees in shortage areas in the projection period compared to the historical experience period.

The factors were applied to the SFY 2017 experience to normalize the PIHP mix differences between the experience period and rate period. Adjustment factors are illustrated in Table 16 for mental health and substance abuse services.

Table 16 State of Michigan Department of Health and Human Services October 1, 2018 to September 30, 2019 Capitation Rates Base Experience PIHP Mix Cost Adjustments						
	Mental Health			**Substance Abuse**		
SFY	**TANF**	**DAB**	**HMP**	**TANF**	**DAB**	**HMP**
2017	1.0000	1.0000	1.0001	1.0000	1.0000	1.0001

viii. Documentation of Material Changes

Material changes to covered benefits and provider payments have been described in program adjustments described in Section I, item 2.B.iii Program Change Adjustments. This information includes the data, assumptions, and methodology used in developing the adjustment, estimated impact by population, and aggregate impact on the managed care program's benefit expense.

4. Special Contract Provisions Related to Payment

A. INCENTIVE ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the incentive payment structure in the SSSW program. The budgeted SFY 2019 incentive payment amount is $8,705,500. This amount is less than 5% of the total capitated amount for the SSSW.

ii. Appropriate Documentation

MDHHS has an incentive program to support increasing access to mental health services under the SSSW for foster children and children in protective service with a serious emotional disturbance. MDHHS has created separate incentive payment criteria to reflect a range of service needs amongst the targeted population. The incentive payment amounts are intended to both increase access to services and provide PIHPs with funding to develop protocols for identifying children that are currently not being served.

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the withhold arrangement in the SSSW program and the HMP.

ii. Appropriate Documentation

(a) Description of the Withhold Arrangement

(i) Time period and purpose

The withhold arrangement is measured on a state fiscal year basis. The withhold measure evaluates quality-based performance by the PIHPs in delivery of services.

(ii) Description of total percentage withheld

Effective January 1, 2016, the contract between MDHHS and the PIHPs was amended to include the following information regarding the withhold arrangement.

MDHHS (Department) shall withhold 0.2% of the approved capitation payment to each PIHP. The withheld funds shall be issued by the Department to the PIHP in the following amounts within 60 days of when the required report is received by the Department:

1. 0.04% for timely submission of the Projection Financial Status Report – Medicaid
2. 0.04%for timely submission of the Interim Financial Status Report – Medicaid
3. 0.04% for timely submission of the Final Medicaid Contract Reconciliation and Cash Settlement
4. 0.04% for timely submission of the Medicaid Utilization and Cost Report
5. 0.04% for timely submission of encounters (defined in Attachment P 7.7.1.1. of the contract)

In accordance with section 105d (18) of Public Act 107 of 2013, MDHHS shall also withhold 0.75% of payments to PIHPs for the purpose of establishing a performance bonus incentive pool (PBIP). Distribution of funds from the performance bonus incentive pool will be calculated on a quarterly basis and be contingent on the PIHP's completion of the required performance of the following compliance metrics.

1. 0.05% for joint performance metrics with MHPs in section 8.4.2.1. of the contract
2. 0.1% if the percent of new adult Medicaid and Healthy Michigan beneficiaries with mental illness receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service is equal or greater than 95%.

3. 0.1% if the percent of new child Medicaid beneficiaries with serious emotional disturbance receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service is equal or greater than 95%.
4. 0.1% if the percent of new adult Medicaid and Healthy Michigan beneficiaries with an intellectual and/or developmental disability receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service is equal or greater than 95%.
5. 0.1% if the percent of new child Medicaid beneficiaries with an intellectual and/or developmental disability receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service is equal or greater than 95%.
6. 0.1% if the percent of new adult Medicaid and Healthy Michigan beneficiaries with a substance use disorder receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service is equal or greater than 95%.
7. 0.1% if the percent of new child Medicaid beneficiaries with a substance use disorder receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service is equal or greater than 95%.
8. 0.1% if the percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours is greater than or equal to 95%

(iii) Estimate of percent to be returned

The calculations for the withhold payments in SFY 2017 (October 1, 2016 to September 30, 2017) have been finalized by MDHHS. The amounts withheld for timely submission of data have been paid out in full to all PIHPs except for Southwest PIHP, which received 60% of the withhold. The amounts withheld for the PBIP have been paid out in full to the PIHPs. Each PIHP received at least 98.5% of the withheld amount for the PBIP.

(iv) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 0.95% of capitation revenue, indicates that it is reasonable within the context of the capitation rate development and the magnitude of the withhold does not have a detrimental impact on the PIHP's financial operating needs and capital reserves. Our interpretation of financial operating needs relates to cash flow needs for the PIHP to pay claims and administer benefits for its covered population. We evaluated the reasonableness of the withhold within this context by reviewing the PIHP's cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by MDHHS.

(v) Effect on the capitation rates

The SFY 2019 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable.

C. RISK SHARING MECHANISMS

i. Rate Development Standards

This section provides information on the risk mitigation, incentives and related contractual provisions included in the contract.

ii. Appropriate Documentation

(a) Description of Risk-sharing Mechanism

The risk-sharing arrangement between MDHHS and the PIHPs is a risk corridor.

A summary of the current risk corridor arrangement between the PIHPs and MDHHS is provided below. The risk corridor is administered across all services, with no separation for mental health and substance abuse funding. The risk corridors are a contractual item between MDHHS and the PIHPs.

- The PIHP shall retain unexpended risk-corridor-related funds between 95% and 100% of said funds. The PIHP shall retain 50% of unexpended risk-corridor related funds between 90% and 95% of said funds. The PIHP shall return unexpended risk-corridor-related funds to MDHHS between 0% and 90% of said funds and 50% of the amount between 90% and 95%.
- The PIHP shall be financially responsible for liabilities incurred above the risk corridor-related operating budget between 100% and 105% of said funds contracted.
- The PIHP shall be responsible for 50% of the financial liabilities above the risk corridor-related operating budget between 105% and 110% of said funds contracted.
- The PIHP shall not be financially responsible for liabilities incurred above the risk corridor-related operating budget over 110% of said funds contracted.

The measurement period of the risk corridor is the state fiscal year. The corresponding incurred time period for this certification is for SFY 2019. Table 17 provides several examples of the risk corridor arrangement.

Table 17
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Examples of the Risk Corridor Arrangement

PIHP Revenue	PIHP Expenses	Initial PIHP Gain(Loss)	MDHHS Risk Corridor Gain(Loss)	Final PIHP Gain(Loss)
$ 100	$ 85	$ 15	$ 7.5	$ 7.5
$ 100	$ 91	$ 9	$ 2.0	$ 7.0
$ 100	$ 97	$ 3	$ 0.0	$ 3.0
$ 100	$ 103	($ 3)	($ 0.0)	($ 3.0)
$ 100	$ 109	($ 9)	($ 2.0)	($ 7.0)
$ 100	$ 115	($ 15)	($ 7.5)	($ 7.5)

The risk-sharing arrangement will not result in payments that exceed the certified capitation rates and is considered actuarially sound under 42 CFR 438.6.

(b) Medical Loss Ratio

Description
The contract between MDHHS and the PIHPs does not include a minimum medical loss ratio. However, the SSSW program capitation rates were developed at approximately a 93% medical loss ratio and the HMP capitation rates were developed at approximately a 94% medical loss ratio.

Financial consequences
Currently there are no financial consequences for having a medical loss ratio below a threshold. However, financial consequences may occur as part of the risk corridor.

(c) Reinsurance Requirements and Effect on Capitation Rates

The PIHPs do not have any State-mandated reinsurance requirements, which has resulted in no impact to the capitation rates.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

i. Rate Development Standards

Consistent with guidance in 42 CFR §438.6(c), the Michigan behavioral health managed care capitation rates reflect consideration of the following delivery system and provider payment initiative:

- Hospital reimbursement adjustment program;
- Opioid Health Home;

ii. Appropriate Documentation

(a) Description of Delivery System and Provider Payment Initiatives

(i) Description of delivery system and provider payment initiatives included in the capitation rates

Utilization of the following delivery system and provider payment initiatives is included in the capitation rates:

- **Hospital rate adjustment program.** MDHHS maintains a hospital rate adjustment (HRA) program, which increases funding to hospitals for inpatient psychiatric treatment. The goal of the HRA is to sustain community psychiatric inpatient capacity and remove Medicaid access barriers. It is incumbent that community inpatient psychiatric capacity be sufficient so that medically necessary inpatient services are readily available to Medicaid beneficiaries and the quality of services, as measured through hospital accreditation and compliance with PIHP contractual requirements, is adequate. In this regard, adequacy of payment for services is a necessary component. The HRA provides a means to assist in assuring access and quality. As such, the purpose of these funds is to promote access as well as maintain quality. This HRA is independent of the local PIHP/Hospital rate setting process. These payments are supplemental to the current PIHP/Hospital current year rate. The HRA program has been in place since SFY 2010.

  Effective October 1, 2018, the State of Michigan re-defined the HRA program to align with the State's approved hospital supplemental upper payment limit program under the Michigan Medicaid managed medical services program. The payments within the HRA program are done so on a retrospective basis to the PIHPs. The actual payment amounts will be a uniform per diem increase to hospital inpatient expenditures developed from the base experience distributed based on reported utilization.

  Based on discussions with MDHHS, we project aggregate UPL payment of approximately $60 million for the SSSW program and HMP. Estimated PMPM values for each population are reflected in Appendix 5 of the certification report, but will be amended following payment of the HRA after SFY 2019 as the actual HRA payments will be paid on a retrospective basis.

- **Opioid Health Home (OHH).** Effective October 1, 2018, MDHHS will provide a monthly case rate to Region 2 (Northern Michigan) based on attributed OHH beneficiaries with at least one OHH service. To facilitate an even greater effort to fight the opioid epidemic and mitigate negative outcomes such as overdoses and hospitalizations, MDHHS will employ a pay-for-performance incentive that will reward providers based on outcomes.

  The OHH payment rates reflect a monthly case rate per OHH beneficiary with at least one proper and successful OHH service within a given month. The rates are defined by an initial "Recovery Action Plan" rate and an "Ongoing Care Management" rate. Moreover, rates are delineated by provider type (i.e., opioid treatment programs (OTP) or office-based opioid treatment (OBOT)). Monthly case rates will be paid on a retrospective basis. We have not included estimated PMPM values in this certification because this is a regional initiative. Based on discussions with MDHHS, we project aggregate payments of approximately $2.5 million for SFY 2019 across the DAB, TANF, and HMP populations.

(ii) Amount of delivery system and provider payment initiatives included in the capitation rates

The HRA amount included in the capitation rates, both in total and on a per member month per basis, associated with the delivery system and provider payment initiatives will be estimated in the final certification.

(iii) Providers receiving delivery system and provider payment initiatives

The HRA payment is provided to hospitals that provide community psychiatric inpatient services to Medicaid beneficiaries. The Opioid Health Home payments will be made to qualifying OTP and OBOT facilities.

(iv) Effect of delivery system and provider payment initiatives on development of capitation rates

The SFY 2019 capitation rate development reflects the value of the delivery system and provider payment initiatives described in (i) above.

(v) Description of consistency with 438.6(c) preprint

The description of the HRA and OHH programs are consistent with the submitted 438.6(c) preprints.

E. PASS-THROUGH PAYMENTS

i. Rate Development Standards

This section is not applicable. The SFY 2019 Michigan Medicaid behavioral health managed care capitation rates do not reflect any pass-through payments.

ii. Appropriate Documentation

(a) Description of Pass-Through Payments

(i) Description

There are no pass-through payments reflected in the SFY 2019 capitation rates.

Amount

Not applicable.

(ii) Providers receiving the payment

Not applicable.

(iii) Financing mechanism

Not applicable.

(iv) Pass-through payments for previous rating period

Not applicable.

(v) Pass-through payments for rating period in effect on July 5, 2016

Not applicable.

(b) Hospital Pass-Through Payments

Not applicable. There are not anticipated to be any hospital pass-through payments in the Michigan Medicaid behavioral health managed care program during SFY 2019.

5. Projected non-benefit costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 CFR §438.5(e), the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to PIHP operation of the SSSW program and the HMP.

The remainder of Section I, item 5 provides documentation of the data, assumptions and methodology that we utilized to develop the non-benefit cost component of the capitation rate.

ii. PMPM versus percentage

The non-benefit cost was developed as a percentage of the capitation rate for all populations with the exception of the additional fixed administration amounts included for DAB and TANF populations.

An additional component of the non-benefit expense is the insurance provider assessment (IPA) that is applicable to insurance providers in the State of Michigan. The IPA assess a PMPM rate of $1.20 to each covered member month throughout the state fiscal year. The ultimate amount paid for the IPA will vary by PIHP based on actual enrollment over the course of SFY 2019. The IPA is set to be effective October 1, 2018 and will be paid on a retrospective basis at the end of each quarter. We have reflected the IPA PMPM for SFY 2019 in Appendix 2.

iii. Basis for variation in assumptions

Any assumption variation between covered populations is the result of program differences and is in no way based on the rate of federal financial participation associated with the population.

iv. Health insurance providers fee

This section is not applicable.

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

(a) Description of the data, assumptions, and methodologies

The estimated benefit expenses were increased to reflect an administrative allowance. For HSW services, a 3% administrative allowance was applied. The mental health and substance abuse HMP population administrative allowance is 6%. The substance abuse administration allowance for the TANF and DAB populations is 7.5%. The administration allowance for the DAB and TANF population mental health services has been split into two components: a fixed per member per month payment and percentage of medical cost. Table 18 provides the administration allowance applied to mental health services for the TANF and DAB populations.

Table 18
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Mental Health Services – SFY 2017 Administration Allowance

Population:	TANF	DAB
Fixed Per Member Per Month Administration	$ 0.97	$ 7.99
Administration Allowance %	4.00%	4.00%

The administrative allowance in the SFY 2019 capitation rates includes a risk margin of 1.00% for the TANF population, 0.75% for the DAB population, and 0.25% for the HSW population for mental health. The risk margins for substance abuse services are 0.75% for both the DAB and TANF populations. The risk margin for the HMP population is 0.60%. This risk margin is approximately 10% of the administrative allowance. We are working with the PIHPs to understand the non-benefit expense split between administrative expenses and care coordination.

The fixed per member per month administration allowance was trended by 1.5% from SFY 2018 to SFY 2019 to reflect inflation expenses, such as a salary, benefits, and overhead. We utilized the historical administrative allowance experience to develop the administrative allowance for SFY 2019.

Table 19 illustrates the historical administrative costs for mental health and substance abuse services for the past two fiscal years across all populations. These costs were taken from MUNC reports submitted by each PIHP, and divided by the capitation payments made to arrive at the PMPM amount. The administrative costs for the HSW population are included under mental health.

Table 19
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Historical Administrative Costs - PMPM Basis

Population	SFY 2016	SFY 2017
Specialty Services		
Mental Health	$ 6.05	$ 6.11
Substance Abuse	$ 0.39	$ 0.17
Healthy Michigan		
Mental Health	$ 1.71	$ 1.83
Substance Abuse	$ 0.58	$ 0.67

Table 20 compares the historical administration costs in SFY 2017 against the assumptions used in the SFY 2019 rate setting. The PIHPs do not separate administrative costs for the DAB, TANF, and HSW populations in their reporting; therefore, we were unable to compare the historical experience to the assumptions used in the rates by population. However, on a program and statewide basis, we believe the non-benefit expense adjustments are appropriate for the functions required under the managed care PIHP contract.

Table 20
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Administrative Costs Comparison

	PMPM	Percent of Revenue (less taxes)
SFY 2017 MUNC Report		
Specialty Services		
MH/DD Admin	$ 6.11	5.9%
SA Admin	$ 0.17	6.3%
Autism	$ 0.35	6.0%
Healthy Michigan		
MH Admin	$ 1.83	6.1%
SA Admin	$ 0.67	6.6%
SFY 2019 Admin Allowance		
Specialty Services		
MH Admin	$ 6.62	7.1%
HSW Admin	$ 148.16	3.0%
MH/DD Admin	$ 7.28	6.3%
SA Admin	$ 0.23	7.4%
Autism	$ 0.29	3.0%
Healthy Michigan		
MH Admin	$ 1.94	6.0%
SA Admin	$ 0.67	6.0%

Fixed Administrative Allowance Methodology

Since the mental health administration allowance is not an equal percentage of capitation revenue for each PIHP, the fixed per member per month administration allowance component cannot be simply added to the base capitation amounts. Table 21 illustrates both the initial projected revenue and the targeted revenue in the process to include fixed administration allowance into the capitation rates. The initial projected revenue includes the fixed administrative allowance in the base rate and reflects the total PIHP capitation revenue by applying the age/gender and existing geographic factors to the base rates. The targeted revenue adds the fixed administration allowance into the rates using the following process:

1. Calculate for each PIHP the total capitation revenue by applying the age/gender and existing geographic factors to the base cap rates (without fixed administration), plus the flat per member per month administration allowance.

2. Solve for new TANF and DAB geographic factors for each PIHP that produce the same capitation revenue for each PIHP as in Step #1 by applying the age/gender and developed geographic factors to the base cap rates (including fixed administration).

Table 21
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Fixed Administration Allowance Demonstration

	Initial Projected Revenue		Targeted Revenue		Adjustment to Geographic Factor	
PIHP	TANF	DAB	TANF	DAB	TANF	DAB
Northcare	$616,245	$4,753,253	$613,209	$4,730,086	0.9951	0.9951
Northern Michigan	1,416,119	7,063,780	1,396,035	7,067,492	0.9858	1.0005
Lakeshore	1,922,118	14,054,350	1,958,510	14,065,403	1.0189	1.0008
Southwest	1,868,411	10,944,412	1,870,641	10,968,767	1.0012	1.0022
Mid-State	4,574,306	25,114,254	4,512,542	25,039,772	0.9865	0.9970
Southeast	810,435	6,595,804	824,773	6,592,001	1.0177	0.9994
Detroit-Wayne	6,790,865	31,491,466	6,740,789	31,657,327	0.9926	1.0053
Oakland	1,124,757	14,145,577	1,146,793	14,054,454	1.0196	0.9936
Macomb	848,729	9,335,341	892,750	9,361,898	1.0519	1.0028
Region 10	1,497,372	12,034,912	1,513,301	11,995,893	1.0106	0.9968
Composite	**$21,469,358**	**$135,533,149**	**$21,469,342**	**$135,533,091**		

(b) Material changes

The claims tax effective for the SFY 2018 rating period was removed and replaced by the IPA for the SFY 2019 effective capitation rates. There were not any other material changes to the data, assumptions, or methodologies used to develop the non-benefit cost since the last certification.

(c) Other material adjustments

There are no other material adjustments applicable to the non-benefit cost component of the capitation rate.

ii. Non-benefit costs, by cost category

Administrative expenses have not been developed from the ground up (based on individual components). However, individual components were reviewed within PIHP administrative cost reports.

The non-benefit costs were developed as a percentage of the capitation rate, with the exception of the IPA and the fixed PMPM component for mental health services.

iii. Health insurance providers fee

(a) Whether the fee is incorporated in the rates

The ACA-mandated health insurer fee has not been calculated and included in these capitation rates. In accordance with section 9010(c)(2)(C)(i)-(iii), the regulations excluded any entity that is incorporated as a nonprofit corporation under State law. The PIHPs who participate in this managed care program fulfill this requirement.

(b) Fee year or data year

This section is not applicable.

(c) Determination of fee impact to rates

This section is not applicable.

(d) Timing of adjustment for health insurance providers fee

This section is not applicable.

(e) Identification of long-term care benefits

This section is not applicable.

6. Risk Adjustment and Acuity Adjustments

This section provides information on the risk adjustment, which is applied to the capitation rates as a geographic factor.

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 CFR §438.5(g), we have followed the rate development standards related to budget-neutral risk adjustment for the Medicaid managed care program. The capitation rates for all populations and benefits are adjusted by regional factors that are budget neutral.

ii. Risk adjustment model

The DAB, TANF, and HMP populations are prospectively risk-adjusted using a regression model that incorporates variables that were identified as having significant differences in beneficiary PMPM costs for each unique value of the variable. Risk adjustment is performed on a budget neutral basis for each of the defined populations, and the analysis uses generally accepted actuarial principles and practices. This model is consistent with the geographic factor methodology applied during the SFY 2018 rating period.

iii. Acuity adjustments

Acuity adjustments are not applicable to the SFY 2019 capitation rates.

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data and adjustments

We have identified incomplete diagnostic information for some of the encounter data in SFY 2017. As a result, the first quarter of SFY 2019 will reflect the risk adjustment analysis using the SFY 2016 encounter data for the populations enrolled in managed care during that time period. We anticipate updating the risk adjustment analysis to use SFY 2017 encounter data for the last nine months of SFY 2019. We have not made any adjustments to the experience for purposes of risk adjustment other than those applied for purposes of rate development documented in Section I, item 2.

(b) Risk adjustment model

We have developed a regression model for purposes of risk adjustment. The methodology and factors included in this model are described in the next section.

(c) Risk adjustment methodology

To help understand key cost drivers for each of the ten PIHPs, we developed a methodology that splits the historical cost factor for each PIHP into four mutually exclusive components:

- Morbidity
- Treatment prevalence
- Utilization per recipient
- Unit cost

Using this methodology, MDHHS decided to use a geographic factor methodology that did not incorporate unit cost differences between PIHPs or utilization differences between similar cohorts of individuals, except for an independent unit cost factor to reflect estimated underlying unit cost differences related to the PIHP's geographic location. The resulting geographic factor is calculated as the product of the following three components:

- Morbidity factor;
- Treatment prevalence factor; and,
- HPSA factor

The first step in the development of the morbidity and treatment prevalence factors is to split each population into smaller cohorts utilizing the following eligibility and diagnostic variables:

Mental Health

DAB Population
- Age Group and Gender;
- Program Code;
- Dual Eligibility;
- HSW Eligibility;
- Prevalence of Developmental Disability (DD) split into 4 categories
    - Severe;
    - Moderate;
    - Mild;
    - Other; and,
- Prevalence of Serious Mental Illness (SMI).

TANF Population
- Age Group and Gender;
- Prevalence of DD split into 4 categories
    - Severe;
    - Moderate;
    - Mild;
    - Other; and,
- Prevalence of SMI.

HMP Population
- Age Group and Gender;
- Program Code;
- Prevalence of DD split into 4 categories
    - Severe;
    - Moderate;
    - Mild;
    - Other; and,
- Prevalence of SMI.

DAB, TANF, and HMP Autism Benefit
- Age Group and Gender;

Substance Abuse

DAB Population
- Age Group and Gender;
- Prevalence of Substance Use Disorder Diagnosis

TANF Population
- Age Group and Gender;
- Prevalence of Substance Use Disorder Diagnosis

HMP Population
- Age Group and Gender;
- Prevalence of Substance Use Disorder Diagnosis

The above variables were identified as having significant differences in beneficiary PMPM costs for each unique value of the variable, and therefore, were used to explain morbidity and treatment prevalence differences between each PIHP and the statewide average.

Age Group, Gender, Program Code, Dual Eligibility status, and HSW Eligibility status were determined from the Medicaid eligibility file and a list of HSW enrollees during SFY 2016. The prevalence of SMI and DD within each population was based on diagnosis information contained in the encounter data submitted by each PIHP. The DD prevalence was split into four groups (mild, moderate, severe, and other) using diagnosis groupings from the RxHCC risk adjustment model. A recipient with at least one diagnosis code incurred for a diagnosis category during the fiscal

year was marked with the respective diagnosis category status. A beneficiary was allowed to be classified in multiple diagnosis categories (DD and SMI). A recipient was only included in the most severe DD group that a diagnosis was present.

For each PIHP and on a statewide basis, member months, PMPM costs, treatment prevalence rates, and the statewide cost per recipient month were created for each combination of the above variables.

The morbidity factor reflects differences in the PIHP distribution of member months by cohort, while holding treatment rates, utilization per case, and unit cost at statewide levels. Table 22 illustrates a simplified example of the morbidity factor calculation for two PIHPs if the population was split into two cohorts.

Table 22
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Morbidity Factor Example

	PMPM			Member Months		
Cohort	PIHP A	PIHP B	Statewide	PIHP A	PIHP B	Statewide
Cohort 1 – DD	$ 2,400	$ 2,000	$ 2,267	10,000	5,000	15,000
Cohort 2 – SMI	1,200	1,300	1,267	5,000	10,000	15,000
Morbidity Factor	**1.11**	**0.93**				

Note: Figures illustrated in this table are for illustrative purposes only and were not utilized in the development of the capitation rates.

The morbidity factor in Table 22 is calculated using the following formula:

$$PIHP\ A\ Morbidity\ Factor = 1.11 = \frac{(\$2{,}400 * 10{,}000 + \$1{,}200 * 5{,}000) / 15{,}000 = \$2{,}000}{(\$2{,}400 * 15{,}000 + \$1{,}200 * 15{,}000) / 30{,}000 = \$1{,}800}$$

$$PIHP\ B\ Morbidity\ Factor = 0.93 = \frac{(\$2{,}000 * 5{,}000 + \$1{,}300 * 10{,}000) / 15{,}000 = \$1{,}533}{(\$2{,}000 * 15{,}000 + \$1{,}300 * 15{,}000) / 30{,}000 = \$1{,}650}$$

The treatment prevalence factor reflects differences in the percentage of member months receiving services while holding the cost per recipient month at statewide levels within each population cohort. Table 23 illustrates a simplified example of the treatment prevalence factor calculation for two PIHPs if the population was split into two cohorts.

Table 23
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Treatment Prevalence Factor Example

	Treatment Prevalence			Member Months			Statewide Cost per Recipient
Cohort	PIHP A	PIHP B	Statewide	PIHP A	PIHP B	Statewide	Month
Cohort 1 – DD	75.0%	100.0%	87.5%	10,000	10,000	20,000	$ 2,250
Cohort 2 - SMI	75.0%	50.0%	62.5%	10,000	10,000	20,000	1,500
Treatment Prevalence Factor	**0.97**	**1.03**					

Note: Figures illustrated in this table are for illustrative purposes only and were not utilized in the development of the capitation rates.

The treatment prevalence factor does not treat low and high cost cohorts with equal weighting. In this example, PIHP A and PIHP B serve the same percentage of member months in aggregate. However, because PIHP B serves a higher percentage of the DD cohort, which is more expensive to treat, the treatment prevalence factor is higher. The treatment prevalence factor in Table 23 is calculated using the following formula:

$$PIHP\ A\ Treatment\ Prev\ Factor = 0.97$$
$$= \frac{(75\% * 20{,}000 * \$2{,}250 + 75\% * 20{,}000 * \$1{,}500) / 40{,}000 = \$1{,}406}{(87.5\% * 20{,}000 * \$2{,}250 + 62.5\% * 20{,}000 * \$1{,}500) / 40{,}000 = \$1{,}453}$$

$$PIHP\ B\ Treatment\ Prev\ Factor = 1.03$$
$$= \frac{(100\% * 20{,}000 * \$2{,}250 + 50\% * 20{,}000 * \$1{,}500) / 40{,}000 = \$1{,}500}{(87.5\% * 20{,}000 * \$2{,}250 + 62.5\% * 20{,}000 * \$1{,}500) / 40{,}000 = \$1{,}453}$$

As discussed above, Tables 22 and 23 illustrate simplified examples of the morbidity and treatment prevalence factor development. The actual calculations take into account all cohorts and PIHPs.

Appendix 9 provides the listing of diagnosis codes used in the development of the SFY 2019 geographic factors for the DAB, TANF, and HMP mental health and substance abuse benefits. Appendix 10 provides the listing of assessment services that were excluded when determining whether a person has a diagnosis for serious mental illness or developmental disability.

The HPSA factor was used to estimate the degree to which underlying provider reimbursement in the rate period varies between PIHPs. Appendix 13 illustrates the development of the HPSA factor.

Table 24 illustrates the development of the geographic factor for the TANF population. SFY 2019 mental health geographic factors reflect the product of the morbidity, treatment prevalence, and HPSA factors. After combining the individual factors and normalizing to the estimated population, we adjust the factors for the fixed administrative allowance (described further in section I.5.A.i) to get to the final geographic factor.

Table 24
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
TANF Population - Mental Health Geographic Factor Development

PIHP	Morbidity Factor	Treatment Prevalence Factor	HPSA Factor	Combined Factor	SFY 2019 Estimated Enrollment	Normalized Factor	Final Factor
Northcare	1.1565	0.9143	1.0491	1.1093	368,770	1.1103	1.1041
Northern Michigan	1.2651	1.0323	1.0516	1.3734	689,635	1.3747	1.3540
Lakeshore	0.7823	0.9571	0.9890	0.7405	1,702,226	0.7411	0.7554
Southwest	1.0870	0.8920	1.0139	0.9831	1,255,702	0.9840	0.9847
Mid-State	1.2362	1.0615	1.0218	1.3409	2,265,110	1.3421	1.3229
Southeast	0.7826	0.9684	0.9885	0.7492	705,611	0.7498	0.7633
Detroit-Wayne	1.1213	1.0265	0.9992	1.1501	3,863,630	1.1512	1.1419
Oakland	0.7338	1.0266	0.9703	0.7310	1,004,994	0.7317	0.7463
Macomb	0.6002	0.8558	0.9703	0.4984	1,088,081	0.4989	0.5262
Region 10	0.8484	0.9958	0.9758	0.8243	1,176,558	0.8251	0.8338
Composite				0.9991	14,120,316	1.0000	

The HSW program provides home and community based services to individuals with developmental disabilities. Based on discussions with MDHHS, the underlying morbidity of the population does not materially vary within a residential living arrangement. In addition, members eligible for this Waiver receive services each month (i.e. there are not treatment prevalence differences). As a result, the geographic factor methodology for the HSW population solely utilizes the HPSA factor. Appendix 13 illustrates the development of the HPSA factor.

Based on discussions with MDHHS, the underlying morbidity of individuals receiving ABA services within each population and age/gender group does not materially vary. As a result, we have not included the morbidity component in the Autism benefit geographic factor development.

(d) Magnitude of the adjustment

Appendices 2 and 3 provide the geographic factors utilized for each population and benefit.

(e) Assessment of predictive value

There are many factors and assumptions that go into assessing the predictive value. We do not have an assessment of the predictive value at this time.

(f) Any concerns the actuary has with the risk adjustment process

At this time, we have no concerns with the risk adjustment process.

ii. Retrospective risk adjustment

Not applicable. The risk adjustment analysis utilizes a prospective methodology.

iii. Changes to risk adjustment model since last rating period

There are no changes to the risk adjustment model since the last rating period.

iv. Acuity adjustments

Acuity adjustments are not applicable to the SFY 2019 capitation rates.

Section II. Medicaid Managed care rates with long-term services and supports

1. Managed Long-Term Services and Supports

This section provides additional information on the base data and methodologies used to develop the capitation rates for the managed long-term services and supports.

A. COMPLETION OF SECTION 1

This section provides additional information on the managed long-term services and supports, which are included as part of the services covered under the capitation rates documented in Section 1. We have followed the guidance from Section 1 regarding standards for rate development and CMS's expectation for appropriate documentation required in the rate certification when developing the MLTSS capitation rates.

B. RATE DEVELOPMENT STANDARDS

i. Approach

(a) Blended

The capitation rates for the DAB, TANF, and HMP populations vary by age, gender, and geographic region for each benefit category and population. The geographic factor represents the health care status of the individuals covered under the program in that geographic region. The capitation rate structure for the October 1, 2018 to September 30, 2019 rating period did not change from the SFY 2018 rating period.

(b) Non-Blended

The capitation rates for the HSW population vary by residential living arrangement, as documented in Section 1, item 3.B.iii.c.

C. APPROPRIATE DOCUMENTATION

i. Considerations

(a) Capitation Rate Structure

The capitation rates for the DAB, TANF, and HMP populations vary by age, gender, and geographic region for each benefit category and population. The geographic factors represent primarily the health care status of the individuals covered under the program in that geographic region. The capitation rates for the HSW population vary by residential living arrangement, as documented in Section 1, item 3.B.iii.c. The capitation rate structure for the October 1, 2018 to September 30, 2019 rating period did not change from the SFY 2018 rating period.

(b) Description of the data, assumptions, and methodologies

The methodology for developing the capitation rates for the mental health, substance abuse, and HSW capitation rates can be found in Section I.

(c) Other payment structures, incentives, or disincentives

We did not utilize any other payment structures, incentives, or disincentives in the development of the capitation rates.

(d) Managed care effect on utilization and unit costs of services

The beneficiaries covered under the SSSW and HMP are all served in the community. The cost of care delivered in the community is significantly lower than the comparable cost of care delivered in an institutional setting.

(e) Managed care effect on care setting

The beneficiaries covered under the SSSW and HMP are all served in the community. The providers of care (often the community mental health service providers (CMHSPs)) work with the beneficiaries to provide the personal care and community living supports required to maintain living within the community.

ii. Projected Non-Benefit Cost

The non-benefit cost assumptions are discussed in Section I, item 5. The non-benefit costs vary by population and benefit type.

iii. Experience and Assumptions

Section I details the experience and assumptions employed for the MLTSS and non-MLTSS services included in the SSSW program and the HMP.

Section III. New adult group capitation rates

This section provides additional information on the base data used to develop the capitation rates for the new adult group.

1. Data

A. DATA USED IN CERTIFICATION

We used SFY 2017 encounter data and PIHP submitted MUNC reports to develop the Healthy Michigan capitation rates for SFY 2019. This is consistent with information previously described in Section I.

B. CONSISTENCY WITH HISTORICAL RATING

i. New data

Although the SFY 2017 base experience represents a new set of base data, this only represents a new year of a similar data source.

ii. Monitoring of experience

We have continued to monitor emerging experience and are re-basing the rates for SFY 2019 using SFY 2017 experience. Adjustments described and documented in other sections of this report represent updates we are making to the base experience based on emerging experience.

iii. Actual Experience vs. Prior Assumptions

Table 25 illustrates the assumptions used to develop the capitation rates for SFY 2017 compared to the actual experience from SFY 2017 for both the mental health and substance abuse benefits.

Table 25
State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
Projected vs. Actual SFY 2017 Experience

Benefit	Average Monthly Capitation Payments	Recipients per Month	RVU PRPM	Cost per RVU	PMPM
Mental Health					
Projected	600,000	17,418	51.7	$15.90	$23.86
Actual	688,000	18,787	63.8	$16.55	$28.83
Substance Abuse					
Projected	600,000	7,845	24.9	$23.20	$7.56
Actual	688,000	10,525	26.1	$24.18	$9.67

In the development of the SFY 2018 capitation rates, we utilized the SFY 2016 and SFY 2017 experience. In the SFY 2019 capitation rate development, we utilized the SFY 2017 experience and reviewed emerging experience from SFY 2018.

iv. Adjustments for differences between projected and actual experience

The actual SFY 2017 experience for mental health and substance abuse services was higher than the projected SFY 2017 experience. We observed material increases to unit cost from SFY 2016 to SFY 2017. For the SFY 2019 capitation rates development, we are only utilizing SFY 2017 experience because of the material increase in cost from SFY 2016 to SFY 2017. However, we have limited unit cost increases, as described in Section I, item 2.B.iii.(d), for purposes of setting the SFY 2019 capitation rates.

2. Projected benefit costs

A. SUPPORTING DOCUMENTATION

This section contains a description of issues related to the projected benefit costs for the new adult group. The state of Michigan has covered the new adult group in previous rating periods.

v. New adult groups covered in previous rating periods

(a) Experience Used in Rate Development

Actual Healthy Michigan experience is being utilized as the base experience for the SFY 2019 rating period, consistent with the rate setting process for SFY 2018. We continue to review the emerging experience as a reasonableness check against the developed capitation rates.

(b) Changes in Data Sources, Assumptions, or Methodologies Since Last Certification

As mentioned previously, we have updated the base experience period and assumptions documented in Section I for purposes of this rate certification. We did not make any other changes from the methodologies utilized to develop the prior capitation rates.

(c) Assumption Changes Since Prior Certification

For the Healthy Michigan population, we did not make adjustments for the following:

- Acuity or health status
- Pent-up demand
- Adverse selection
- Differences in provider reimbursement or provider networks

We are adjusting for underlying changes in the population demographics from SFY 2017 to the contract period, as documented in Section 1, item 3.B.vii.f.

B. REQUIRED ELEMENTS

Key assumptions unique to the Healthy Michigan population have been outlined in Section 1.

i. Acuity or health status adjustments

Not applicable, no acuity adjustments were applied in the development of Healthy Michigan capitation rates.

ii. Adjustments for pent-up demand

Not applicable, no pent-up demand adjustments were applied in the development of Healthy Michigan capitation rates.

iii. Adjustments for adverse selection

Not applicable, no adverse selection adjustments were applied in the development of Healthy Michigan capitation rates.

iv. Adjustments for demographics

Not applicable, no demographic adjustments were applied in the development of Healthy Michigan capitation rates.

v. Differences in provider reimbursement rates or provider networks

No adjustments for provider reimbursement or provider network were applied in the development of Healthy Michigan capitation rates, other than those documented in Section I of this report.

vi. Other material adjustments

No other material adjustments were applied in the development of Healthy Michigan capitation rates.

C. CHANGES TO BENEFIT PLAN

No benefit changes have been made to the Healthy Michigan benefit plan outside of those previously discussed. These changes were not specific to Healthy Michigan enrollees.

D. OTHER MATERIAL CHANGES OR ADJUSTMENTS TO BENEFIT COSTS

We did not make any other adjustments in the Healthy Michigan rate development process other than those previously outlined in the report.

3. Projected Non-Benefit costs

A. NEW ADULT GROUP CONSIDERATIONS

i. Changes in Data Sources, Assumptions, or Methodologies Since Last Certification

The development of the non-benefit costs was discussed in Section 1, item 5. We have not made any changes from the SFY 2018 certification.

ii. Assumption Differences Relative to Other Medicaid Populations

The non-benefit cost percentages are lower in the Healthy Michigan program than the traditional Medicaid managed care program based because of the economies of scale gained from already performing many of the administrative services that are required for this population. The assumptions are documented in Section 1, item 5.

B. KEY ASSUMPTIONS

The differences between assumptions for the new adult group and other Medicaid populations are detailed in Section I, item 5.

4. Final certified rates or rate ranges

A. REQUIRED ELEMENTS

In accordance with 42 CFR §438.7(d), we are providing the following sections.

i. Comparison to Previous Certification

Fiscal impact and rate changes for the Healthy Michigan population are illustrated in Tables 1 and 2 of Section I.

ii. Description of Other Material Changes to the Capitation Rates

We have documented all of the material changes to the capitation rates and the development process in Section 1 of this report.

5. Risk mitigation strategies

A. DESCRIPTION OF RISK MITIGATION STRATEGY

In accordance with 42 CFR §438.7(d), we are providing the following sections, a description of the risk mitigation strategy is documented in Section 1, item 4.C.

B. NEW ADULT GROUPS COVERED IN PREVIOUS RATE SETTING

i. Changes to Risk Mitigation Strategy Relative to Prior Certifications

We have not made any changes to the risk mitigation strategy from the SFY 2018 to SFY 2019 rating period.

ii. Rationale for changes in risk mitigation strategy

This section is not applicable.

iii. Relevant Experience, Results, or Preliminary Information

This section is not applicable.

Limitations

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved February 27, 2017.

The information contained in this letter, 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 this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter 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 letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for MDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

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.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

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. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Appendix 1: Actuarial Certification

State of Michigan
Department of Health and Human Services
Behavioral Health Managed Care Programs
Capitation Rates Effective October 1, 2018 through September 30, 2019

Actuarial Certification

I, Christopher T. Pettit, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Michigan and am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- the capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the MCO for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

For the purposes of this certification and consistent with the requirements under 42 CFR 438.4(a), "actuarial soundness" is defined as in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."

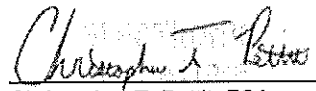
The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of Michigan. The "actuarially sound" capitation rates that are associated with this certification are effective for the rate period October 1, 2018 through September 30, 2019.

The capitation rates are considered actuarially sound after adjustment for the amount of the withhold not expected to be earned.

The "actuarially sound" capitation rates are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the rates.

In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by the State. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency.

The capitation rates developed may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.



Christopher T. Pettit, FSA
Member, American Academy of Actuaries

September 14, 2018
Date

Appendix 2: State Plan and 1915(b)(3) Rates

State of Michigan, Department of Health and Human Services
Specialty Services and Supports Waiver
Proposed Paid Rates - October 1, 2018 to September 30, 2019

Service and Population	State Plan	1915(b)(3)	Autism	IPA	HRA
TANF Mental Health	$ 16.90	$ 0.76	$ 4.40	$ 1.20	$ 0.58
DAB Mental Health	$ 133.21	$ 140.10	$ 22.14	$ 1.20	$ 3.80
HMP Mental Health	$ 32.25		$ 0.38	$ 1.20	$ 3.49
TANF Substance Abuse	$ 2.16	$ 0.01			
DAB Substance Abuse	$ 5.36	$ 0.01			
HMP Substance Abuse	$ 11.09				

October 1, 2018 to September 30, 2019 Age / Gender Factors

Service and Population	0 - 5	6 - 18	19 - 21	22 - 25	26 - 39	40 - 49	50 - 64	65+
Mental Health - TANF								
Male - SP	0.3800	1.3097	0.7899	0.6164	0.6969	0.6103	0.5244	0.3487
Female - SP	0.2205	1.1549	1.3457	1.9966	1.5193	1.1329	0.8100	0.1856
Male - B3	0.5946	1.3517	0.2016	0.6773	0.6042	0.4401	0.6817	0.0594
Female - B3	0.5974	0.8142	0.8048	1.4836	1.4716	1.7511	1.3496	1.9470
Male - Autism	3.7708	1.2463	0.0093					
Female - Autism	0.9508	0.2827	0.0137					
Mental Health - DAB								
Male - SP	0.6551	1.1048	1.7637	1.2199	1.5987	1.5368	1.2810	0.5435
Female - SP	0.4031	0.9500	1.3275	1.2357	1.4120	1.2349	0.9858	0.3368
Male - B3	0.0948	0.1546	0.5935	2.3761	2.8680	1.8271	1.3270	0.6540
Female - B3	0.0581	0.1118	0.5209	1.9092	2.1781	1.2052	0.8749	0.3667
Male - Autism	20.1881	4.5900	0.6204					
Female - Autism	7.4237	1.7889	0.3102					
Mental Health - HMP								
Male			0.9538	1.1993	1.2445	1.2187	1.0409	
Female			0.6807	0.7076	0.8363	1.0646	0.8044	
Male - Autism			1.3483					
Female - Autism			0.6740					
Substance Abuse - TANF								
Male	0.0397	0.2315	0.5499	2.5156	4.4666	2.6431	1.7247	0.0397
Female	0.0397	0.1159	1.0722	2.3566	4.7281	2.5511	1.5277	0.2612
Substance Abuse - DAB								
Male	0.0400	0.2088	0.3101	0.5931	1.3860	1.7401	2.4848	0.5687
Female	0.0400	0.1030	0.3185	0.6645	1.6329	1.3695	1.3362	0.1696
Substance Abuse - HMP								
Male			0.3006	0.7563	1.7441	1.4835	1.1801	
Female			0.1832	0.4402	0.9867	0.8202	0.5096	

October 1, 2018 to September 30, 2019 Geographic Factors

	Mental Health			Substance Abuse			Autism		
PIHP Name	TANF	DAB	HMP	TANF	DAB	HMP	TANF	DAB	HMP
Northcare Network	1.1041	1.2425	0.8292	1.2236	0.2259	0.8057	0.7599	0.7830	1.0000
Northern Michigan Regional Entity	1.3540	0.9823	0.8765	1.5305	0.7484	1.1882	1.1944	1.3322	1.0000
Lakeshore Regional Entity	0.7554	0.9754	0.6636	1.1909	0.9737	1.0608	1.0644	1.0946	1.0000
Southwest Michigan Behavioral Health	0.9847	0.9294	1.1027	1.2213	0.9498	1.3682	0.7965	0.5705	1.0000
Mid-State Health Network	1.3229	1.0804	1.1136	1.5216	0.8840	1.2353	1.3184	1.2525	1.0000
CMH Partnership of Southeast Michigan	0.7633	1.0044	0.7196	0.8860	0.7876	0.9487	1.3026	0.8332	1.0000
Detroit Wayne Mental Health Authority	1.1419	0.8450	1.1881	0.4040	1.2787	0.6651	0.7925	1.0172	1.0000
Oakland County CMH Authority	0.7463	1.3645	1.3534	1.0012	0.8051	0.8875	0.9634	0.8069	1.0000
Macomb County CMH Services	0.5262	0.9698	0.6440	0.9678	0.9211	0.9881	1.3734	1.3660	1.0000
Region 10 PIHP	0.8338	1.0726	0.7643	1.2711	1.1519	1.3692	0.6382	0.7051	1.0000

Appendix 3: Waiver (c) Rates

State of Michigan, Department of Health and Human Services
Specialty Services and Supports Waiver
Waiver Capitation Rate Development
Proposed Paid Rates - October 1, 2018 to September 30, 2019

Habilitation Supports Waiver (HSW)	Total
Rate Development Base:	$ 1,654.64
Residential Living Arrangement	
Private Residence with Spouse or Non-family/Supported Independence Program	5,330.45
Specialized Residential Home	2,890.22
Private Residence with Family / Foster Home	1,928.32

Multiplicative Factor (HSW)	
Northcare Network	1.0457
Northern Michigan Regional Entity	1.0492
Lakeshore Regional Entity	0.9880
Southwest Michigan Behavioral Health	1.0059
Mid-State Health Network	1.0208
CMH Partnership of Southeast Michigan	0.9830
Detroit Wayne Mental Health Authority	0.9954
Oakland County CMH Authority	0.9666
Macomb County CMH Services	0.9666
Region 10 PIHP	0.9719

Appendix 4: Claim Cost Development

State of Michigan, Department of Health and Human Services
October 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
Claim Cost Development
DAB Population

Service Type	SFY 2017 Base PMPM	DCW Adjustment	MCPI Adjustment	SA Assessment Adjustment	Autism Fee Schedule Adjustment	Adjusted Base PMPM	Covered Population Adjustment	Shortage Area Adjustment	Managed Care Adjustment	IMD Adjustment	Normalized PMPM	Trend Adjustment	SFY 2019 Service Cost Eligibility PMPM
Mental Health													
Proposed Paid Rates													
State Plan Inpatient	$ 13.08	1.0000	0.9749	1.0000	1.0000	$ 12.75	0.9920	1.0000	1.0000	0.8988	$ 11.37	1.0506	$ 11.95
State Plan Outpatient	0.32	1.0000	0.9646	1.0000	1.0000	0.31	0.9920	1.0000	1.0000	0.9965	0.31	1.0506	0.32
State Plan Professional CLS	38.39	1.0822	0.9851	1.0000	1.0000	40.93	0.9920	1.0000	1.0000	1.0000	40.60	1.0506	42.66
State Plan Professional Non-CLS	62.85	1.0001	0.9797	1.0000	1.0000	61.58	0.9920	1.0000	1.0000	0.9992	61.04	1.0506	64.13
State Plan Total	$ 114.65					$ 115.58					$ 113.32		$ 119.06
B3 Professional CLS	$ 79.17	1.0384	0.9789	1.0000	1.0000	$ 80.47	0.9920	1.0000	1.0000	0.9998	$ 79.81	1.0506	$ 83.85
B3 Professional Non-CLS	39.63	1.0192	0.9824	1.0000	1.0000	39.68	0.9920	1.0000	1.0000	0.9999	39.36	1.0506	41.35
B3 Total	$ 118.79					$ 120.15					$ 119.17		$ 125.20
Total	$ 233.44					$ 235.72					$ 232.49		$ 244.26
Autism	$ 13.16	1.0000	1.0000	1.0000	0.8304	$ 10.93	1.8116	1.0000	1.0000	1.0000	$ 19.80	1.0404	$ 20.60
Substance Abuse													
Proposed Paid Rates													
State Plan	$ 4.51	1.0000	0.9830	1.0115	1.0000	$ 4.48	1.0001	1.0000	1.0000	1.0000	$ 4.48	1.0609	$ 4.75
B3	0.01	1.0000	1.0000	1.0000	1.0000	0.01	1.0001	1.0000	1.0000	1.0000	0.01	1.0000	0.01
Total	$ 4.52					$ 4.49					$ 4.49		$ 4.76

State of Michigan, Department of Health and Human Services
October 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
Claim Cost Development
TANF Population

Service Type	SFY 2017 Base PMPM	DCW Adjustment	MCPI Adjustment	SA Assessment Adjustment	Autism Fee Schedule Adjustment	Adjusted Base PMPM	Covered Population Adjustment	Shortage Area Adjustment	Managed Care Adjustment	IMD Adjustment	Normalized PMPM	Trend Adjustment	SFY 2019 Service Cost Eligibility PMPM
Mental Health													
Proposed Paid Rates													
State Plan Inpatient	$ 1.99	1.0000	0.9770	1.0000	1.0000	$ 1.94	1.0001	1.0000	1.0000	0.9907	$ 1.92	1.0712	$ 2.06
State Plan Outpatient	0.20	1.0000	0.9872	1.0000	1.0000	0.20	1.0001	1.0000	1.0000	0.9988	0.20	1.0712	0.21
State Plan Professional CLS	0.34	1.0344	0.9857	1.0000	1.0000	0.35	1.0001	1.0000	1.0000	0.9999	0.35	1.0712	0.38
State Plan Professional Non-CLS	11.52	1.0000	0.9774	1.0000	1.0000	11.26	1.0001	1.0000	1.0000	0.9999	11.26	1.0712	12.06
State Plan Total	$ 14.06					$ 13.75					$ 13.74		$ 14.72
B3 Professional CLS	$0.05	1.0395	0.9773	1.0000	1.0000	$ 0.05	1.0001	1.0000	1.0000	0.9991	$0.05	1.0712	$0.05
B3 Professional Non-CLS	0.58	1.0145	0.9749	1.0000	1.0000	0.57	1.0001	1.0000	1.0000	0.9999	0.57	1.0712	0.61
B3 Total	$ 0.63					$ 0.62					$ 0.62		$ 0.66
Total	$ 14.68					$ 14.38					$ 14.36		$ 15.38
Autism	$2.38	1.0000	1.0000	1.0000	0.8354	$ 1.99	1.9810	1.0000	1.0000	1.0000	$ 3.94	1.0404	$ 4.10
Substance Abuse													
Proposed Paid Rates													
State Plan	$1.81	1.0000	0.9882	1.0184	1.0000	$ 1.82	0.9955	1.0000	1.0000	1.0000	$ 1.81	1.0609	$ 1.92
B3	0.01	1.0000	1.0000	1.0000	1.0000	0.01	0.9955	1.0000	1.0000	1.0000	0.01	1.0000	0.01
Total	$ 1.82					$ 1.83					$ 1.82		$ 1.93

State of Michigan, Department of Health and Human Services
October 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
Claim Cost Development
Waiver (c) Populations

Service Type	SFY 2017 Base PMPM	DCW Adjustment	MCPI Adjustment	Adjusted Base PMPM	Population Adjustment	Normalized PMPM	Trend Adjustment	SFY 2019 Service Cost Eligibility PMPM
HSW Waiver								
Community Living Supports	$ 3,597.26	1.0375	0.9678	$ 3,612.15	0.9926	$ 3,585.58	1.0506	$ 3,767.10
Non-Community Living Supports	907.00	1.0181	0.9684	894.26	0.9926	887.68	1.0506	932.62
Total	$ 4,504.26			$ 4,506.42		$ 4,473.26		$ 4,699.72

State of Michigan, Department of Health and Human Services
October 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
Claim Cost Development
HMP Population

Service Type	SFY 2017 Base PMPM	DCW Adjustment	MCPI Adjustment	SA Assessment Adjustment	Autism Fee Schedule Adjustment	Adjusted Base PMPM	Covered Population Adjustment	Shortage Area Adjustment	Managed Care Adjustment	IMD Adjustment	Normalized PMPM	Trend Adjustment	SFY 2019 Service Cost Eligibility PMPM
Mental Health													
Proposed Paid Rates													
Inpatient	$ 8.71	1.0000	0.9466	1.0000	1.0000	$ 8.24	0.9973	1.0001	1.0000	0.9602	$ 7.90	1.0712	$ 8.46
Outpatient	0.20	1.0000	0.9713	1.0000	1.0000	0.19	0.9973	1.0001	1.0000	0.9947	0.19	1.0712	0.20
Professional CLS	3.07	1.0444	0.9387	1.0000	1.0000	3.01	0.9973	1.0001	1.0000	0.9988	3.00	1.0712	3.21
Professional Non-CLS	16.86	1.0011	0.9402	1.0000	1.0000	15.87	0.9973	1.0001	1.0000	0.9985	15.80	1.0712	16.93
Total	$ 28.83					$ 27.31					$ 26.89		$ 28.80
Autism	$ 0.20	1.0000	1.0000	1.0000	0.8488	$ 0.17	1.9810	1.0001	1.0000	1.0000	$ 0.34	1.0404	$ 0.35
Substance Abuse													
Proposed Paid Rates													
Total	$9.67	1.0000	0.9538	1.0158	1.0000	$9.37	0.9958	1.0001	1.0000	1.0000	$ 9.33	1.0609	$ 9.90

Appendix 5: Capitation Rate Development

State of Michigan, Department of Health and Human Services
October 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
Capitation Rate Build
DAB Population

Service Type	SFY 2019 Service Cost Eligibility PMPM	Estimated Capitation to Eligibility Ratio	SFY 2019 Service Cost Capitation PMPM	Variable Admin Load	Fixed Admin Load	SFY 2019 Capitation Rate
Mental Health						
Proposed Paid Rates						
State Plan Inpatient	$ 11.95	0.9590	$ 12.46	$ 0.52	$ 0.39	$ 13.37
State Plan Outpatient	0.32	0.9590	0.34	0.01	0.01	0.36
State Plan Professional CLS	42.66	0.9590	44.48	1.85	1.39	47.72
State Plan Professional Non-CLS	64.13	0.9590	66.87	2.79	2.10	71.76
State Plan Total	$ 119.06		$ 124.15	$ 5.17	$ 3.89	$ 133.21
B3 Professional CLS	$ 83.85	0.9590	$ 87.44	$ 3.64	$ 2.74	$ 93.82
B3 Professional Non-CLS	41.35	0.9590	43.12	1.80	1.36	46.28
B3 Total	$ 125.20		$ 130.56	$ 5.44	$ 4.10	$ 140.10
Total	$ 244.26		$ 254.71	$ 10.61	$ 7.99	$ 273.31
Autism	$ 20.60	0.9590	$ 21.48	$ 0.66		$ 22.14
Substance Abuse						
Proposed Paid Rates						
State Plan	$ 4.75	0.9590	$4.96	$ 0.40		$ 5.36
B3	0.01	0.9590	0.01	-		0.01
Total	$ 4.76		$ 4.97	$ 0.40		$ 5.37

State of Michigan, Department of Health and Human Services
October 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
Capitation Rate Build
TANF Population

Service Type	SFY 2019 Service Cost Eligibility PMPM	Estimated Capitation to Eligibility Ratio	SFY 2019 Service Cost Capitation PMPM	Variable Admin Load	Fixed Admin Load	SFY 2019 Capitation Rate
Mental Health						
Proposed Paid Rates						
State Plan Inpatient	$ 2.06	0.9590	$ 2.15	$ 0.09	$ 0.13	$ 2.37
State Plan Outpatient	0.21	0.9590	0.22	0.01	0.01	0.24
State Plan Professional CLS	0.38	0.9590	0.39	0.02	0.03	0.44
State Plan Professional Non-CLS	12.06	0.9590	12.58	0.52	0.75	13.85
State Plan Total	$ 14.72		$ 15.34	$ 0.64	$ 0.92	$ 16.90
B3 Professional CLS	$ 0.05	0.9590	$ 0.05	$ 0.00	$ 0.00	$ 0.05
B3 Professional Non-CLS	0.61	0.9590	0.64	0.03	0.04	0.71
B3 Total	$ 0.66		$ 0.69	$ 0.03	$ 0.04	$ 0.76
Total	$ 15.38		$ 16.03	$ 0.67	$ 0.97	$ 17.66
Autism	$ 4.10	0.9590	$ 4.27	$ 0.13		$ 4.40
Substance Abuse						
Proposed Paid Rates						
State Plan	$ 1.92	0.9590	$ 2.00	$0.16		$ 2.16
B3	0.01	0.9590	0.01	-		0.01
Total	$ 1.93		$ 2.01	$ 0.16		$ 2.17

State of Michigan, Department of Health and Human Services
October 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
Capitation Rate Build
Waiver (c) Populations

Service Type	SFY 2019 Service Cost Eligibility PMPM	Estimated Capitation to Eligibility Ratio	SFY 2019 Service Cost Capitation PMPM	Variable Admin Load	Fixed Admin Load	SFY 2019 Capitation Rate
HSW Waiver						$ 3,958.82
Community Living Supports	$ 3,767.10	0.9810	$ 3,840.06	$ 118.76		980.09
Non-Community Living Supports	932.62	0.9810	950.69	29.40		
Total	$ 4,699.72		$ 4,790.75	$ 148.16		$ 4,938.91

State of Michigan, Department of Health and Human Services
October 1, 2018 to September 30, 2019 Specialty Service Capitation Rates
Capitation Rate Build
HMP Population

Service Type	SFY 2019 Service Cost Eligibility PMPM	Estimated Capitation to Eligibility Ratio	SFY 2019 Service Cost Capitation PMPM	Variable Admin Load	SFY 2019 Capitation Rate
Mental Health					
Proposed Paid Rates					
Inpatient	$ 8.46	0.9500	$ 8.90	$ 0.57	$ 9.47
Outpatient	0.20	0.9500	0.21	0.01	0.22
Professional CLS	3.21	0.9500	3.38	0.22	3.60
Professional Non-CLS	16.93	0.9500	17.82	1.14	18.96
Total	$ 28.80		$ 30.31	$ 1.94	$ 32.25
Autism	$ 0.35	0.9500	$ 0.37	$ 0.01	$ 0.38
Substance Abuse					
Proposed Paid Rates					
Total	$ 9.90	0.9500	$ 10.42	$ 0.67	$ 11.09

Appendix 6: Historical Trend Analysis Data

State of Michigan, Department of Health and Human Services
Specialty Services and Supports Waiver
Historical Trend Analysis Data

DAB Population

	SFY 2015			SFY 2016			SFY 2017			SFY 2015 - SFY 2017 Trend			SFY 2016 - SFY 2017 Trend		
	RVUs/1000	Cost/RVU	PMPM	RVUs/1000	Cost/RVU	PMPM	RVUs/1000	Cost/RVU	PMPM	Utilization	Cost Per Unit	PMPM	Utilization	Cost Per Unit	PMPM
Mental Health															
State Plan															
Inpatient	9,172.4	$ 13.34	$ 10.19	9,623.4	$ 14.44	$ 11.58	9,378.6	$ 16.74	$ 13.08	1.1%	12.0%	13.3%	(2.5%)	15.9%	13.0%
Outpatient	277.7	13.61	0.31	273.7	13.06	0.30	263.0	14.78	0.32	(2.7%)	4.2%	1.4%	(3.9%)	13.1%	8.7%
Professional CLS	29,743.0	14.24	35.30	29,334.4	15.33	37.47	29,029.8	15.87	38.39	(1.2%)	5.6%	4.3%	(1.0%)	3.5%	2.5%
Professional Non-CLS	49,404.2	14.90	61.34	47,459.1	15.40	60.90	47,911.0	15.74	62.85	(1.5%)	2.8%	1.2%	1.0%	2.2%	3.2%
State Plan Total	88,597.3	$ 14.51	$ 107.15	86,690.6	$ 15.26	$ 110.25	86,582.5	$ 15.89	$ 114.65	(1.1%)	4.6%	3.4%	(0.1%)	4.1%	4.0%
B(3)															
Professional CLS	61,066.3	$ 13.79	$ 70.19	61,671.5	$ 14.38	$ 73.90	60,690.8	$ 15.65	$ 79.17	(0.3%)	6.5%	6.2%	(1.6%)	8.9%	7.1%
Professional Non-CLS	33,169.9	13.74	37.98	31,756.2	14.13	37.40	32,821.9	14.49	39.63	(0.5%)	2.7%	2.1%	3.4%	2.5%	5.9%
B(3) Total	94,236.3	13.77	108.17	93,427.7	14.30	111.31	93,512.7	15.24	118.79	(0.4%)	5.2%	4.8%	0.1%	6.6%	6.7%
Mental Health Total	**182,833.6**	**$ 14.13**	**$ 215.32**	**180,118.3**	**$ 14.76**	**$ 221.56**	**180,095.1**	**$ 15.55**	**$ 233.44**	**(0.8%)**	**4.9%**	**4.1%**	**(0.0%)**	**5.4%**	**5.4%**
Substance Abuse															
State Plan Total	1,044.4	$ 21.01	$ 1.83	2,133.2	$ 23.13	$ 4.11	2,270.3	$ 23.82	$ 4.51	47.4%	6.5%	57.0%	6.4%	3.0%	9.6%
B(3) Total	870.1	19.43	1.41												
Substance Abuse Total	**1,914.5**	**$ 20.29**	**$ 3.24**	**2,133.2**	**$ 23.13**	**$ 4.11**	**2,270.3**	**$ 23.82**	**$ 4.51**	**8.9%**	**8.3%**	**18.0%**	**6.4%**	**3.0%**	**9.6%**

TANF Population

	SFY 2015			SFY 2016			SFY 2017			SFY 2015 - SFY 2017 Trend			SFY 2016 - SFY 2017 Trend		
	RVUs/1000	Cost/RVU	PMPM	RVUs	Cost/RVU	PMPM	RVUs/1000	Cost/RVU	PMPM	Utilization	Cost Per Unit	PMPM	Utilization	Cost Per Unit	PMPM
Mental Health															
State Plan															
Inpatient	1,187.5	$ 13.96	$ 1.38	1,243.6	$ 15.06	$ 1.56	1,394.2	$ 17.12	$ 1.99	8.4%	10.7%	20.0%	12.1%	13.6%	27.4%
Outpatient	151.2	13.64	0.17	187.9	12.83	0.20	163.6	14.82	0.20	4.0%	4.2%	8.4%	(12.9%)	15.5%	0.6%
Professional CLS	218.1	18.81	0.34	195.6	18.30	0.30	231.7	17.86	0.34	3.1%	(2.6%)	0.4%	18.5%	(2.4%)	15.6%
Professional Non-CLS	7,661.6	15.57	9.94	7,708.5	15.98	10.26	8,315.5	16.63	11.52	4.2%	3.3%	7.7%	7.9%	4.1%	12.3%
State Plan Total	9,218.4	$ 15.41	$ 11.84	9,335.5	$ 15.84	$ 12.32	10,105.0	$ 16.69	$ 14.06	4.7%	4.1%	9.0%	8.2%	5.4%	14.1%
B(3)															
Professional CLS	21.3	$ 12.42	$ 0.02	35.2	$ 15.37	$ 0.05	38.9	$ 14.80	$ 0.05	35.2%	9.2%	47.6%	10.4%	(3.7%)	6.3%
Professional Non-CLS	466.1	14.00	0.54	460.1	14.37	0.55	446.4	15.54	0.58	(2.1%)	5.4%	3.1%	(3.0%)	8.1%	4.9%
B(3) Total	487.3	13.93	0.57	495.3	14.44	0.60	485.3	15.48	0.63	(0.2%)	5.4%	5.2%	(2.0%)	7.2%	5.0%
Mental Health Total	**9,705.7**	**$ 15.33**	**$ 12.40**	**9,830.8**	**$ 15.77**	**$ 12.92**	**10,590.3**	**$ 16.64**	**$ 14.68**	**4.5%**	**4.2%**	**8.8%**	**7.7%**	**5.5%**	**13.7%**
Substance Abuse															
State Plan Total	415.3	$ 22.84	$ 0.79	801.4	$ 24.99	$ 1.67	858.2	$ 25.28	$ 1.81	43.7%	5.2%	51.2%	7.1%	1.1%	8.3%
B(3) Total	253.6	21.46	0.45												
Substance Abuse Total	**669.0**	**$ 22.31**	**$ 1.24**	**801.4**	**$ 24.99**	**$ 1.67**	**858.2**	**$ 25.28**	**$ 1.81**	**13.3%**	**6.4%**	**20.6%**	**7.1%**	**1.1%**	**8.3%**

HMP Population

	SFY 2015			SFY 2016			SFY 2017			SFY 2015 - SFY 2017 Trend			SFY 2016 - SFY 2017 Trend		
	RVUs/1000	Cost/RVU	PMPM	RVUs	Cost/RVU	PMPM	RVUs/1000	Cost/RVU	PMPM	Utilization	Cost Per Unit	PMPM	Utilization	Cost Per Unit	PMPM
Mental Health															
State Plan															
Inpatient	4,861.4	$ 17.01	$ 6.89	5,481.9	$ 17.86	$ 8.16	5,553.6	$ 18.82	$ 8.71	6.9%	5.2%	12.4%	1.3%	5.4%	6.7%
Outpatient	79.2	16.63	0.11	95.4	15.80	0.13	147.3	15.98	0.20	36.4%	(2.0%)	33.7%	52.8%	1.1%	54.5%
Professional CLS	1,348.8	13.72	1.54	1,711.8	14.63	2.09	2,235.6	15.48	3.07	28.7%	9.6%	41.1%	30.6%	12.6%	47.1%
Professional Non-CLS	12,625.5	14.19	14.93	12,447.6	14.46	15.00	12,970.9	15.60	16.86	1.4%	4.8%	6.3%	4.2%	7.9%	12.4%
State Plan Total	**18,915.0**	**$ 14.89**	**$ 23.47**	**19,737.6**	**$ 15.43**	**$ 25.37**	**20,907.4**	**$ 16.55**	**$ 28.83**	**5.1%**	**5.4%**	**10.8%**	**5.9%**	**7.3%**	**13.6%**
Substance Abuse															
Substance Abuse Total	**4,183.3**	**$ 20.75**	**$ 7.23**	**4,716.9**	**$ 22.53**	**$ 8.85**	**4,799.9**	**$ 24.18**	**$ 9.67**	**7.1%**	**7.9%**	**15.6%**	**1.8%**	**7.4%**	**9.2%**

HSW Population

	SFY 2015			SFY 2016			SFY 2017			SFY 2015 - SFY 2017 Trend			SFY 2016 - SFY 2017 Trend		
	RVUs/1000	Cost/RVU	PMPM	RVUs/1000	Cost/RVU	PMPM	RVUs/1000	Cost/RVU	PMPM	Utilization	Cost Per Unit	PMPM	Utilization	Cost Per Unit	PMPM
Waiver (c)															
Professional CLS	2,651,361.8	$ 15.27	$ 3,374.25	2,573,688.2	$ 15.84	$ 3,396.89	2,524,474.9	$ 17.10	$ 3,597.88	(2.4%)	5.8%	3.3%	(1.9%)	8.0%	5.9%
Professional Non-CLS	784,363.0	14.73	962.74	781,121.0	14.54	946.68	756,084.5	14.39	906.38	(1.8%)	(1.2%)	(3.0%)	(3.2%)	(1.1%)	(4.3%)
Waiver (c) Total	**3,435,724.8**	**$ 15.15**	**$ 4,336.99**	**3,354,809.2**	**$ 15.54**	**$ 4,343.57**	**3,280,559.4**	**$ 16.48**	**$ 4,504.26**	**(2.3%)**	**4.3%**	**1.9%**	**(2.2%)**	**6.0%**	**3.7%**

Appendix 7: MUNC Service Listing

State of Michigan, Department of Health and Human Services
SFY 2017 Encounter Data Quality
SFY 2017 MUNC Mental Health Services by Service Category
Specialty Services

Service_Category	LineID	Service	Service Description	State Plan	EPSDT	B(3)	HSW
Inpatient	1	PT68	Local Psychiatric Hospital/IMD PT68 bundled per diem	X			
Inpatient	2	PT68	Local Psychiatric Hospital/IMD PT68bundled per diem	X			
Inpatient	3	PT68	Local Psychiatric Hospital/IMD PT68physician costs excluded	X			
Inpatient	4	PT68	Local Psychiatric Hospital/IMD PT68physician costs excluded	X			
Inpatient	5	PT73	Local Psychiatric Hospital - Acute Community PT73bundled per diem	X			
Inpatient	6	PT73	Local Psychiatric Hospital - Acute Community PT73bundled per diem	X			
Inpatient	7	PT73	Local Psychiatric Hospital - Acute Community PT73physician costs excluded	X			
Inpatient	8	PT73	Local Psychiatric Hospital - Acute Community PT73physician costs excluded	X			
Inpatient	10	PT68	Local Psychiatric Hospital/IMD	X			
Inpatient	11	PT73	Local Psychiatric Hospital/Acute Community	X			
Outpatient	14	0370	ECT Anesthesia	X			
Outpatient	15	0710	ECT Recovery Room	X			
Outpatient	16	0901	Electro-Convulsive Therapy	X			
Outpatient	18	0912	Outpatient Partial Hospitalization	X			
Outpatient	19	0913	Outpatient Partial Hospitalization	X			
Professional CLS	212	H0043	Community Living Supports in Independent living/own home		X	X	X
Professional CLS	224	H2015	Community Living Supports (15 Minutes)		X	X	X
Professional CLS	225	H2016	Community Living Supports (Daily)		X	X	X
Professional CLS	274	T1020	Personal Care in Licensed Specialized Residential Setting	X			
Professional CLS	288	T2036	Community Living Supports/Respite Care-Therapeutic Camping			X	X
Professional CLS	289	T2037	Community Living Supports/Respite Care-Therapeutic Camping			X	X
Professional Non-CLS	21	00104	Electro-Convulsive Therapy	X			
Professional Non-CLS	22	00104	Additional Codes-ECT Anesthesia	X			
Professional Non-CLS	31	90785	Interactive Complexity - Add On Code	X			
Professional Non-CLS	33	90791	Assessment	X			
Professional Non-CLS	35	90792	Assessment	X			
Professional Non-CLS	37	90832	Mental Health: Outpatient Care	X			
Professional Non-CLS	39	90833	Add on Code with evaluation management and psychotherapy	X			
Professional Non-CLS	40	90834	Mental Health: Outpatient Care	X			
Professional Non-CLS	42	90836	Add on Code with evaluation management and psychotherapy	X			
Professional Non-CLS	43	90837	Mental Health: Outpatient Care	X			
Professional Non-CLS	45	90838	Add on Code with evaluation management and psychotherapy	X			
Professional Non-CLS	46	90839	Psychotherapy for Crisis First 60 Minutes	X			
Professional Non-CLS	47	90840	Psychotherapy for Crisis Each Additional 30 Minutes	X			
Professional Non-CLS	48	90846	Therapy-Family Therapy	X			
Professional Non-CLS	50	90847	Therapy-Family Therapy	X			
Professional Non-CLS	52	90849	Therapy-Family Therapy	X			
Professional Non-CLS	53	90849HS	Therapy-Family Therapy	X			
Professional Non-CLS	55	90853	Therapy-Group Therapy	X			
Professional Non-CLS	57	90870	Electroconvulsive Therapy	X			
Professional Non-CLS	58	90870	Additional Codes-ECT Physician	X			
Professional Non-CLS	59	90887	Assessments-Other	X			
Professional Non-CLS	60	92507	Speech & Language Therapy	X			
Professional Non-CLS	61	92508	Speech & Language Therapy	X			
Professional Non-CLS	62	92521	Speech & Language Therapy	X			
Professional Non-CLS	63	92522	Speech & Language Therapy	X			
Professional Non-CLS	64	92523	Speech & Language Therapy	X			
Professional Non-CLS	65	92524	Speech & Language Therapy	X			
Professional Non-CLS	66	92526	Speech & Language Therapy	X			
Professional Non-CLS	67	92607	Speech & Language Therapy	X			
Professional Non-CLS	68	92608	Speech & Language Therapy	X			
Professional Non-CLS	69	92609	Speech & Language Therapy	X			
Professional Non-CLS	70	92610	Speech & Language Therapy	X			
Professional Non-CLS	71	96101	Assessments - Testing	X			
Professional Non-CLS	72	96102	Assessments - Testing	X			
Professional Non-CLS	73	96103	Assessments - Testing	X			
Professional Non-CLS	74	96105	Assessments - Other	X			
Professional Non-CLS	75	96110	Assessments - Other	X			
Professional Non-CLS	76	96111	Assessments - Other	X			
Professional Non-CLS	77	96116	Assessments - Testing	X			
Professional Non-CLS	78	96118	Assessments - Testing	X			
Professional Non-CLS	79	96119	Assessments - Testing	X			
Professional Non-CLS	80	96120	Assessments - Testing	X			
Professional Non-CLS	81	96127	Assessments-Other	X			
Professional Non-CLS	82	96372	Medication Administration	X			
Professional Non-CLS	83	97001	Physical Therapy	X			
Professional Non-CLS	84	97002	Physical Therapy	X			
Professional Non-CLS	85	97003	Occupational Therapy	X			
Professional Non-CLS	86	97004	Occupational Therapy	X			
Professional Non-CLS	87	97110	Occupational or Physical Therapy	X			
Professional Non-CLS	88	97112	Occupational or Physical Therapy	X			
Professional Non-CLS	89	97113	Occupational or Physical Therapy	X			
Professional Non-CLS	90	97116	Occupational or Physical Therapy	X			
Professional Non-CLS	91	97124	Occupational or Physical Therapy	X			
Professional Non-CLS	92	97140	Occupational or Physical Therapy	X			
Professional Non-CLS	93	97150	Occupational or Physical Therapy	X			
Professional Non-CLS	94	97161	Physical Therapy	X			
Professional Non-CLS	95	97162	Physical Therapy	X			
Professional Non-CLS	96	97163	Physical Therapy	X			
Professional Non-CLS	97	97164	Physical Therapy	X			
Professional Non-CLS	98	97165	Occupational Therapy	X			

Service_Category	LineID	Service	Service Description	State Plan	EPSDT	B(3)	HSW
Professional Non-CLS	99	97166	Occupational Therapy	X			
Professional Non-CLS	100	97167	Occupational Therapy	X			
Professional Non-CLS	101	97168	Occupational Therapy	X			
Professional Non-CLS	102	97530	Occupational or Physical Therapy	X			
Professional Non-CLS	103	97532	Occupational or Physical Therapy	X			
Professional Non-CLS	104	97533	Occupational or Physical Therapy	X			
Professional Non-CLS	105	97535	Occupational or Physical Therapy	X			
Professional Non-CLS	106	97537	Occupational or Physical Therapy	X			
Professional Non-CLS	107	97542	Occupational or Physical Therapy	X			
Professional Non-CLS	108	97750	Occupational or Physical Therapy	X			
Professional Non-CLS	109	97755	Occupational Therapy	X			
Professional Non-CLS	110	97760	Occupational or Physical Therapy	X			
Professional Non-CLS	111	97762	Occupational or Physical Therapy	X			
Professional Non-CLS	112	97802	Assessment or Health Services	X			
Professional Non-CLS	113	97803	Assessment or Health Services	X			
Professional Non-CLS	114	97804	Health Services	X			
Professional Non-CLS	115	99201	Psychiatric Evaluation and Medicaid Management	X			
Professional Non-CLS	117	99202	Psychiatric Evaluation and Medicaid Management	X			
Professional Non-CLS	119	99203	Psychiatric Evaluation and Medicaid Management	X			
Professional Non-CLS	121	99204	Psychiatric Evaluation and Medicaid Management	X			
Professional Non-CLS	123	99205	Psychiatric Evaluation and Medicaid Management	X			
Professional Non-CLS	125	99211	Psychiatric Evaluation and Medicaid Management	X			
Professional Non-CLS	127	99212	Psychiatric Evaluation and Medicaid Management	X			
Professional Non-CLS	129	99213	Psychiatric Evaluation and Medicaid Management	X			
Professional Non-CLS	131	99214	Psychiatric Evaluation and Medicaid Management	X			
Professional Non-CLS	133	99215	Psychiatric Evaluation and Medicaid Management	X			
Professional Non-CLS	135	99221	Additional Codes-Physician Services	X			
Professional Non-CLS	136	99222	Additional Codes-Physician Services	X			
Professional Non-CLS	137	99223	Additional Codes-Physician Services	X			
Professional Non-CLS	138	99224	Additional Codes-Physician Services	X			
Professional Non-CLS	139	99225	Additional Codes-Physician Services	X			
Professional Non-CLS	140	99226	Additional Codes-Physician Services	X			
Professional Non-CLS	141	99231	Additional Codes-Physician Services	X			
Professional Non-CLS	142	99232	Additional Codes-Physician Services	X			
Professional Non-CLS	143	99233	Additional Codes-Physician Services	X			
Professional Non-CLS	144	99304	Nursing Facility Services evaluation and management	X			
Professional Non-CLS	145	99305	Nursing Facility Services evaluation and management	X			
Professional Non-CLS	146	99306	Nursing Facility Services evaluation and management	X			
Professional Non-CLS	147	99307	Nursing Facility Services evaluation and management	X			
Professional Non-CLS	148	99308	Nursing Facility Services evaluation and management	X			
Professional Non-CLS	149	99309	Nursing Facility Services evaluation and management	X			
Professional Non-CLS	150	99310	Nursing Facility Services evaluation and management	X			
Professional Non-CLS	151	99324	Assessment	X			
Professional Non-CLS	152	99325	Assessment	X			
Professional Non-CLS	153	99326	Assessment	X			
Professional Non-CLS	154	99327	Assessment	X			
Professional Non-CLS	155	99328	Assessment	X			
Professional Non-CLS	156	99334	Assessment	X			
Professional Non-CLS	157	99335	Assessment	X			
Professional Non-CLS	158	99336	Assessment	X			
Professional Non-CLS	159	99337	Assessment	X			
Professional Non-CLS	160	99341	Assessment	X			
Professional Non-CLS	161	99342	Assessment	X			
Professional Non-CLS	162	99343	Assessment	X			
Professional Non-CLS	163	99344	Assessment	X			
Professional Non-CLS	164	99345	Assessment	X			
Professional Non-CLS	165	99347	Assessment	X			
Professional Non-CLS	166	99348	Assessment	X			
Professional Non-CLS	167	99349	Assessment	X			
Professional Non-CLS	168	99350	Assessment	X			
Professional Non-CLS	169	99506	Medication Administration	X			
Professional Non-CLS	170	99605	Medication Management	X			
Professional Non-CLS	171	A0080	Transportation	X		X	
Professional Non-CLS	172	A0090	Transportation	X		X	
Professional Non-CLS	173	A0100	Transportation	X		X	
Professional Non-CLS	174	A0110	Transportation	X		X	
Professional Non-CLS	175	A0120	Transportation	X		X	
Professional Non-CLS	176	A0130	Transportation	X		X	
Professional Non-CLS	177	A0140	Transportation	X		X	
Professional Non-CLS	178	A0170	Transportation	X		X	
Professional Non-CLS	179	E1399	Enhanced Medical Equipment-Supplies			X	X
Professional Non-CLS	180	G0177	Family Training/Support			X	
Professional Non-CLS	183	H0002	Assessment	X			
Professional Non-CLS	191	H0018	Crisis Residential Services	X			
Professional Non-CLS	196	H0023	Peer Directed and Operated Support Services		X	X	
Professional Non-CLS	198	H0025	Prevention Services - Direct Model			X	
Professional Non-CLS	199	H0031	Assessment	X			
Professional Non-CLS	200	H0031HW	Support Intensity Scale (SIS) Face-to-Face Assessment	X			
Professional Non-CLS	201	H0032	Treatment Planning	X			
Professional Non-CLS	202	H0032TS	Treatment Planning	X			
Professional Non-CLS	204	H0034	Health Services	X			

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SFY 2017 MUNC Mental Health Services by Service Category
Specialty Services

Service_Category	LineID	Service	Service Description	State Plan	EPSDT	B(3)	HSW
Professional Non-CLS	205	H0036	Home Based Services	X			
Professional Non-CLS	206	H0036ST	Home Based Services	X			
Professional Non-CLS	207	H0038	Peer Directed and Operated Support Services		X	X	
Professional Non-CLS	208	H0038TJ	Peer Directed and Operated Support Services		X	X	
Professional Non-CLS	210	NA	Peer Directed and Operated Support Services				
Professional Non-CLS	211	H0039	Assertive Community Treatment (ACT)	X			
Professional Non-CLS	213	H0045	Respite Care			X	X
Professional Non-CLS	214	H0046	Peer Mentor Services DD Consumers		X	X	
Professional Non-CLS	217	H2000	Behavior Treatment Plan Review	X			
Professional Non-CLS	218	H2000TS	Monitoring Activities	X			
Professional Non-CLS	219	H2010	Medication Review	X			
Professional Non-CLS	220	H2011	Crisis Intervention	X			
Professional Non-CLS	222	H2014	Skill-Building		X	X	
Professional Non-CLS	223	H2014HK	Out of Home Non Vocational Habilitation				X
Professional Non-CLS	226	H2019	Mental Health Therapy	X			
Professional Non-CLS	227	H2019TT	Mental Health Therapy	X			
Professional Non-CLS	228	H2021	Wraparound Services		X		
Professional Non-CLS	229	H2023	Supported Employment Services		X	X	X
Professional Non-CLS	230	H2027	Prevention Services - Direct Model		X		
Professional Non-CLS	232	H2030	Clubhouse Psychosocial Rehabilitation Programs	X			
Professional Non-CLS	233	H2033	Home Based Services	X			
Professional Non-CLS	236	Q3014GT	Telemedicine Facility Fee	X			
Professional Non-CLS	237	S0209	Transportation	X		X	
Professional Non-CLS	238	S0215	Transportation	X		X	
Professional Non-CLS	239	S5110	Family Training			X	
Professional Non-CLS	240	S5111	Family Training		X	X	X
Professional Non-CLS	241	S5111HA	Family Training		X	X	X
Professional Non-CLS	242	S5111HM	Family Training		X	X	X
Professional Non-CLS	243	S5151	Respite			X	X
Professional Non-CLS	244	S5160	Personal Emergency Response System (PERS)			X	X
Professional Non-CLS	245	S5161	Personal Emergency Response System (PERS)			X	X
Professional Non-CLS	246	S5165	Environmental Modification			X	X
Professional Non-CLS	247	S5199	Enhanced Medical Equipment-Supplies			X	X
Professional Non-CLS	248	S8990	Occupational or Physical Therapy	X			
Professional Non-CLS	249	S9123	Private Duty Nursing				X
Professional Non-CLS	250	S9123	Private Duty Nursing				X
Professional Non-CLS	251	S9123TT	Private Duty Nursing				X
Professional Non-CLS	252	S9124	Private Duty Nursing				X
Professional Non-CLS	253	S9124	Private Duty Nursing				X
Professional Non-CLS	254	S9124TT	Private Duty Nursing				X
Professional Non-CLS	255	S9445	Health Services	X			
Professional Non-CLS	256	S9446	Health Services	X			
Professional Non-CLS	257	S9470	Health Services	X			
Professional Non-CLS	258	S9482	Prevention Services - Direct Model			X	
Professional Non-CLS	259	S9484	Intensive Crisis Stabilization	X			
Professional Non-CLS	260	T1000	Private Duty Nursing				X
Professional Non-CLS	261	T1000TD	Private Duty Nursing				X
Professional Non-CLS	262	T1000TE	Private Duty Nursing				X
Professional Non-CLS	263	T1001	Assessment	X			
Professional Non-CLS	264	T1002	Health Services	X			
Professional Non-CLS	265	T1005	Respite Care			X	X
Professional Non-CLS	266	T1005TD	Respite Care			X	X
Professional Non-CLS	267	T1005TE	Respite Care			X	X
Professional Non-CLS	270	T1015	Family Training			X	
Professional Non-CLS	271	T1016	Supports Coordination		X	X	X
Professional Non-CLS	272	T1017	Targeted Case Management	X			
Professional Non-CLS	273	T1017SE	Nursing Facility Mental Health Monitoring	X			
Professional Non-CLS	275	T1023	Assessments	X			
Professional Non-CLS	276	T1027	Prevention Services - Direct Model		X		
Professional Non-CLS	277	T1999	Enhanced Pharmacy			X	X
Professional Non-CLS	278	T2001	Transportation	X		X	
Professional Non-CLS	279	T2002	Transportation	X		X	
Professional Non-CLS	280	T2003	Transportation	X		X	
Professional Non-CLS	281	T2004	Transportation	X		X	
Professional Non-CLS	282	T2005	Transportation	X		X	
Professional Non-CLS	283	T2015	Out of Home Prevocational Service				X
Professional Non-CLS	284	T2024	Prevention Services - Direct Model		X		
Professional Non-CLS	285	T2025	Fiscal Intermediary Services			X	
Professional Non-CLS	286	T2028	Enhanced Medical Equipment-Supplies			X	X
Professional Non-CLS	287	T2029	Enhanced Medical Equipment-Supplies			X	X
Professional Non-CLS	290	T2038	Housing Assistance			X	
Professional Non-CLS	291	T2039	Enhanced Medical Equipment-Supplies			X	X
Professional Non-CLS	292	T5999	Goods and Services				X

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Specialty Services

Service_Category	LineID	Service	Service Description	State Plan	B(3)
Professional Non-CLS	17	0906	Substance Abuse: Outpatient	X	
Professional Non-CLS	20	1002	Substance Abuse: Subacute Detoxification	X	
Professional Non-CLS	23	80300	Substance Abuse: Drug Screen for Methadone Clients Only	X	
Professional Non-CLS	24	80301	Substance Abuse: Drug Screen for Methadone Clients Only	X	
Professional Non-CLS	25	80302	Substance Abuse: Drug Screen for Methadone Clients Only	X	
Professional Non-CLS	26	80303	Substance Abuse: Drug Screen for Methadone Clients Only	X	
Professional Non-CLS	27	80304	Substance Abuse: Drug Screen for Methadone Clients Only	X	
Professional Non-CLS	28	80305	Substance Abuse: Drug Screen for Methadone Clients Only	X	
Professional Non-CLS	29	80306	Substance Abuse: Drug Screen for Methadone Clients Only	X	
Professional Non-CLS	30	80307	Substance Abuse: Drug Screen for Methadone Clients Only	X	
Professional Non-CLS	32	90785	Substance Abuse: Interactive Complexity - Add On Code	X	
Professional Non-CLS	34	90791	Substance Use: Assessment	X	
Professional Non-CLS	36	90792	Substance Use: Assessment	X	
Professional Non-CLS	38	90832	Substance abuse: Outpatient Care	X	
Professional Non-CLS	41	90834	Substance abuse: Outpatient Care	X	
Professional Non-CLS	44	90837	Substance abuse: Outpatient Care	X	
Professional Non-CLS	49	90846	Substance Abuse: Psychotherapy (group)	X	
Professional Non-CLS	51	90847	Substance Abuse: Outpatient Care	X	
Professional Non-CLS	54	90849	Substance Abuse: Psychotherapy (group)	X	
Professional Non-CLS	56	90853	Substance Abuse: Outpatient Treatment	X	
Professional Non-CLS	116	99201	Substance Abuse: New Patient Evaluation and Management	X	
Professional Non-CLS	118	99202	Substance Abuse: New Patient Evaluation and Management	X	
Professional Non-CLS	120	99203	Substance Abuse: Physician Evaluation/Exam Under methadone	X	
Professional Non-CLS	122	99204	Substance Abuse: Physician Evaluation/Exam Under methadone	X	
Professional Non-CLS	124	99205	Substance Abuse: Physician Evaluation/Exam Under methadone	X	
Professional Non-CLS	126	99211	Substance Abuse: Established Patient Evaluation and Management	X	
Professional Non-CLS	128	99212	Substance Abuse: Established Patient Evaluation and Management	X	
Professional Non-CLS	130	99213	Substance Abuse: Established Patient Evaluation and Management	X	
Professional Non-CLS	132	99214	Substance Abuse: Established Patient Evaluation and Management	X	
Professional Non-CLS	134	99215	Substance Abuse: Established Patient Evaluation and Management	X	
Professional Non-CLS	181	G0409	Substance Abuse: Recovery Support Services	X	
Professional Non-CLS	182	H0001	Substance Abuse: Individual Assessment	X	
Professional Non-CLS	184	H0003	Substance Abuse: Laboratory Tests	X	
Professional Non-CLS	185	H0004	Substance Abuse: Outpatient Treatment	X	
Professional Non-CLS	186	H0005	Substance Abuse: Outpatient Care	X	
Professional Non-CLS	187	H0010	Substance Abuse: Sub-Acute Detoxification	X	
Professional Non-CLS	188	H0012	Substance Abuse: Sub-Acute Detoxification	X	
Professional Non-CLS	189	H0014	Substance Abuse: Sub-Acute Detoxification	X	
Professional Non-CLS	190	H0015	Substance Abuse: Outpatient Care	X	
Professional Non-CLS	192	H0018	Substance Abuse: Residential Services	X	
Professional Non-CLS	193	H0019	Substance Abuse: Residential Services	X	
Professional Non-CLS	194	H0020	Substance Abuse: Methadone	X	
Professional Non-CLS	195	H0022	Substance Abuse: Early Intervention	X	
Professional Non-CLS	197	H0023	Substance Abuse: Peer Directed and Operated Support Services	X	
Professional Non-CLS	203	H0033	Substance Abuse: Pharmalogical Support - Suboxone	X	
Professional Non-CLS	209	H0038	Substance Abuse: Peer Services	X	
Professional Non-CLS	215	H0048	Substance Abuse: Laboratory Tests	X	
Professional Non-CLS	216	H0050	Substance Abuse: Individual Treatment	X	
Professional Non-CLS	221	H2011	Substance Abuse: Crisis Intervention, per 15 minutes	X	
Professional Non-CLS	231	H2027	Substance Abuse Outpatient: Didactics	X	
Professional Non-CLS	234	H2035	Substance Abuse Outpatient	X	
Professional Non-CLS	235	H2036	Substance Abuse: Outpatient Care	X	
Professional Non-CLS	268	T1007	Substance Abuse: Treatment Planning	X	
Professional Non-CLS	269	T1012	Substance Abuse: Recovery Supports	X	

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Healthy Michigan

Service_Category	LineID	Service	Service Description
Inpatient	1	PT68	Local Psychiatric Hospital/IMD PT68 bundled per diem
Inpatient	2	PT68	Local Psychiatric Hospital/IMD PT68bundled per diem
Inpatient	3	PT68	Local Psychiatric Hospital/IMD PT68physician costs excluded
Inpatient	4	PT68	Local Psychiatric Hospital/IMD PT68physician costs excluded
Inpatient	5	PT73	Local Psychiatric Hospital - Acute Community PT73bundled per diem
Inpatient	6	PT73	Local Psychiatric Hospital - Acute Community PT73bundled per diem
Inpatient	7	PT73	Local Psychiatric Hospital - Acute Community PT73physician costs excluded
Inpatient	8	PT73	Local Psychiatric Hospital - Acute Community PT73physician costs excluded
Inpatient	10	PT68	Local Psychiatric Hospital/IMD
Inpatient	11	PT73	Local Psychiatric Hospital/Acute Community
Outpatient	14	0370	ECT Anesthesia
Outpatient	15	0710	ECT Recovery Room
Outpatient	16	0901	Electro-Convulsive Therapy
Outpatient	18	0912	Outpatient Partial Hospitalization
Outpatient	19	0913	Outpatient Partial Hospitalization
Professional CLS	212	H0043	Community Living Supports in Independent living/own home
Professional CLS	224	H2015	Community Living Supports (15 Minutes)
Professional CLS	225	H2016	Community Living Supports (Daily)
Professional CLS	274	T1020	Personal Care in Licensed Specialized Residential Setting
Professional CLS	288	T2036	Community Living Supports/Respite Care-Therapeutic Camping
Professional CLS	289	T2037	Community Living Supports/Respite Care-Therapeutic Camping
Professional Non-CLS	21	00104	Electro-Convulsive Therapy
Professional Non-CLS	22	00104	Additional Codes-ECT Anesthesia
Professional Non-CLS	31	90785	Interactive Complexity - Add On Code
Professional Non-CLS	33	90791	Assessment
Professional Non-CLS	35	90792	Assessment
Professional Non-CLS	37	90832	Mental Health: Outpatient Care
Professional Non-CLS	39	90833	Add on Code with evaluation management and psychotherapy
Professional Non-CLS	40	90834	Mental Health: Outpatient Care
Professional Non-CLS	42	90836	Add on Code with evaluation management and psychotherapy
Professional Non-CLS	43	90837	Mental Health: Outpatient Care
Professional Non-CLS	45	90838	Add on Code with evaluation management and psychotherapy
Professional Non-CLS	46	90839	Psychotherapy for Crisis First 60 Minutes
Professional Non-CLS	47	90840	Psychotherapy for Crisis Each Additional 30 Minutes
Professional Non-CLS	48	90846	Therapy-Family Therapy
Professional Non-CLS	50	90847	Therapy-Family Therapy
Professional Non-CLS	52	90849	Therapy-Family Therapy
Professional Non-CLS	53	90849HS	Therapy-Family Therapy
Professional Non-CLS	55	90853	Therapy-Group Therapy
Professional Non-CLS	57	90870	Electroconvulsive Therapy
Professional Non-CLS	58	90870	Additional Codes-ECT Physician
Professional Non-CLS	59	90887	Assessments-Other
Professional Non-CLS	60	92507	Speech & Language Therapy
Professional Non-CLS	61	92508	Speech & Language Therapy
Professional Non-CLS	62	92521	Speech & Language Therapy
Professional Non-CLS	63	92522	Speech & Language Therapy
Professional Non-CLS	64	92523	Speech & Language Therapy
Professional Non-CLS	65	92524	Speech & Language Therapy
Professional Non-CLS	66	92526	Speech & Language Therapy
Professional Non-CLS	67	92607	Speech & Language Therapy
Professional Non-CLS	68	92608	Speech & Language Therapy
Professional Non-CLS	69	92609	Speech & Language Therapy
Professional Non-CLS	70	92610	Speech & Language Therapy
Professional Non-CLS	71	96101	Assessments - Testing
Professional Non-CLS	72	96102	Assessments - Testing
Professional Non-CLS	73	96103	Assessments - Testing
Professional Non-CLS	74	96105	Assessments - Other
Professional Non-CLS	75	96110	Assessments - Other
Professional Non-CLS	76	96111	Assessments - Other
Professional Non-CLS	77	96116	Assessments - Testing
Professional Non-CLS	78	96118	Assessments - Testing
Professional Non-CLS	79	96119	Assessments - Testing
Professional Non-CLS	80	96120	Assessments - Testing
Professional Non-CLS	81	96127	Assessments-Other
Professional Non-CLS	82	96372	Medication Administration
Professional Non-CLS	83	97001	Physical Therapy
Professional Non-CLS	84	97002	Physical Therapy
Professional Non-CLS	85	97003	Occupational Therapy
Professional Non-CLS	86	97004	Occupational Therapy
Professional Non-CLS	87	97110	Occupational or Physical Therapy
Professional Non-CLS	88	97112	Occupational or Physical Therapy
Professional Non-CLS	89	97113	Occupational or Physical Therapy
Professional Non-CLS	90	97116	Occupational or Physical Therapy
Professional Non-CLS	91	97124	Occupational or Physical Therapy
Professional Non-CLS	92	97140	Occupational or Physical Therapy
Professional Non-CLS	93	97150	Occupational or Physical Therapy
Professional Non-CLS	94	97161	Physical Therapy
Professional Non-CLS	95	97162	Physical Therapy
Professional Non-CLS	96	97163	Physical Therapy
Professional Non-CLS	97	97164	Physical Therapy
Professional Non-CLS	98	97165	Occupational Therapy

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Healthy Michigan

Service_Category	LineID	Service	Service Description
Professional Non-CLS	99	97166	Occupational Therapy
Professional Non-CLS	100	97167	Occupational Therapy
Professional Non-CLS	101	97168	Occupational Therapy
Professional Non-CLS	102	97530	Occupational or Physical Therapy
Professional Non-CLS	103	97532	Occupational or Physical Therapy
Professional Non-CLS	104	97533	Occupational or Physical Therapy
Professional Non-CLS	105	97535	Occupational or Physical Therapy
Professional Non-CLS	106	97537	Occupational or Physical Therapy
Professional Non-CLS	107	97542	Occupational or Physical Therapy
Professional Non-CLS	108	97750	Occupational or Physical Therapy
Professional Non-CLS	109	97755	Occupational Therapy
Professional Non-CLS	110	97760	Occupational or Physical Therapy
Professional Non-CLS	111	97762	Occupational or Physical Therapy
Professional Non-CLS	112	97802	Assessment or Health Services
Professional Non-CLS	113	97803	Assessment or Health Services
Professional Non-CLS	114	97804	Health Services
Professional Non-CLS	115	99201	Psychiatric Evaluation and Medicaid Management
Professional Non-CLS	117	99202	Psychiatric Evaluation and Medicaid Management
Professional Non-CLS	119	99203	Psychiatric Evaluation and Medicaid Management
Professional Non-CLS	121	99204	Psychiatric Evaluation and Medicaid Management
Professional Non-CLS	123	99205	Psychiatric Evaluation and Medicaid Management
Professional Non-CLS	125	99211	Psychiatric Evaluation and Medicaid Management
Professional Non-CLS	127	99212	Psychiatric Evaluation and Medicaid Management
Professional Non-CLS	129	99213	Psychiatric Evaluation and Medicaid Management
Professional Non-CLS	131	99214	Psychiatric Evaluation and Medicaid Management
Professional Non-CLS	133	99215	Psychiatric Evaluation and Medicaid Management
Professional Non-CLS	135	99221	Additional Codes-Physician Services
Professional Non-CLS	136	99222	Additional Codes-Physician Services
Professional Non-CLS	137	99223	Additional Codes-Physician Services
Professional Non-CLS	138	99224	Additional Codes-Physician Services
Professional Non-CLS	139	99225	Additional Codes-Physician Services
Professional Non-CLS	140	99226	Additional Codes-Physician Services
Professional Non-CLS	141	99231	Additional Codes-Physician Services
Professional Non-CLS	142	99232	Additional Codes-Physician Services
Professional Non-CLS	143	99233	Additional Codes-Physician Services
Professional Non-CLS	144	99304	Nursing Facility Services evaluation and management
Professional Non-CLS	145	99305	Nursing Facility Services evaluation and management
Professional Non-CLS	146	99306	Nursing Facility Services evaluation and management
Professional Non-CLS	147	99307	Nursing Facility Services evaluation and management
Professional Non-CLS	148	99308	Nursing Facility Services evaluation and management
Professional Non-CLS	149	99309	Nursing Facility Services evaluation and management
Professional Non-CLS	150	99310	Nursing Facility Services evaluation and management
Professional Non-CLS	151	99324	Assessment
Professional Non-CLS	152	99325	Assessment
Professional Non-CLS	153	99326	Assessment
Professional Non-CLS	154	99327	Assessment
Professional Non-CLS	155	99328	Assessment
Professional Non-CLS	156	99334	Assessment
Professional Non-CLS	157	99335	Assessment
Professional Non-CLS	158	99336	Assessment
Professional Non-CLS	159	99337	Assessment
Professional Non-CLS	160	99341	Assessment
Professional Non-CLS	161	99342	Assessment
Professional Non-CLS	162	99343	Assessment
Professional Non-CLS	163	99344	Assessment
Professional Non-CLS	164	99345	Assessment
Professional Non-CLS	165	99347	Assessment
Professional Non-CLS	166	99348	Assessment
Professional Non-CLS	167	99349	Assessment
Professional Non-CLS	168	99350	Assessment
Professional Non-CLS	169	99506	Medication Administration
Professional Non-CLS	170	99605	Medication Management
Professional Non-CLS	171	A0080	Transportation
Professional Non-CLS	172	A0090	Transportation
Professional Non-CLS	173	A0100	Transportation
Professional Non-CLS	174	A0110	Transportation
Professional Non-CLS	175	A0120	Transportation
Professional Non-CLS	176	A0130	Transportation
Professional Non-CLS	177	A0140	Transportation
Professional Non-CLS	178	A0170	Transportation
Professional Non-CLS	179	E1399	Enhanced Medical Equipment-Supplies
Professional Non-CLS	180	G0177	Family Training/Support
Professional Non-CLS	183	H0002	Assessment
Professional Non-CLS	191	H0018	Crisis Residential Services
Professional Non-CLS	196	H0023	Peer Directed and Operated Support Services
Professional Non-CLS	198	H0025	Prevention Services - Direct Model
Professional Non-CLS	199	H0031	Assessment
Professional Non-CLS	200	H0031HW	Support Intensity Scale (SIS) Face-to-Face Assessment
Professional Non-CLS	201	H0032	Treatment Planning
Professional Non-CLS	202	H0032TS	Treatment Planning
Professional Non-CLS	204	H0034	Health Services

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SFY 2017 MUNC Mental Health Services by Service Category
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Service_Category	LineID	Service	Service Description
Professional Non-CLS	205	H0036	Home Based Services
Professional Non-CLS	206	H0036ST	Home Based Services
Professional Non-CLS	207	H0038	Peer Directed and Operated Support Services
Professional Non-CLS	208	H0038TJ	Peer Directed and Operated Support Services
Professional Non-CLS	210	NA	Peer Directed and Operated Support Services
Professional Non-CLS	211	H0039	Assertive Community Treatment (ACT)
Professional Non-CLS	213	H0045	Respite Care
Professional Non-CLS	214	H0046	Peer Mentor Services DD Consumers
Professional Non-CLS	217	H2000	Behavior Treatment Plan Review
Professional Non-CLS	218	H2000TS	Monitoring Activities
Professional Non-CLS	219	H2010	Medication Review
Professional Non-CLS	220	H2011	Crisis Intervention
Professional Non-CLS	222	H2014	Skill-Building
Professional Non-CLS	223	H2014HK	Out of Home Non Vocational Habilitation
Professional Non-CLS	226	H2019	Mental Health Therapy
Professional Non-CLS	227	H2019TT	Mental Health Therapy
Professional Non-CLS	228	H2021	Wraparound Services
Professional Non-CLS	229	H2023	Supported Employment Services
Professional Non-CLS	230	H2027	Prevention Services - Direct Model
Professional Non-CLS	232	H2030	Clubhouse Psychosocial Rehabilitation Programs
Professional Non-CLS	233	H2033	Home Based Services
Professional Non-CLS	236	Q3014GT	Telemedicine Facility Fee
Professional Non-CLS	237	S0209	Transportation
Professional Non-CLS	238	S0215	Transportation
Professional Non-CLS	239	S5110	Family Training
Professional Non-CLS	240	S5111	Family Training
Professional Non-CLS	241	S5111HA	Family Training
Professional Non-CLS	242	S5111HM	Family Training
Professional Non-CLS	243	S5151	Respite
Professional Non-CLS	244	S5160	Personal Emergency Response System (PERS)
Professional Non-CLS	245	S5161	Personal Emergency Response System (PERS)
Professional Non-CLS	246	S5165	Environmental Modification
Professional Non-CLS	247	S5199	Enhanced Medical Equipment-Supplies
Professional Non-CLS	248	S8990	Occupational or Physical Therapy
Professional Non-CLS	249	S9123	Private Duty Nursing
Professional Non-CLS	250	S9123	Private Duty Nursing
Professional Non-CLS	251	S9123TT	Private Duty Nursing
Professional Non-CLS	252	S9124	Private Duty Nursing
Professional Non-CLS	253	S9124	Private Duty Nursing
Professional Non-CLS	254	S9124TT	Private Duty Nursing
Professional Non-CLS	255	S9445	Health Services
Professional Non-CLS	256	S9446	Health Services
Professional Non-CLS	257	S9470	Health Services
Professional Non-CLS	258	S9482	Prevention Services - Direct Model
Professional Non-CLS	259	S9484	Intensive Crisis Stabilization
Professional Non-CLS	260	T1000	Private Duty Nursing
Professional Non-CLS	261	T1000TD	Private Duty Nursing
Professional Non-CLS	262	T1000TE	Private Duty Nursing
Professional Non-CLS	263	T1001	Assessment
Professional Non-CLS	264	T1002	Health Services
Professional Non-CLS	265	T1005	Respite Care
Professional Non-CLS	266	T1005TD	Respite Care
Professional Non-CLS	267	T1005TE	Respite Care
Professional Non-CLS	270	T1015	Family Training
Professional Non-CLS	271	T1016	Supports Coordination
Professional Non-CLS	272	T1017	Targeted Case Management
Professional Non-CLS	273	T1017SE	Nursing Facility Mental Health Monitoring
Professional Non-CLS	275	T1023	Assessments
Professional Non-CLS	276	T1027	Prevention Services - Direct Model
Professional Non-CLS	277	T1999	Enhanced Pharmacy
Professional Non-CLS	278	T2001	Transportation
Professional Non-CLS	279	T2002	Transportation
Professional Non-CLS	280	T2003	Transportation
Professional Non-CLS	281	T2004	Transportation
Professional Non-CLS	282	T2005	Transportation
Professional Non-CLS	283	T2015	Out of Home Prevocational Service
Professional Non-CLS	284	T2024	Prevention Services - Direct Model
Professional Non-CLS	285	T2025	Fiscal Intermediary Services
Professional Non-CLS	286	T2028	Enhanced Medical Equipment-Supplies
Professional Non-CLS	287	T2029	Enhanced Medical Equipment-Supplies
Professional Non-CLS	290	T2038	Housing Assistance
Professional Non-CLS	291	T2039	Enhanced Medical Equipment-Supplies

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Service_Category	LineID	Service	Service Description
Outpatient	18	0912	Outpatient Partial Hospitalization
Outpatient	19	0913	Outpatient Partial Hospitalization
Professional CLS	212	H0043	Community Living Supports in Independent living/own home
Professional CLS	224	H2015	Community Living Supports (15 Minutes)
Professional CLS	225	H2016	Community Living Supports (Daily)
Professional CLS	274	T1020	Personal Care in Licensed Specialized Residential Setting
Professional CLS	288	T2036	Community Living Supports/Respite Care-Therapeutic Camping
Professional CLS	289	T2037	Community Living Supports/Respite Care-Therapeutic Camping
Professional Non-CLS	39	90833	Add on Code with evaluation management and psychotherapy
Professional Non-CLS	42	90836	Add on Code with evaluation management and psychotherapy
Professional Non-CLS	45	90838	Add on Code with evaluation management and psychotherapy
Professional Non-CLS	46	90839	Psychotherapy for Crisis First 60 Minutes
Professional Non-CLS	47	90840	Psychotherapy for Crisis Each Additional 30 Minutes
Professional Non-CLS	59	90887	Assessments-Other
Professional Non-CLS	60	92507	Speech & Language Therapy
Professional Non-CLS	61	92508	Speech & Language Therapy
Professional Non-CLS	62	92521	Speech & Language Therapy
Professional Non-CLS	63	92522	Speech & Language Therapy
Professional Non-CLS	64	92523	Speech & Language Therapy
Professional Non-CLS	65	92524	Speech & Language Therapy
Professional Non-CLS	66	92526	Speech & Language Therapy
Professional Non-CLS	67	92607	Speech & Language Therapy
Professional Non-CLS	68	92608	Speech & Language Therapy
Professional Non-CLS	69	92609	Speech & Language Therapy
Professional Non-CLS	70	92610	Speech & Language Therapy
Professional Non-CLS	71	96101	Assessments - Testing
Professional Non-CLS	72	96102	Assessments - Testing
Professional Non-CLS	73	96103	Assessments - Testing
Professional Non-CLS	74	96105	Assessments - Other
Professional Non-CLS	75	96110	Assessments - Other
Professional Non-CLS	76	96111	Assessments - Other
Professional Non-CLS	77	96116	Assessments - Testing
Professional Non-CLS	78	96118	Assessments - Testing
Professional Non-CLS	79	96119	Assessments - Testing
Professional Non-CLS	80	96120	Assessments - Testing
Professional Non-CLS	81	96127	Assessments-Other
Professional Non-CLS	82	96372	Medication Administration
Professional Non-CLS	83	97001	Physical Therapy
Professional Non-CLS	84	97002	Physical Therapy
Professional Non-CLS	85	97003	Occupational Therapy
Professional Non-CLS	86	97004	Occupational Therapy
Professional Non-CLS	87	97110	Occupational or Physical Therapy
Professional Non-CLS	88	97112	Occupational or Physical Therapy
Professional Non-CLS	89	97113	Occupational or Physical Therapy
Professional Non-CLS	90	97116	Occupational or Physical Therapy
Professional Non-CLS	91	97124	Occupational or Physical Therapy
Professional Non-CLS	92	97140	Occupational or Physical Therapy
Professional Non-CLS	93	97150	Occupational or Physical Therapy
Professional Non-CLS	102	97530	Occupational or Physical Therapy
Professional Non-CLS	103	97532	Occupational or Physical Therapy
Professional Non-CLS	104	97533	Occupational or Physical Therapy
Professional Non-CLS	105	97535	Occupational or Physical Therapy
Professional Non-CLS	106	97537	Occupational or Physical Therapy
Professional Non-CLS	107	97542	Occupational or Physical Therapy
Professional Non-CLS	108	97750	Occupational or Physical Therapy
Professional Non-CLS	109	97755	Occupational Therapy
Professional Non-CLS	110	97760	Occupational or Physical Therapy
Professional Non-CLS	111	97762	Occupational or Physical Therapy
Professional Non-CLS	112	97802	Assessment or Health Services
Professional Non-CLS	113	97803	Assessment or Health Services
Professional Non-CLS	114	97804	Health Services
Professional Non-CLS	135	99221	Additional Codes-Physician Services
Professional Non-CLS	136	99222	Additional Codes-Physician Services
Professional Non-CLS	137	99223	Additional Codes-Physician Services
Professional Non-CLS	138	99224	Additional Codes-Physician Services
Professional Non-CLS	139	99225	Additional Codes-Physician Services
Professional Non-CLS	140	99226	Additional Codes-Physician Services
Professional Non-CLS	141	99231	Additional Codes-Physician Services
Professional Non-CLS	142	99232	Additional Codes-Physician Services
Professional Non-CLS	143	99233	Additional Codes-Physician Services

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Service_Category	LineID	Service	Service Description
Professional Non-CLS	151	99324	Assessment
Professional Non-CLS	152	99325	Assessment
Professional Non-CLS	153	99326	Assessment
Professional Non-CLS	154	99327	Assessment
Professional Non-CLS	155	99328	Assessment
Professional Non-CLS	156	99334	Assessment
Professional Non-CLS	157	99335	Assessment
Professional Non-CLS	158	99336	Assessment
Professional Non-CLS	159	99337	Assessment
Professional Non-CLS	160	99341	Assessment
Professional Non-CLS	161	99342	Assessment
Professional Non-CLS	162	99343	Assessment
Professional Non-CLS	163	99344	Assessment
Professional Non-CLS	164	99345	Assessment
Professional Non-CLS	165	99347	Assessment
Professional Non-CLS	166	99348	Assessment
Professional Non-CLS	167	99349	Assessment
Professional Non-CLS	168	99350	Assessment
Professional Non-CLS	169	99506	Medication Administration
Professional Non-CLS	170	99605	Medication Management
Professional Non-CLS	171	A0080	Transportation
Professional Non-CLS	172	A0090	Transportation
Professional Non-CLS	173	A0100	Transportation
Professional Non-CLS	174	A0110	Transportation
Professional Non-CLS	175	A0120	Transportation
Professional Non-CLS	176	A0130	Transportation
Professional Non-CLS	177	A0140	Transportation
Professional Non-CLS	178	A0170	Transportation
Professional Non-CLS	179	E1399	Enhanced Medical Equipment-Supplies
Professional Non-CLS	183	H0002	Assessment
Professional Non-CLS	198	H0025	Prevention Services - Direct Model
Professional Non-CLS	199	H0031	Assessment
Professional Non-CLS	200	H0031HW	Support Intensity Scale (SIS) Face-to-Face Assessment
Professional Non-CLS	201	H0032	Treatment Planning
Professional Non-CLS	202	H0032TS	Treatment Planning
Professional Non-CLS	204	H0034	Health Services
Professional Non-CLS	210	NA	Peer Directed and Operated Support Services
Professional Non-CLS	213	H0045	Respite Care
Professional Non-CLS	217	H2000	Behavior Treatment Plan Review
Professional Non-CLS	218	H2000TS	Monitoring Activities
Professional Non-CLS	222	H2014	Skill-Building
Professional Non-CLS	223	H2014HK	Out of Home Non Vocational Habilitation
Professional Non-CLS	237	S0209	Transportation
Professional Non-CLS	238	S0215	Transportation
Professional Non-CLS	243	S5151	Respite
Professional Non-CLS	244	S5160	Personal Emergency Response System (PERS)
Professional Non-CLS	246	S5165	Environmental Modification
Professional Non-CLS	247	S5199	Enhanced Medical Equipment-Supplies
Professional Non-CLS	248	S8990	Occupational or Physical Therapy
Professional Non-CLS	255	S9445	Health Services
Professional Non-CLS	256	S9446	Health Services
Professional Non-CLS	257	S9470	Health Services
Professional Non-CLS	258	S9482	Prevention Services - Direct Model
Professional Non-CLS	259	S9484	Intensive Crisis Stabilization
Professional Non-CLS	263	T1001	Assessment
Professional Non-CLS	264	T1002	Health Services
Professional Non-CLS	265	T1005	Respite Care
Professional Non-CLS	266	T1005TD	Respite Care
Professional Non-CLS	267	T1005TE	Respite Care
Professional Non-CLS	271	T1016	Supports Coordination
Professional Non-CLS	272	T1017	Targeted Case Management
Professional Non-CLS	273	T1017SE	Nursing Facility Mental Health Monitoring
Professional Non-CLS	275	T1023	Assessments
Professional Non-CLS	276	T1027	Prevention Services - Direct Model
Professional Non-CLS	277	T1999	Enhanced Pharmacy
Professional Non-CLS	278	T2001	Transportation
Professional Non-CLS	279	T2002	Transportation
Professional Non-CLS	280	T2003	Transportation
Professional Non-CLS	281	T2004	Transportation
Professional Non-CLS	282	T2005	Transportation

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Service_Category	LineID	Service	Service Description
Professional Non-CLS	284	T2024	Prevention Services - Direct Model
Professional Non-CLS	285	T2025	Fiscal Intermediary Services
Professional Non-CLS	286	T2028	Enhanced Medical Equipment-Supplies
Professional Non-CLS	287	T2029	Enhanced Medical Equipment-Supplies
Professional Non-CLS	290	T2038	Housing Assistance
Professional Non-CLS	291	T2039	Enhanced Medical Equipment-Supplies
Professional Non-CLS	17	0906	Substance Abuse: Outpatient
Professional Non-CLS	20	1002	Substance Abuse: Subacute Detoxification
Professional Non-CLS	23	80300	Substance Abuse: Drug Screen for Methadone Clients Only
Professional Non-CLS	24	80301	Substance Abuse: Drug Screen for Methadone Clients Only
Professional Non-CLS	25	80302	Substance Abuse: Drug Screen for Methadone Clients Only
Professional Non-CLS	26	80303	Substance Abuse: Drug Screen for Methadone Clients Only
Professional Non-CLS	27	80304	Substance Abuse: Drug Screen for Methadone Clients Only
Professional Non-CLS	28	80305	Substance Abuse: Drug Screen for Methadone Clients Only
Professional Non-CLS	29	80306	Substance Abuse: Drug Screen for Methadone Clients Only
Professional Non-CLS	30	80307	Substance Abuse: Drug Screen for Methadone Clients Only
Professional Non-CLS	32	90785	Substance Abuse: Interactive Complexity - Add On Code
Professional Non-CLS	34	90791	Substance Use: Assessment
Professional Non-CLS	36	90792	Substance Use: Assessment
Professional Non-CLS	38	90832	Substance abuse: Outpatient Care
Professional Non-CLS	41	90834	Substance abuse: Outpatient Care
Professional Non-CLS	44	90837	Substance abuse: Outpatient Care
Professional Non-CLS	49	90846	Substance Abuse: Psychotherapy (group)
Professional Non-CLS	51	90847	Substance Abuse: Outpatient Care
Professional Non-CLS	54	90849	Substance Abuse: Psychotherapy (group)
Professional Non-CLS	56	90853	Substance Abuse: Outpatient Treatment
Professional Non-CLS	116	99201	Substance Abuse: New Patient Evaluation and Management
Professional Non-CLS	118	99202	Substance Abuse: New Patient Evaluation and Management
Professional Non-CLS	120	99203	Substance Abuse: Physician Evaluation/Exam Under methadone
Professional Non-CLS	122	99204	Substance Abuse: Physician Evaluation/Exam Under methadone
Professional Non-CLS	124	99205	Substance Abuse: Physician Evaluation/Exam Under methadone
Professional Non-CLS	126	99211	Substance Abuse: Established Patient Evaluation and Management
Professional Non-CLS	128	99212	Substance Abuse: Established Patient Evaluation and Management
Professional Non-CLS	130	99213	Substance Abuse: Established Patient Evaluation and Management
Professional Non-CLS	132	99214	Substance Abuse: Established Patient Evaluation and Management
Professional Non-CLS	134	99215	Substance Abuse: Established Patient Evaluation and Management
Professional Non-CLS	181	G0409	Substance Abuse: Recovery Support Services
Professional Non-CLS	182	H0001	Substance Abuse: Individual Assessment
Professional Non-CLS	184	H0003	Substance Abuse: Laboratory Tests
Professional Non-CLS	185	H0004	Substance Abuse: Outpatient Treatment
Professional Non-CLS	186	H0005	Substance Abuse: Outpatient Care
Professional Non-CLS	187	H0010	Substance Abuse: Sub-Acute Detoxification
Professional Non-CLS	188	H0012	Substance Abuse: Sub-Acute Detoxification
Professional Non-CLS	189	H0014	Substance Abuse: Sub-Acute Detoxification
Professional Non-CLS	190	H0015	Substance Abuse: Outpatient Care
Professional Non-CLS	192	H0018	Substance Abuse: Residential Services
Professional Non-CLS	193	H0019	Substance Abuse: Residential Services
Professional Non-CLS	194	H0020	Substance Abuse: Methadone
Professional Non-CLS	195	H0022	Substance Abuse: Early Intervention
Professional Non-CLS	197	H0023	Substance Abuse: Peer Directed and Operated Support Services
Professional Non-CLS	203	H0033	Substance Abuse: Pharmalogical Support - Suboxone
Professional Non-CLS	209	H0038	Substance Abuse: Peer Services
Professional Non-CLS	215	H0048	Substance Abuse: Laboratory Tests
Professional Non-CLS	216	H0050	Substance Abuse: Individual Treatment
Professional Non-CLS	221	H2011	Substance Abuse: Crisis Intervention, per 15 minutes
Professional Non-CLS	231	H2027	Substance Abuse Outpatient: Didactics
Professional Non-CLS	234	H2035	Substance Abuse Outpatient
Professional Non-CLS	235	H2036	Substance Abuse: Outpatient Care
Professional Non-CLS	268	T1007	Substance Abuse: Treatment Planning
Professional Non-CLS	269	T1012	Substance Abuse: Recovery Supports

Appendix 8: Eligibility Data Dictionary

State of Michigan Department of Health and Human Services Specialty Services and Supports Waiver Scope Code Dictionary		
Scope Code	**Description**	**Qualifying Information**
0	Medicaid	Not eligible
1	Medicaid	When used in conjunction with Coverage Codes D, E, F, K, P, Q, T, U, or V
2	Medicaid	When used in conjunction with Coverage Codes B, C, E, F, J, H, T, V, or 0 (zero)
3	Healthy Michigan Plan	When used in conjunction with Coverage Codes E or G
4	Refugees and Repatriates	When used in conjunction with Coverage Code F
5		Restricted to those counties participating in HCAP
6	APS (Ambulatory Prenatal Services)	Presumptive
7	MiChild	When used in conjunction with Coverage Codes E or W
8	Medicaid - Flint	When used in conjunction with Coverage Codes L or E

State of Michigan Department of Health and Human Services Specialty Services and Supports Waiver Coverage Code Dictionary	
Coverage Code	**Description**
0 (zero)	No Medicaid eligibility/coverage (refer to the Medicaid Deductible Beneficiaries Section of this chapter for additional information)
B	Qualified Medicare Beneficiary (QMB) (pays Medicare Parts A & B premiums, coinsurances, and deductibles; member still has to meet spend down)
C	Specified Low Income Medicare Beneficiary (SLMB) (pays Medicare Part B premium only, no MA coverage)
D	Freedom to Work Beneficiary (full Medicaid coverage)
E	Emergency or urgent Medicaid coverage only
F	Full Medicaid coverage
G	Adult Benefits Waiver (ABW) (full ABW coverage)
H	Additional Low Income Medicare Beneficiary (ALMB) (pays Medicare Part B premium only, no MA coverage)
J	Additional Low Income Medicare Beneficiary (ALMB) (pays part of Medicare Part B premium)
K	Freedom to Work Beneficiary (full Medicaid coverage)
L	Flint Water, Program code is F
M	ABW prior to 2004 called SMP (State Medical Program)
P	Transitional Medical Assistance-Plus (TMA-Plus) (full Medicaid coverage)
Q	Medicare Qualified Disabled Working Individual - State covers premium only
R	Resident County Hospitalization only (administered by the local DHS office which approves hospitalization and is the payer)
S	Ambulatory Prenatal Services (APS)
T	Healthy Kids (full Medicaid coverage)
U	Transitional Medical Assistance-Plus (TMA-Plus) (emergency services only)
V	Healthy Kids Expansion (emergency services only)
W	MiChild (or whatever TOA Bridges selects) Full coverage
Y	Family Planning Waiver (family planning services only)

State of Michigan Department of Health and Human Services Specialty Services and Supports Waiver Program Code Dictionary	
Program Code	**Description**
A	Medicaid for aged SSI recipients
B	Medicaid for blind SSI recipients
C	FIP and LIF recipients
E	Medicad for disabled SSI recipients
F	Full Medicaid (will be used with scope/coverage 8L or 8E)
G	ABW Recipeints
H	Healthy Michigan Plan
I	FIP and Refugee Assistance Program Medical Aid
J	Refugee Assistance Program Medical Aid
K	Ambulatory Prenatal Services (APS)
L	Medicaid for Pregnant Women and Healthy Kids categories
M	Medicaid for the aged
N	Medicaid under: Caretaker relatives, Low-Income Family, Transitional MA, and Special N Support. Also, for Medical coverage under TMA-Plus
O	Medicaid for the blind
P	Medicaid for the disabled
Q	Medicaid for persons under age 21
R	Repatriate Assistance Program
T	MiChild
W	Default used by DCH

Appendix 9: Diagnosis Code Listing

State of Michigan Department of Health and Human Services Specialty Services and Supports Waiver Serious Mental Illness Diagnosis Codes			
Diagnosis Code	*Description of Diagnosis*	*Adult*	*Children*
F01	Vascular dementia	Y	Y
F02	Dementia in other diseases classified elsewhere	Y	Y
F03	Unspecified dementia	Y	Y
F04	Amnestic disorder due to known physiological condition	Y	Y
F05	Delirium due to known physiological condition	Y	Y
F06	Other mental disorders due to known physiological condition	Y	Y
F07	Personality and behavioral disorders due to known physiological condition	Y	Y
F09	Unspecified mental disorder due to known physiological condition	Y	Y
F20	Schizophrenia	Y	Y
F21	Schizotypal disorder	Y	Y
F22	Delusional disorders	Y	Y
F23	Brief psychotic disorder	Y	Y
F24	Shared psychotic disorder	Y	Y
F25	Schizoaffective disorders	Y	Y
F28	Other psychotic disorder not due to a substance or known physiological condition	Y	Y
F29	Unspecified psychosis not due to a substance or known physiological condition	Y	Y
F30	Manic episode	Y	Y
F31	Bipolar disorder	Y	Y
F32	Major depressive disorder, single episode	Y	Y
F33	Major depressive disorder, recurrent	Y	Y
F34	Persistent mood [affective] disorders	Y	Y
F39	Unspecified mood [affective] disorder	Y	Y
F40	Phobic anxiety disorders	Y	Y
F41	Other anxiety disorders	Y	Y
F42	Obsessive-compulsive disorder	Y	Y
F44	Dissociative and conversion disorders	Y	Y
F45	Somatoform disorders	Y	Y
F48	Other nonpsychotic mental disorders	Y	Y
F50	Eating disorders	Y	Y
F51	Sleep disorders not due to a substance or known physiological condition	Y	Y
F52	Sexual dysfunction not due to a substance or known physiological condition	Y	Y
F53	Puerperal psychosis	Y	Y
F54	Psychological and behavioral factors associated with disorders or diseases classified elsewhere	Y	Y
F55	Abuse of non-psychoactive substances	Y	Y
F59	Unspecified behavioral syndromes associated with physiological disturbances and physical factors	Y	Y
F60	Specific personality disorders	Y	Y
F63	Impulse disorders	Y	Y
F64	Gender identitiy disorders	Y	Y
F65	Paraphilias	Y	Y
F66	Other sexual disorders	Y	Y
F68	Other disorders of adult personality and behavior	Y	Y
F69	Unspecified disorder of adult personality and behavior	Y	Y
F93	Emotional disorders with onset specific to childhood	Y	Y
F94	Disorders of social functioning with onset specific to childhood and adolescence	Y	Y
F95	Tic disorder	Y	Y
F98	Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence	Y	Y
F99	Mental disorder, not otherwise specified	Y	Y
F43	Reaction to severe stress, and adjustment disorders	N	Y
F90	Attention-deficit hyperactivity disorders	N	Y
F91	Conduct disorders	N	Y

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Developmentally Disabled Diagnosis Codes

Rx HCC Group	Diagnosis Code	Description of Diagnosis	Adult	Children
Mild	F70	Mild intellectual disabilities	Y	Y
Moderate	F71	Moderate intellectual disabilities	Y	Y
Severe	F72	Severe intellectual disabilities	Y	Y
Severe	F73	Profound intellectual disabilities	Y	Y
Mild	F78	Other intellectual disabilities	Y	Y
Mild	F79	Unspecified intellectual disabilities	Y	Y
Other	G31.84	Mild cognitive impairment, so stated	Y	Y
Other	E75.23	Krabbe disease	Y	Y
Other	E75.25	Metachromatic leukodystophy	Y	Y
Other	E75.29	Other sphingolipidosis	Y	Y
Other	F80	Specific developmental disorders of speech and language	Y	Y
Other	F81	Specific developmental disorders of scholastic skills	Y	Y
Other	F82	Specific developmental disorder of motor function	Y	Y
Other	F84	Pervasive developmental disorders	Y	Y
Other	F88	Other disorders of psychological development	Y	Y
Other	F89	Unspecified disorder of psychological development	Y	Y
Other	G40.9	Epilepsy, unspecified	Y	Y
Other	G80.0	Spastic quadriplegic cerebral palsy	Y	Y
Other	G80.9	Cerebral palsy, unspecified	Y	Y
Other	Q871	Congenital malformation syndromes predominantly associated with short stature	Y	Y
Other	Q90	Down syndrome	Y	Y
Mild	Q91	Trisomy 18 and Trisomy 13	Y	Y
Mild	Q92	Other trisomies and partial trisomies of the autosomes, not elsewhere classified	Y	Y
Mild	Q93	Monosomies and deletions from the autosomes, not elsewhere classified	Y	Y
Mild	Q95.2	Balanced autosomal rearrangement in abnormal individual	Y	Y
Mild	Q95.3	Balanced sex/autosomal rearrangement in abnormal individual	Y	Y
Mild	Q99.2	Fragile X chromosome	Y	Y

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Department of Health and Human Services
Specialty Services and Supports Waiver
Alcohol and Drug Abuse Diagnosis Codes

Diagnosis Code	Description of Diagnosis	Adults	Children
F10	Alcohol related disorders	Y	Y
F11	Opioid related disorders	Y	Y
F12	Cannabis related disorders	Y	Y
F13	Sedative, hypnotic, or anxiolytic related disorders	Y	Y
F14	Cocaine related disorders	Y	Y
F15	Other stimulant related disorders	Y	Y
F16	Hallucinogen related disorders	Y	Y
F17	Nicotine dependence	Y	Y
F18	Inhalant related disorders	Y	Y
F19	Other psychoactive substance related disorders	Y	Y

Appendix 10: Assessment Services

State of Michigan Department of Health and Human Services Specialty Services and Supports Waiver Specialty Services Assessment Code List	
Service Code	***Description of Service Code***
90791	Assessment
90792	Assessment
90887	Assessments – Other
96101	Assessments – Testing
96102	Assessments – Testing
96103	Assessments – Testing
96105	Assessments – Other
96110	Assessments – Other
96111	Assessments – Other
96116	Assessments - Testing
96118	Assessments – Testing
96119	Assessments – Testing
96120	Assessments - Testing
97802	Assessment or Health Services
97803	Assessment or Health Services
H0001	Substance Abuse: Individual Assessment
H0002	Assessment
H0003	Laboratory Tests
H0031	Assessment
H0048	Assessment
T1001	Assessment
T1023	Assessments

Appendix 11: County to Region Crosswalk

State of Michigan, Department of Health and Human Services
October 1, 2017 to September 30, 2018 Specialty Service Capitation Rates
County to Region Crosswalk

County Name	County Code	PIHP ID	PIHP Name	Region
Alcona	01	174476116	North Country	2
Alger	02	174456786	North Care	1
Allegan	03	174456543	Southwest Alliance	3
Alpena	04	174476116	North Country	2
Antrim	05	174476116	North Country	2
Arenac	06	174454629	Access Alliance	5
Baraga	07	174456786	North Care	1
Barry	08	174458360	Venture	4
Bay	09	174454629	Access Alliance	5
Benzie	10	174456650	CMH Affiliation of Mid-MI	2
Berrien	11	174458360	Venture	4
Branch	12	174458360	Venture	4
Calhoun	13	174458360	Venture	4
Cass	14	174456543	Southwest Alliance	4
Charlevoix	15	174476116	North Country	2
Cheboygan	16	174476116	North Country	2
Chippewa	17	174456786	North Care	1
Clare	18	174454530	CMH for Central Michigan	5
Clinton	19	174456650	CMH Affiliation of Mid-MI	5
Crawford	20	174540039	Northern Lakes	2
Delta	21	174456786	North Care	1
Dickinson	22	174456786	North Care	1
Eaton	23	174456650	CMH Affiliation of Mid-MI	5
Emmet	24	174476116	North Country	2
Genesee	25	174456580	Genesee	10
Gladwin	26	174454530	CMH for Central Michigan	5
Gogebic	27	174456786	North Care	1
Grand Traverse	28	174540039	Northern Lakes	2
Gratiot	29	174456650	CMH Affiliation of Mid-MI	5
Hillsdale	30	174456848	Lifeways	5
Houghton	31	174456786	North Care	1
Huron	32	174454629	Access Alliance	5
Ingham	33	174456650	CMH Affiliation of Mid-MI	5
Ionia	34	174456650	CMH Affiliation of Mid-MI	5
Iosco	35	174476116	North Country	2
Iron	36	174456786	North Care	1
Isabella	37	174454530	CMH for Central Michigan	5
Jackson	38	174456848	Lifeways	5
Kalamazoo	39	174456543	Southwest Alliance	4
Kalkaska	40	174476116	North Country	2
Kent	41	174483611	Network 180	3
Keweenaw	42	174456786	North Care	1
Lake	43	174540039	Northern Lakes	3
Lapeer	44	174458261	Thumb Alliance	10
Leelanau	45	174540039	Northern Lakes	2
Lenawee	46	174455653	Southeast Partnership	6
Livingston	47	174455653	Southeast Partnership	6
Luce	48	174456786	North Care	1
Mackinac	49	174456786	North Care	1
Macomb	50	174456875	Macomb	9
Manistee	51	174456650	CMH Affiliation of Mid-MI	2
Marquette	52	174456786	North Care	1
Mason	53	174540039	Northern Lakes	3
Mecosta	54	174454530	CMH for Central Michigan	5
Menominee	55	174456786	North Care	1
Midland	56	174454530	CMH for Central Michigan	5
Missaukee	57	174540039	Northern Lakes	2
Monroe	58	174455653	Southeast Partnership	6
Montcalm	59	174454629	Access Alliance	5
Montmorency	60	174476116	North Country	2
Muskegon	61	174454413	Lakeshore Affiliation	3
Newaygo	62	174456650	CMH Affiliation of Mid-MI	5
Oakland	63	174458252	Oakland	8
Oceana	64	174540039	Northern Lakes	3
Ogemaw	65	174476116	North Country	2
Ontonagon	66	174456786	North Care	1
Osceola	67	174454530	CMH for Central Michigan	5
Oscoda	68	174476116	North Country	2
Otsego	69	174476116	North Country	2
Ottawa	70	174454413	Lakeshore Affiliation	3
Presque Isle	71	174476116	North Country	2
Roscommon	72	174540039	Northern Lakes	2
Saginaw	73	174456561	Saginaw	5
St. Clair	74	174458261	Thumb Alliance	10
St. Joseph	75	174456543	Southwest Alliance	4
Sanilac	76	174458261	Thumb Alliance	10
Schoolcraft	77	174456786	North Care	1
Shiawassee	78	174454629	Access Alliance	5
Tuscola	79	174454629	Access Alliance	5
Van Buren	80	174458360	Venture	4
Washtenaw	81	174455653	Southeast Partnership	6
Wayne	82	174456679	Detroit-Wayne	7
Wexford	83	174540039	Northern Lakes	2
Foreign	84	174456679	Detroit-Wayne	Unknown

Appendix 12: Autism Fee Schedule

State of Michigan, Department of Health and Human Services October 1, 2018 to September 30, 2019 Specialty Service Capitation Rates Autism Program Reimbursement Rates by Provider Type								
New Code	Service Description	Reporting Units	Provider Type	BCBA	BCaBA	QBHP	LP/LLP	BT
0359T	Behavior identification assessment includes interpretation of results and development of the behavioral plan of care. Untimed typically 4 hours and no more than twice a year.	Encounter	BCBA, BCaBA or QBHP, LP/LLP	$ 480.00	$ 340.00	$ 480.00	$ 480.00	
0362T	Exposure behavioral follow-up assessment (Functional Behavior Analysis/FBA)	First 30 minutes	BCBA, BCaBA or QBHP, LP/LLP	$ 60.00	$ 42.50	$ 60.00	$ 60.00	
+0363T	Exposure behavioral follow-up assessment (FBA) each additional 30 minutes	Each additional 30		$ 60.00	$ 42.50	$ 60.00	$ 60.00	
0364T	Adaptive behavior treatment by protocol administered by technician first 30 minutes	First 30 minutes	BCBA, BCaBA or QBHP, LP/LLP, BT	$ 30.00	$ 30.00	$ 30.00	$ 30.00	$ 25.00
+0365T	Adaptive behavior treatment by protocol administered by technician each additional 30 minutes	Each additional 30		$ 30.00	$ 30.00	$ 30.00	$ 30.00	$ 25.00
0366T	Group adaptive behavior treatment by protocol administered by technician first 30 minutes	First 30 minutes	BCBA, BCaBA or QBHP, LP/LLP, BT	$ 8.57	$ 8.57	$ 8.57	$ 8.57	$ 7.86
+0367T	Group adaptive behavior treatment by protocol administered by technician additional 30 minutes	Each additional 30		$ 8.57	$ 8.57	$ 8.57	$ 8.57	$ 7.86
0368T	Adaptive behavior treatment with protocol modification and clinical observation & direction administered by qualified professional first 30 minutes	First 30 minutes	BCBA, BCaBA or QBHP, LP/LLP	$ 60.00	$ 42.50	$ 60.00	$ 60.00	
+0369T	Adaptive behavior treatment with protocol modification and clinical observation & direction administered qualified professional each additional 30 minutes	Each additional 30	BCBA, BCaBA or QBHP, LP/LLP	$ 60.00	$ 42.50	$ 60.00	$ 60.00	
0370T	Family behavior treatment guidance administered by qualified professional. Untimed typically 60 - 75 min	Encounter	BCBA, BCaBA or QBHP, LP/LLP	$ 120.00	$ 85.00	$ 120.00	$ 120.00	
0371T	Multiple Family behavior treatment guidance administered by qualified professional. Untimed typically 90-105.	Encounter	BCBA, BCaBA or QBHP, LP/LLP	$ 72.00	$ 51.00	$ 72.00	$ 72.00	
0372T	Adaptive behavior treatment social skills group. Untimed typically 90-105	Encounter	BCBA, BCaBA or QBHP, LP/LLP	$ 51.43	$ 36.43	$ 51.43	$ 51.43	
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior (s); first 60 minutes of technician's time, face to face	First 60 minutes	BCBA, BCaBA or QBHP, LP/LLP, BT	$ 120.00	$ 120.00	$ 120.00	$ 120.00	$ 110.00
0374T		Each additional 30		$ 60.00	$ 60.00	$ 60.00	$ 60.00	$ 55.00

Appendix 13: Health Professional Shortage Area Factors

Health Professional Shortage Area Factors

Health professional shortage area designations are used to identify geographic rations within the U.S. that are experiencing a shortage of health professionals. The criteria for being a mental health geographic shortage area include:

- Population to core mental health professional ratio above 9,000:1; or,
- Population to psychiatrist ratio above 30,000:1; or,
- Mental health professionals in contiguous areas are over utilized, excessively distant, or inaccessible.

The mental health professionals included in this calculation are the following:

- Psychiatrists
- Clinical psychologists
- Clinical social workers
- Psychiatric nurse specialists
- Marriage and family therapists

More information regarding the mental health professional shortage areas can be found at: http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaoverview.html.

We determined the percentage of each county that is identified as a shortage area using a listing of shortage areas provided by CMS at the zip code level and the total population by zip code. To get the information at a PIHP level, we utilized DAB and TANF membership by county.

Consistent with CMS methodology[2], our methodology assumes that PIHPs serving health professional shortage areas reimburse providers at a rate 10% greater than geographic areas that are not classified as a shortage area. The table below illustrates the development of the HPSA factors. The unadjusted HPSA factor is normalized by calculating the composite HPSA factor (by weighting the HPSA factor by the projected SFY 2018 capitation payments) and dividing the unadjusted HPSA factor by the composite HPSA factor. The HPSA factors were normalized so that the impact of including it is budget neutral from MDHHS' perspective. It is not intended to introduce additional funding into the delivery system. The table below illustrates the development of the HPSA factor for the DAB population. The HPSA factors for the TANF and HMP populations do not vary materially.

State of Michigan
Department of Health and Human Services
October 1, 2018 to September 30, 2019 Capitation Rates
HPSA Factor Development – DAB

PIHP	% of Population in Shortage Area	Unadjusted HPSA Factor	Normalized HPSA Factor
Northcare	82%	1.08	1.05
Northern Michigan	86%	1.09	1.05
Lakeshore	22%	1.02	0.99
Southwest	41%	1.04	1.01
Mid-State	56%	1.06	1.02
Southeast	17%	1.02	0.99
Detroit-Wayne	30%	1.03	1.00
Oakland	0%	1.00	0.97
Macomb	0%	1.00	0.97
Region 10	6%	1.01	0.97
Composite HPSA Factor		**1.03**	**1.00**

The unadjusted HPSA factor is calculated as one plus the percentage of the population in a shortage area multiplied by 10%. For Region 1, this is (1 + (0.82 * 10%)) = 1.08.

[2] See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html?redirect=/hpsapsaphysicianbonuses/01_overview.asp for more information.

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